HIV Integrated Planning Council
Comprehensive Planning
Thursday, April 19, 2018
2:00-4:00pm
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Baron, Mark Coleman, Tiffany Dominique, Gerry Keys, La'Seana Jones, Nicole Miller, Jeannette Murdock, Ann Ricksecker, Joseph Roderick

Excused: Pamela Gorman, Peter Houle, Adam Thompson, Lorrita Wellington

Absent: Keith Carter, Dorothy McBride-Wesley, Leroy Way

Guests: Jessica Browne— *AACO*

Staff: Nicole Johns, Briana Morgan, Stephen Budhu

Call to Order: T. Dominque called the meeting to order at 2:05pm. Those present then introduced themselves.

Approval of Agenda: T. Dominque presented the agenda for approval. **Motion:** G. Keys moved, D. Gana seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: T. Dominque presented the minutes for approval. **Motion:** D. Gana moved, G. Keys seconded to approve the minutes. **Motion Passed:** All in favor.

Report of Chair: T. Dominique stated A. Thompson sends his apologies for his absence.

Report of Staff: N. Johns explained the agenda items to the committee. Under the "Discussion Items" section the committee will continue review of the November brainstorming session. The committee is on the last section of recommendations (green), and there are only a few recommendations left to discuss. The committee will also look at the strategies under goals 2 and 3 of the integrated plan and 2016 baseline data that is associated with each strategy. Under the "New Business" section the committee will discuss the racial disparities, in reference to J. Malloy's public comment in the April HIPC meeting.

Action Items: None

Discussion Items:

- **Continuation of Brainstorming Recommendations Review (Green)**

Guidance on reporting issues formal complaint process

N. Johns stated the remaining recommendations under the green category were written on the white board in the front of the room.

K. Baron asked what the intended scope of this recommendation was. She stated agencies already have grievance procedures; is the purpose of this recommendation to change those procedures or review them? D. Gana replied, in his opinion, this recommendation may be about having a centralized grievances process where clients will have a clear idea on how to file a grievance. In many cases the grievance procedures of agencies are complex and systematic, so clients are unsure on what steps to take in order to

file one. Agencies often do not explain their grievance procedures to their clients and they divert them to the health department help line.

T. Dominique asked if this recommendation is about changing grievance processes of agencies or making sure the processes that are already in place are properly explained to clients. N. Johns explained there may be a lack of knowledge from clients and agencies may defer clients to call the help line for complaints. G. Keys stated often agencies handle grievances in house, and there is no way to track these complaints. She suggested agencies may not review their grievances and the grievances do not get escalated further. There is no mechanism for the grievances to be sent to the health department, and she suggested the committee could look into this further. J. Browne stated even though she did not work for the Client Services Unit, in her experience at AACO it has been a rare occurrence for grievances to be sent to the Recipient from provider agencies.

N. Johns explained the grievance procedures of agencies are systematic. When a grievance is filed at an agency that agency will try to solve the issue in house before sending the grievance to the Recipient.

K. Baron stated she was unsure of this recommendation's scope; the term "guidance" is unusual in this context. Guidance is usually given to AACO from HIPC not necessarily to clients in this context. A. Ricksecker suggested the grievance procedure needs to be centralized and these grievances should be heard by the Recipient. Grievances could be reviewed by the Recipient possibly quarterly, and the Recipient could report on reoccurring issues to the HIPC.

After discussion, the committee voiced their concerns with this recommendation's ambiguity. The committee decided to table discussion of this recommendation.

Agency-level training for all staff about Ryan White

N. Johns stated this recommendation is about training all agency staff who are in contact with Ryan White clients. All staff should have a basic understanding of the Ryan White system. K. Baron asked if this was asking the Recipient to require a mass training. N. Johns replied that would be the discretion of the HIPC to recommend to the Recipient. Agencies could have in house trainings possibly during staff meetings, as opposed to a mass training.

D. Gana stated providers may be aware of services within the Ryan White System; they may not advertise services that are not offered outside of their agency. Healthcare is still a business and a provider may not advertise services that are offered by their direct competition. Funding is distributed proportional to the number of clients served within the fiscal year.

A. Ricksecker stated this recommendation is tricky for large health centers that have HIV services embedded in a larger facility. The training for these agencies would be large scale even if the training was in house. This recommendation is only practical for agencies that are HIV specific. G. Keys agreed and added with health centers there are numerous patients and only a small percentage of the patients maybe HIV+. Within health centers there are many clinics that have different focuses, and it would not be practical for large scale agencies to institute these trainings. Nonetheless, staff working in the HIV clinic should be aware of the Ryan White services. T. Dominique asked if this was a tiered approach based on the agency. A. Ricksecker stated it should be tiered to include all HIV-related staff.

T. Dominique asked how agencies would report their trainings to the Recipient. How would the process be documented to show agencies are doing training? A. Ricksecker suggested agencies could add a training section in their quarterly report to the Recipient.

Service recovery training for all staff to help recover from difficult interactions to preserve relationships.

N. Johns stated this recommendation was for the recovery of staff after a client miss-gendering or other problematic event. For example: when staff has a miss-gendering event with a client who is transgender. This training would be used to make sure staff can recover from such events and have a positive relationship with the client going forward.

T. Dominique stated service recovery training is not applicable in all situations. Service recovery training cannot be applied in situations where lab tests ask for sex at birth. If staff reads off lab results and miss-genders someone who has a different sex than they were assigned at birth, there may be a potential issue. A. Ricksecker stated in that situation it would require a system change not a training. A. Ricksecker asked what labs would ask about sex at birth. T. Dominique replied many lab tests frequently ask about sex at birth.

K. Baron stated if the committee were to recommend these trainings could we provide a list of places that host trainings and recommend front line staff receive trainings first.

A. Ricksecker stated this recommendation came out of a brainstorming session, and some of the recommendations did not need to be further discussed, they could be tabled until further notice. This recommendation should be tabled, in her opinion.

D. Gana stated this recommendation may go past mis-gendering persons, and it could also be extrapolated to when case managers misinform their clients, clients may suffer when they are misinformed.

N. Johns asked the committee if they wanted to continue discussion going forward or table this recommendation, as per A. Ricksecker's suggestion. The committee decided to table discussion of this recommendation.

- **Review of Activities from the Integrated Plan**

N. Johns asked the committee to review the meeting packet. In the packet there is printout of excerpts from the integrated plan, specifically goals 2 and 3; goals 1 and 4 were omitted because they do not fall into the scope of this committee. T. Dominique asked what the orange color coating signified. N. Johns replied items in orange are ideas that should be discussed today.

N. Johns reviewed the integrated plan handout. She explained the columns from left to right are as follows: Strategy #, Activity, Responsible parties, Target population, Data Source, Baseline 2016, and Notes. N. Johns explained the OHP was in the process of updating the integrated plan but reminded the committee the plan is a 5-year plan from 2017-2021. The plan itself was written in 2016.

M. Coleman asked how funding cuts by the presidential administration will affect the activities within the plan. Is the plan flexible enough to absorb funding changes? N. Johns replied there is no expected change in Ryan White funded services at this point in time. The Ryan White grant is well supported within congress. Other health care services, that are not Ryan White affiliated, may be subject to change. A. Ricksecker suggested there should be updates about funding in the Ryan White system within HIPC meetings. K. Baron stated she would bring this up at the next HIPC meeting.

The committee began review of goal 2: Increase access to care and improve health outcomes for people living with HIV. The committee discussed strategies under objective 2.1.

2.1.1: Reduce individual and programmatic barriers to care under goal 2.1: Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis. Under strategy 2.1.1 there are two activities: *continue development and delivery of evidence-based (and informed) and protocol driven linkage services such as CORECT, DIS linkage, services and NJ clinical navigation programs and expand access to supportive services that enable timely linkage to care, including transportation and psychosocial support. Responsible parties are PDPH, PADOH, NJDPH, HIPC.*

A. Ricksecker stated a larger proportion of the EMA's budget has been designated to support services. She suggested the baseline data should include the proportion of funding for support services in the part A grant. To address linkage to care issues psychosocial services need to receive funding. N. Johns stated A. Ricksecker's suggestion could be an activity under strategy 2.1.1.T. Dominique stated this strategy did not focus about retention in care just new engagement in care. N. Johns replied there are strategies that are focused on care retention later on in the plan. She reminded the committee the plan does not include all activities in the Ryan White system, it is more of a snap shot.

The committee discussed strategy 2.1.2: reduce systemic barriers to timely linkage to care. Under this strategy are 2 activities: *continue to support a range of co-located HIV testing and clinical services and develop protocols for immediate linkage to care for persons who test in community settings*. T. Dominique asked why MOUs are in strikethrough under the data source column. N. Johns stated this was because the Recipient did not have MOU data to give at this time.

The committee discussed strategy 2.1.3: reduce individual barriers to Ryan White services for newly diagnosed individuals. Under this strategy there are 2 activities: *disseminate information about Ryan White services for newly diagnosed individuals and continue provision of centralized medical case management intake*. The responsible parties for both activities are the PDPH, Mid-Atlantic AETC, NJ AETC, and the HIPC. The target population is non-Ryan White clinical providers, hospitals and PLWH.

T. Dominique stated the target population of Non-Ryan White clinical providers and hospitals is vast. It may not be feasible to reach that target population. A. Ricksecker stated this activity (disseminate info) is not the job of the AETC. The AETC has specific job requirements given by HRSA, and this activity does not align with them. The role of the AETC is to disseminate information that will cause more people link to HIV treatment. N. Johns suggested the responsible parties could be updated to omit the AETC and to include the PDPH and the HIPC. A. Ricksecker stated the #TA units would not be the data source. N. Johns also suggested the target population could change to newly diagnosed PLWH. T. Dominique suggested the responsible parties should be the NJDOH, PADOH, PDPH as well as the HIPC.

N. Johns moved the committee's discussion to strategy 2.2.1: reduce individual barriers to retention in HIV care. This strategy has 3 activities: continue co-located clinical and supportive services including mental health, substance use treatment, and medical case management; provide ongoing assessment of behavioral health needs of patients in HIV clinical providers and linkages to appropriate services; provide data-to-care activities including CoRECT and ARTAS to find and reengage clients to care who have been lost to care. The target population for the strategy are PDPH, PADOH, HIPC, Ryan White providers, and Ryan White clinical providers. The target populations are PLWH and PLWH who have fallen out of care. Baseline 2016 data shows 16 clinical sites have supportive services, 302 ARTAS clients have been linked to care, and 84.1% were Ryan White clients.

A. Ricksecker stated the activity should expand on activity 2 under strategy 2.2.1. The plan is a 5-year plan and it should incorporate more data on the behavioral health needs of HIV+ persons. The plan should look to identify "warm hand-offs' in linkage to care data for PWID who are HIV+. N. Johns explained strategies under goal 1 focus on expanding services for PWID. Specifically, strategy 1.2.3: Ensure equitable access to syringe access services, substance use treatment and related harm reduction services. Goal 1's objectives and strategies were not presented to this committee, it's scope did not coincide with that of the committee. The Prevention Committee is reviewed goal 1.

The committee reviewed strategy 2.2.2: reduce programmatic and provider barriers to retention in HIV care. Under this strategy there are three activities: ensure all Ryan White services are linguistically and culturally competent and LGBTQ affirming; promote adoption of trauma-informed approaches; support vigorous pursuit of health insurance enrollment of all eligible Ryan White clients. N. Johns stated under this activity the CSU grievance data is the data measure. As mentioned there is not much grievance data so there is no 2016 baseline data to review. In regards to the consumer survey, there was fewer than expected survey responses received in Spanish. It is possible those who had language barriers with the survey could not say they had language barriers. A. Ricksecker suggested auditing providers for cultural competence would be useful, but she admitted there was not enough funding or personnel for this to happen. T. Dominique noted José Bauermeister, presidential professor at UPenn, was conducting a provider research study. The study scored providers based on certain criteria including linguistic and cultural competence. T. Dominique suggested his research could be incorporated into the data measures and baseline data sections for integrated plan review.

T. Dominique asked J. Browne if the Recipient uses culturally appropriate dialogues in "secret shopper calls". J. Browne replied it does not happen currently, but there are plans to have secret shopper calls conducted in Spanish.

The committee reviewed strategy 2.2.3: reduce systemic barriers to retention in HIV care. Under this strategy there are 2 activities: develop a plan to address documented barriers to retention in care, including transportation; determine the most cost-effective, and feasible mechanism to provide health insurance cost-sharing assistance.

The committee briefly reviewed strategies 2.3.1, 2.3.2, 2.3.3, 2.4.1, 2.4.2. In reference to the activity under 2.3.3, support comprehensive ADAP formulary including access to Hep-C treatment, B. Morgan notified the committee there was an ADDP presentation at the NJ HPG meeting. In New Jersey there is an open formulary for FDA approved treatments. A. Ricksecker stated the ADAP formulary percentage (91%), could be improved since the Recipient has recently received a grant to fund treatment of PLWH who are co-infected with Hep-C.

The committee reviewed strategy 2.4.3: provide services that combat economic and individual barriers to housing. Strategy 2.4.3 has 1 activity: ensure medical case managers assess and address housing instability when developing and reviewing the care plan. N. Johns stated there was no baseline data at the moment for this strategy. A. Ricksecker asked if there were features in Careware where the case manager could report the housing status of clients. J. Browne replied there are features and it is required that medical case managers report the housing status of their clients at least once a year; the Recipient encourages medical case managers to update housing statuses more frequently, however. D. Gana asked since Ryan White clients need to do recertification every 6 months could a housing status report be given at the time of recertification.

The committee concluded their discussion about the integrated plan with review of the strategies under goal 3. The committee briefly discussed strategies 3.1.1, and 3.2.1. In reference to first activity, "ensure

quality improvement efforts to address disparities along the care continuum in the Ryan White clinical and MCM services" under strategy 3.2.1, J. Browne stated the Recipient will be analyzing reported disparities in the health care settings. The Recipient will be looking for provider participation to conduct the analysis. Results will be reported to the HIPC at some point after the data collection and analysis period has ended.

A. Ricksecker stated strategy 3.2.1 carries the assumption the disparities are still vast in the Ryan White system. She noted the Recipient used to provide demographics data to the HIPC to help visualize disparities in the past. T. Dominique noted K Brady recently presented disparities data in her Epi presentation.

The committee briefly reviewed strategies 3.2.2, and 3.2.3. A. Ricksecker noted her comment about the Recipient receiving a Hep-C treatment grant, was better suited for strategy 3.2.3.

Motion: G. Keys moved, J. Murdock seconded to table the conversation and rest of the agenda due to time constraints. **Motion Passed:** All in favor.

Old Business: None

New Business: None

Announcements: M. Coleman announced April is sexual assault awareness month.

J. Murdock announced Hahnemann University Hospital is hosting an anal health symposium on Friday, April 20, 2018 from 8:30 am-12:00pm. You can register for the event on www.eventbrite.com

Adjournment: Motion: J. Murdock moved, D. Gana seconded to adjourn the meeting at 3:58 pm. **Motion Passed:** All in favor.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- Integrated Plan Excerpts