HIV Integrated Planning Council
Comprehensive Planning Committee
Thursday, June 21, 2018
2-4pm

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Baron, Mark Coleman, Tiffany Dominique, Pamela Gorman, Peter Houle, Gerry Keys, La'Seana Jones, Nicole Miller, Jeanette Murdock, Joseph Roderick, Gail Thomas,

Excused: Keith Carter, Dorothy McBride-Wesley, Ann Ricksecker, Adam Thompson, Leroy Way

Absent: Dave Gana, Loritta Wellington

Guests: Jessica Browne, Kristine Ousry, Stacy Smith

Staff: Nicole Johns, Stephen Budhu

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

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

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

Report of Chair: No report.

Report of Staff: N. Johns stated the OHP recently polled the HIPC members about committee meeting times. Of the 40 HIPC members, only 15 members completed the survey. Of the 15 responses, 6 of them were from the Comprehensive Planning Committee and they requested different meeting times for that committee. The responses suggested members were interested in having earlier meeting times, specifically mornings. Most of the other member responses stated they can attend the current meeting times of the HIPC subcommittees. N. Johns added A. Thompson has adjusted his schedule so his attendance will improve in the near future. From the lack of responses to the survey it was not likely committee meeting times would change, if change happens it would be at the discretion of the individual committee.

P. Houle referenced conversation from the May Comprehensive Planning meeting. He asked if it was still in the works to have the Executive Committee meet before the Comprehensive Planning Committee. If so, it may be easier for members who are out of state or have busy schedules to attend. N. Johns replied the Executive Committee does not meet regularly and they have not met since May 2018. Instead of shifting committee meeting days/times the HIPC now has the ability to host conference calling. The Nominations Committee announced in the June HIPC 2018 they are trying out a 3-month pilot with conference calling in the HIPC subcommittees. During the pilot period members will be able to participate virtually only once for their attendance to be marked as "present" on the attendance sheet.

T. Dominique reminded the committee that A. Thompson participated virtually via the Zoom platform in the last committee meeting. She asked how the committee how they felt about virtual participation in meetings. G. Thomas stated the Zoom platform was easy to use and the committee was able to hear A. Thompson clearly. J. Murdock agreed. G. Thomas added she thinks that conference calling should only

be used when a member is outside of the Philadelphia EMA. T. Dominique asked does the committee think the Nominations 3-month pilot should be followed, or should the committee allow more than 1 time for virtual attendance. G. Thomas replied she doesn't necessarily think that members should be limited to one time during that period but conference calling should only be used when members are outside of the Philadelphia EMA. K. Baron stated in some cases members could still be in the EMA but will be unable to make the meeting on time. In this case would it make more sense to just have those members to call into meetings in that situation? G. Thomas replied no; those members can be late, if they are still within the EMA they should make an effort to be here. Otherwise if we allow that, people will begin to take advantage of the privilege.

M. Ross-Russell stated the HIPC will start to examine the epidemic in the PA Counties; specifically, why the percentage of AIDS cases has increased over the last few years compared to the rest of the EMA.

N. Johns stated the OHP hosted a successful workshop at the Prevention and Outreach Summit earlier in June. She thanked T. Dominique, J. Murdock, and A. McCann-Woods for their participation during the workshop and stated positive feedback about the workshop has been received.

Action Items: None

Discussion Items:

- **Finalize Retention Plan**

N. Johns reminded the committee this discussion stems from the committee's November 2017 brainstorming session. Over the course of the past 6 months or so the committee has discussed some of its final recommendations towards retention. To help prioritize ideas the committee grouped ideas by feasibility by stratifying them into categories: green, yellow, and red; where green means a go, yellow means its plausible, and red means it's not feasible at this time.

N. Johns mentioned from the committee conversations over the past few months some of the recommendations may fall under an instruction to the Recipient. In some cases, instructions to the Recipient may require an allocation of funding. For those instructions to the Recipient that require funding it is imperative the committee finalizes those ideas and submits them before the summer allocations process. T. Dominique asked what the time frame was the committee had to submit instructions to the Recipient. N. Johns replied the committee should look to finalize instructions sooner rather than later, the committee will not meet in July due to the allocations meetings. If necessary the committee could schedule another meeting before the allocations period.

T. Dominique asked the committee to review the "Results of Comprehensive Planning Committee's work on improving retention in care November 2017-April 2018" handout. She suggested the committee could reviews its recommendations and discuss them before finalizing them.

Transportation

Under this section there are 3 main bullet points with two subpoints. They are as follows:

- AACO to develop mechanisms for providers to use Septa Key Cards to provide "on demand" fares for PLWH in need, especially when other forms of transportation are unreliable or unavailable. These could include adding fares to Key cards issued by providers on a monthly or "on demand" basis for medical appointments and other Ryan White-eligible services.
    - Definition of "failed transportation" needed

    - Assess whether UBER Health is an option for the Ryan White system as an alternative
- Advocate for alternative distribution for Medicaid SEPTA day passes since mailing passes to clients leads to delays. This will also help those PLWH experiencing homelessness or with housing insecurity. MCMs would be a good distribution point.
- Invite state-level Medicaid transportation person to HIPC to talk about barriers — working on this currently with PADOH

G. Keys stated the committee has had previous discussion about transportation. Recently the committee has discussed the change over from tokens to SEPTA Key cards. With the phase out of token ASOs are able to issue 24-hour round-trip non-reloadable passes to clients.

K. Baron suggested the directive to the Recipient could be to look into alternative methods to transportation, especially when it pertains to SEPTA. She suggested the committee should make the language not as direct, so the committee could expand on the language when necessary. P. Gorman agreed. The committee moved forward to make the first bullet under transportation a directive.

N. Johns stated the third bullet under transportation was not necessarily a directive but something that was in the works already. The OHP has developed a relationship with that individual and they may attend HIC meetings in the upcoming months.

MCM

Under this section there are two bullet points:

- Develop communication tools and resources for MCM to increase knowledge of RW services in the EMA
- Non-medical case management/including peers to help with social support, enhanced personal contact, paperwork and red tape, assistance reducing barriers like transportation and lack of information about services and eligibility. (Dependent on the implementation of the new MCM model)

P. Houle inquired about the medical case management recommendation. He stated the committee reviews MCM annually, but he emphasized you should not be a Ryan White MCM if you are not familiar with Ryan White services. He knows the recommendations says to make a mandate that Ryan White MCM increase their knowledge and training about Ryan White services but he felt as though it should already be a job requirement. G. Thomas commented it's not that MCM do not know about Ryan White services, or rather not all of them don't; the issue is there is a high rate of turnover within that position and the ones who are aware of services do not necessarily share that information with new hires.

T. Dominique asked the origin of the MCM recommendation point. She admitted she was not part of the committee at the beginning of these discussions and in her opinion the recommendations read as though medical case managers should distribute information about Ryan White services. P. Houle replied from his memory the committee was recommending a training to ensure all case managers had a comprehensive knowledge set. Some of the time case managers may not always give their clients ample information about Ryan White services. P. Houle admitted this was one of his pet peeves, he suggested you should not be a case manager if you're unaware of Ryan White services. "You have to demand excellence to get excellence". T. Dominique asked P. Houle if he is recommending a mandate that case managers should be tested and if they do not pass they can no longer be an MCM or if testing was required to become an MCM. P. Houle stated he felt the committee should put forward a directive about

the knowledge MCM should possess. M. Ross-Russell stated MCM do have mandatory trainings annually, it's just that not all individuals may choose to participate. J. Browne stated the Recipient does have mandatory training for case management, and there are 6 trainings required annually.

P. Gorman suggested the committee should make a directive that assessed MCM training. Was the training about the details of doing the job or a holistic training that included explanations of services?

N. Johns stated this recommendation was not about the teaching an MCM how to do their jobs, but rather to ensure that MCM are well aware of the Ryan White continuum. It's not that MCM need to be aware of all services within Ryan White, it's to make sure MCM have the ability to direct their clients to services appropriately.

K. Baron asked what happens in the case if MCM are unable to attend all the annual trainings by the Recipient. Are there any repercussions in this case? J. Browne stated in that case the MCM will be held accountable but the Recipient makes sure all funded MCM agencies attend trainings. Also, the Recipient has a streamlined resource inventory that MCMs can use as a service directory for clients.

M. Ross-Russell stated case management has been a hot topic for many years. In some cases it comes down to fact that MCM don't know what they don't know; with high rates of turnover new case managers may be unaware of Ryan White services.

P. Gorman stated this needs to be a directive, the conversation has been had for many years and changes need to be made. Even though there are mandatory trainings it seems case managers are still unaware. P. Gorman stated PWLH have complained for years about MCM being unaware of services. She suggested the committee should put forward a PLWH-driven directive. The committee needs to make a directive that addresses the disconnect in MCM; we are aware of the trainings the MCM are required to attend but there is some disconnect or gap in knowledge.

G. Keys asked if MCM have been surveyed much like the consumer survey the OHP conducts every so often. P. Gorman replied agencies are responsible for their evaluation, and the evaluations are qualitative. Evaluations are at the discretion of the subrecipient and agencies are not evaluated by the Recipient. Due to this system, it is difficult to truly hold individual MCM accountable in some circumstances.

G. Thomas explained that in some cases MCM are let go for doing "too much" for their clients. Veteran case managers may not always be as aware of things as you would expect them to.

P. Houle stated this comes down to human complacency. It's not that we expect people to know everything; to M. Ross-Russell's earlier comment, we just expect people to at least try and to obtain answers whether it's from a supervisor or a resource inventory.

P. Gorman polished up her suggested directive. She stated, "Based on consistent consumer feedback about a lack of knowledge of MCM, the Comprehensive Planning Committee would like to make a directive that the Recipient assess the evaluation process of subrecipients for their MCM standards."

T. Dominique stated there was another bullet another MCM, non-medical case management. P. Gorman moved to table this discussion. The committee moved to table discussion about non-medical case management.

Provider training

Under this section there are two bullet points:

- Ryan White and PDPH prevention-funded provider training about Ryan White program for all staff (including front desk/clerical)
- EMA-wide training on Enhanced Personal Contact for Ryan White clinical sites to increase retention and improve health outcomes

P. Houle asked about the required mandated training for subrecipients. P. Gorman replied subrecipients are mandated to give training to their staff, but like MCM evaluations the Recipient does not assess the subrecipients' ability to evaluate their programs.

T. Dominique stated this recommendation comes from earlier discussion about "secret shopper" calls. The committee discussed this a few months ago, and it comes down to what the committee wants to do with the information from secret shopper calls. There was also talk about the committee making recommendations about training front desk staff since they are the first to answer phones and the first to greet clients.

M. Ross-Russell asked J. Browne now that "secret shopper" calls have been conducted what are the next steps in terms of corrective action. J. Browne replied there is a plan of action for corrective measures.

N. Johns stated a lot of the discussion about provider trainings is about the quality of services provided not the lack of services provided.

P. Houle suggested the committee needed to broaden the recommendation. The recommendation should also give a scope of what the trainings are required for provider staff. Part of the issue is that we do not have a requirement for what provider staff needs to know. For example, the committee could require front desk staff at least know referral services.

P. Gorman suggested the committee should broaden the recommendation to require the Recipient to access and evaluate the subrecipients' training and resources available to staff. Then to make minimum recommendations about knowledge-based trainings, sensitivity, culture appropriation, and etc. Also, to look at qualitative ways to look at the agency's ability to provide service to its clients.

N. Johns stated she could finalize a succinct list of directives made the committee thus far and distribute them via email to the committee.

N. Johns asked if the committee wanted to discuss the enhanced personal contact recommendation. P. Gorman suggested the committee should not include this recommendation in the directive, further discussion of this should be tabled until later on. The Committee moved to table discussion about enhanced personal contact.

HIPC/AACO

Under this section there are two bullet points:

- Request update from AACO on integration of BHCs at CPC meeting
- Update from AACO on MCM model to assess whether non-medical case management is a viable or feasible addition to the EMA

The committee reviewed the first bullet point under the HIPC/AACO. N. Johns reminded the committee A. Ricksecker brought up BHCs, specifically how they are funded and how the HIPC can help with the funding process or any recommendations that can help the progression of them. The committee moved to table discussion.

The committee reviewed the second bullet point under the HIPC/AACO. P. Houle stated it was important to receive updates about the MCM model. Obviously, the model is not out yet but when it is its important to receive feedback. The committee moved to put forward this as a recommendation, not as a directive.

Communications about RW services and co-pays/fees

Under this recommendation there are 3 bullet points:

- AACO to review the current RW system to see where it is feasible and advantageous to add information about the availability of services and that they are available regardless of ability to pay or insurance status.
- AACO to leverage "secret shopper" calls to include questions about specific service availability (aside from HIV medical care) and also assess how costs and sliding scale fees are communicated.
- Providers to develop handouts and/or signs about costs/fees for services to be given at appointments. The copy should read to the effect that PLWH will receive services regardless of their ability to pay or insurance status. There should ne some communication about sliding scale fees and co-pays at check-in when appropriate.
    - A sample script for front desk/intake staff should be provided that communicates clearly sliding scale fees and co-pays. Those on Medicaid and Medicare and those with income below 100% FPL will incur no costs

P. Gorman stated this comes from previous committee discussion about the lack of understanding PLWH have about co-pays. She referenced discussion from the committee's January 2018 meeting. She stated the issue is when clients opt of receiving services because of fear of cost. It would not be feasible to include the entire sliding fee scale on a flyer but at the least have fees associate with Medicaid and Medicare. Also, a brief statement saying clients will receive service regardless of cost. Often clients may not understand the sliding fee scale and it's also not conveyed properly by providers, so clients may not seek treatment due to perceived cost. The committee moved to include their concerns within a directive about an assessment of subrecipient staff training and evaluation.

Misc

Under the miscellaneous section there are three bullets:

- Checklist for HIV testers that helps them convey key messages about the Ryan White system and to assess the individuals needs/barriers that may impact linkage and retention (Linking to Care tool developed by the Points of Integration Workgroup to be updated)
- Educate PLWH about formal grievance process. Encourage PLWH who are not comfortable filing grievances at agencies to do so with CSU Central Intake. Marketing campaign for health information line throughout the RW system.
- Create more specific patient satisfaction surveys that seek information about interactions with different staff, including front desk/reception and scheduling. Review NY HIV-specific patient satisfaction survey to see if it can translate to something for the EMA, as well as request examples from EMA's providers to collect some best practices. Also review the in real time satisfaction tools and see which maybe something to recommend in the EMA.

The committee reviewed the first bullet under the miscellaneous list, the bullet referred to a checklist for HIV testers. N. Johns stated this recommendation was presented to the Prevention Committee.

The committee moved their discussion to the second and third bullets under the miscellaneous section. N. Johns reminded the committee the third recommendation was made by A. Thompson and it requested the committee to review the NY HIV-specific patient satisfaction surveys and if it can translate to the Philadelphia EMA. J. Murdock questioned the effectiveness of these satisfaction surveys; are they actually being reviewed by the agency, and how candid are these surveys really? To a degree people may not be honest because they are scared of the repercussions. N. Johns stated this plays into the second bullet under the miscellaneous section about the formal complaint process. This is where that process would be used.

P. Houle asked if it was required that agencies keep a complaint box and provide the client with ways to access their complaint process. He explained it's not just the agency's responsibility to review clients' complaints, but it is the clients' responsibility to ensure that their complaint is heard.

G. Keys stated in the complaint process it is important that the client records their complaints in writing and takes their complaints to the Client Services Unit.

The committee moved to table this recommendation.

Outside the HIPC purview but CPC endorsed

Under this section there are four bullet points:

- Peer receptionists/front desk staff — is there a way to target recruitment for positions at provider sites to PLWH clients/volunteers and/or a way to share opportunities with interested PLWH or others with shared lived experiences?
- Community bulletin board — a place for social events and social support opportunities to be shared with the broader PLWH community, real or virtual
- Social activities for PLWH not about HIV — cannot be funded with Ryan White money but can be encouraged at provider sites where other unrestricted funds can be used
- Support groups for PLWH throughout the EMA

The committee moved to table discussion about all bullet points under this section.

Old Business:

- **Racial Inequity**

N. Johns stated this discussion was a continuation of the last committee discussion. The discussion stems from J. Malloy's public comment in the April 2018 HIPC meeting where he implored the HIPC to review the racial inequalities in the Ryan White system. T. Dominque stated the committee had a spirited discussion about this topic in the last committee meeting even though attendance was poor. She suggested all members who were not present for the last meeting to review the discussion about racial inequity.

K. Baron suggested the committee should table this discussion due to time constraints. Racial inequity should be a discussion item on the committee's next agenda.

New Business: M. Ross-Russell stated the HIPC reviews the percentage of AIDS cases within PLWH living in each EMA region as part of its allocations process. She noted the number of AIDS cases has risen over the course the last few years in the PA counties, which now represents 16% of the EMA's epidemic. The Recipient will also be looking into this increase as well as the Prevention Committee in the near future. As part of its investigation the Recipient will evaluate the services that are provided in the region. P. Gorman asked if the spike in the percentage was due to relocation of PLWH or is it because of

newly diagnosed. M. Ross-Russell replied its only the number of total cases, it is plausible that the increase could be due to relocation of PLWH.

Announcements: T. Dominique announced the committee will not meet in July 2018 due to NJ allocations meetings.

P. Houle announced he has the contact information for Stephen Miller, the senior political advisor for President Trump, who was instrumental in the current immigration scandal. He stated he would share the information with all those who are interested and encouraged the committee to contact him to protest.

Adjournment: Meeting adjourned by consensus at 4:05 pm.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- Priority Settings and Resource Allocations
- Results of Comprehensive Planning's improving retention in care