

HIV Integrated Planning Council

Thursday, June 13, 2019

2:00 p.m. – 4:30 pm.

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

Present: Juan Baez, Katelyn Baron, Michael Cappuccilli, Keith Carter, Mark Coleman, Evette Colon-Street, Maisaloon Dias, Lupe Diaz, Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, Sharee Heaven, Gerry Keys, Dena Lewis-Salley, Loretta Matus, Nicole Miller, Jeanette Murdock, Christine Quimby, Erica Rand, Joseph Roderick, Samuel Romero, Gloria Taylor, Coleman Terrell (AACO), Gail Thomas, Jacquelyn Whitfield

Excused: Janice Horan, Peter Houle, Clint Steib

Absent: La'Seana Jones, Richard LaBoy, Brian Langley, George Matthews, Dorothy McBride-Wesley, Nhakia Outland, Eran Sargent, Terry Smith-Flores, Lorrina Wellington, Zora Wesley, Melvin White, Steven Zick

Guests: Blake Rowley, Chris Chu (AACO), Jessica Browne (AACO), Monique Gordon, Marie Jackson, Ameenah McCann-Woods (AACO), Tahira Tyler (AACO)

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan

Call to Order

S. Heaven called the meeting to order at 2:02pm

Welcome and Introductions

L. Diaz asked for introductions and an ice breaker. All present introduced themselves.

Approval of Agenda

S. Heaven called for an approval for the agenda. **Motion:** G. Keys moved, D. Gana seconded to approve the agenda as written. Motion passed: all in favor.

Approval of Minutes (May 9, 2019)

S. Heaven called for an approval of the meeting minutes from May 9, 2019. **Motion:** J. Whitfield moved, J. Diaz seconded, to approve the meeting minutes as presented. Motion passed: all in favor.

Report of Co-Chairs – End the Epidemic (Coleman Terrell)

C. Terrell explained that he gave this presentation at the AACO Executive Director meeting. It gives a grounding and framework for an End the Epidemic (ETE) plan. He said that earlier this afternoon the CDC released a funding opportunity for funding an ETE plan. The goal is to have 75% reduction in HIV infections in 5 years and a 90% reduction in 10 years. He reviewed the five pillars of the ETE: diagnose people as early as possible in treat the infection rapidly and effectively to achieve sustainable viral load, protect people at risk for HIV infection using proven and potent prevention interventions including PrEP, to detect and respond to growing HIV clusters and new HIV infections, and establish an HIV healthcare workforce committed to the success of the local initiatives. He explained that the ETE initiative includes things the jurisdiction is already doing. He noted that the federal plan doesn't acknowledge the importance of poverty in HIV. He explained that we can't address HIV without addressing social determinants of health. C. Terrell shared a map of the HIV epidemic and poverty in Philadelphia. He said that other disease states follow the same patterns of poverty.

C. Terrell noted that there has been progress in decreasing HIV cases. He reported there are 413 new diagnosis in Philadelphia in 2018, data to be officially released soon. There is a 94% increase of HIV cases in PWID. Over 200 people in a PWID risk network that have been identified. A portion of the network report male to male sexual contact. He noted disparities in HIV – 80% male, 63% black 16% Hispanic. 24% among people 13- 24 years old. He shared data from the National HIV Behavioral Surveillance (NHBS) – people tested in the last 12 months from most recent cycles. He noted that for men who have sex with men (MSM) cycle 80% were tested in the last 12 months that should be 100%. 37% of the MSM interviewed were HIV+. 4.9% of people who inject drugs (PWID) and 0.6% of high risk heterosexuals. C. Terrell noted that MSM are more likely to know their HIV status. 43% of PWID were unaware. 66.7% of high risk heterosexual. He explained that is the percent of people who tested positive during the study.

C. Terrell shared a slide of CDC with PLWH and estimates of percentage of new infections. 38% of new infections are accounted for by the people who do not know their status (15% unaware). He noted that no transmission for people who are undetectable. K. Carter asked how long someone needs to be undetectable in order to not be able to transmit the virus. C. Terrell answered that the guidelines say a person has to have an undetectable viral load for 6 months and in care. He noted that in Philadelphia there are an estimated 1,900 people unaware of their HIV status and 9,500 people who know they HIV but are not in care.

C. Terrell shared the care continuum for Philadelphia for the previous three years and reported that 86% of people with new diagnoses are linked to care. There has been no change in the other three bars over three years according to HIV surveillance data. He reiterated that these are surveillance numbers and the HIPC has the responsibility to all people living with HIV, not just those in the Ryan White system. He offered that as the jurisdiction moves forward, we need to see linkage, retention and reengagement are related challenges. We need to do the work for evidence-informed patient centered practices. He noted that the provider system is very comfortable with the status quo, but we need to do new things.

He proposed that the jurisdiction uses data for public health action. These include data to care activities that identify people out of care and get them in care. ‘Data to PrEP’ activities which find people who are eligible for PrEP or have fallen out of PrEP programs. He also noted that there are activities in ‘data to testing’ – testing in non-healthcare settings. C. Terrell explained that it is a very small number of people that testing efforts are trying to identify. We need people to think about where they are testing and make sure it is the right place. And lastly there is ‘Data2healthequity’ which uses data to prioritize resources and efforts to communities most impacted. Health equity is essential to ending the epidemic. He noted that we don’t want an equal system, we want an equitable system. Disparities throughout the system need to be addressed. He stated that the HIPC needs to take health equity and disparities seriously. He noted that the Health Resources and Services administration (HRSA) has offered feedback that the HIPC don’t have enough African American men on the council and the Centers for Disease Control and Prevention (CDC) was even more specific about young Black men. He suggested that the HIPC and AACO need to expand membership and find other ways to engage people in planning decisions.

C. Terrell noted that he handed out some activities around HIV testing (see information on handout). He noted that continuous quality improvement staff member has been hired for testing. He noted that 78% of new diagnoses are made in clinical settings. He reported that PrEP implementation needs to be scaled up. He explained that PrEP uptake is higher among white gay men than Black gay men, and that needs to change. He further explained that the system needs to get PrEP to PWID and women at risk. He noted that PrEP campaign (Philly Keep on Lovin) is out and working well to get the word out through social media and print. He noted that the greatest amount of interest has been from cisgender women, maybe because of the novelty of the message for that group. He noted that condoms and syringe programs are very important to HIV prevention, so some old ways still work. He noted that PrEP is standard of care and must be paid for by insurance companies thanks to the grade A rating by the United States Preventative Task Force. He stated that the data sources from the RW system, Medical monitoring project, Data to care activities, and surveillance need to be used to direct planning.

C. Terrell observed that there should be no threshold access to HIV treatment. Access to HIV care and treatment needs to be immediate and easy. He noted that the linkage is the medical providers’ responsibility. They need to be open and ready to receive people. PDPH is looking at how to use the client Services Unit to aid that. He stated that no one should wait a month or two for treatment, but all PLWH should have immediate access to ART. He commented that a provider’s hours of operation are essential to access, and noted that all RW sites have extended hours. PDPH/AACO is working on realigning standards of care to help keep people in care based on the data we have from various sources.

He explained that outbreak response: an increase in HIV cases in space/time. He explained that groups of related infections are identified through surveillance data to see cases who are linked. PDPH can interview people to help people get care and stay negative. Providers can then be mobilized in specific geographic areas or for specific groups. He noted that a focus group of people at Prevention Point noted that no one in the group knew about the HIV outbreak in PWID.

C. Terrell explained the community support of these efforts is vital, including the HIPC. He offered that he wanted to share what AACO/PDPH is doing and where we want to go to End the Epidemic. He stated that PDPH/AACO wants to make sure all our plans build on what we have been doing and the resources we have.

Report of Staff

N. Johns reported that OHP conducted a brief survey about community member's availability for meetings and events. She reported that there were 50 responses. She reported that 74% of respondents were a member of a priority population (PLWH, men who have sex with men, former/current drug user, transgender, etc.). 26% were under 30 years old. She reported that 46% were available weeknights, 38% on Saturday afternoons, 24% on weekday mornings, and 20% on weekday afternoons and Saturday mornings. This information will be shared with Nominations and Executive Committees as they move forward with recruitment and retention efforts.

M. Ross-Russell announced that the regional allocations meeting dates have been scheduled for July 16th for New Jersey, July 18 for Philadelphia, and July 23 for the PA Counties. All the meetings will be at the Office of HIV Planning between 12:00 and 5:00pm and lunch will be provided. R.S.V.P. is requested.

She noted that there are four service categories to review in preparation for allocations. She asked members to see her to volunteer to review those at the HIPC July meeting.

B. Morgan reported that OHP had a brown bag event on understanding affirming terminology on June 7th. There was a small group in attendance and OHP shared the presentation via Facebook Live. The video is still available on our Facebook page for viewing. There will be other sessions about transgender experiences and skills building in the future. B. Morgan noted that the next 'brown bag' will be on the second Friday July 12th about data. M. Ross-Russell explained that "brown bag" program. It is a way to do special training and presentations on Friday's at lunch where people bring their own lunch. She noted that someone from Census will be invited to talk about Census data.

Public Comment

L. Diaz asked for public comment. There was none.

Presentation: Client Services Unit Annual Update (Jessica Browne)

T. Tyler introduced herself as the CSU supervisor. She encouraged people to call the unit to find out more about services. She reviewed the CSU mission which is to provide advocacy and reinforce self-determination and self-efficacy. This is done through education, collaborative planning and problem solving. CSU is responsible for connecting individuals to medical case management (MCM), information and referral services, grievances about AACO funded services, and transitional planning

for returning citizens. CSU also works with the Positive Committee and the homeless death review with the Medical Examiner's Office (MEO). T. Tyler explained the MEO may want to have more information about a deceased person if they found out that person is HIV-positive.

She explained that CSU is the key point of entry to MCM. She noted that the MCM intake covers the nine counties and there are 27 MCM providers. She reviewed HRSA's definition of MCM. She explained that it is client-centered, encounters can be text message, face to face, doctor's visits, home visits, etc. A major part of the job is monitoring access to care and health outcomes. MCM's access level of need, develop care plans, follow up with healthcare visits and other services they need, advocacy for whatever the client needs like benefits, plan is re-evaluate every six months.

M. Coleman asked about young people calling. T. Tyler noted that there are two providers who serve youth which include babies and children through adolescents. She noted that the youth intake is sometimes done at the provider site and information is relayed to CSU. She explained that there was \$9.3 million in MCM.

T. Tyler reported in 2018, there were 7,827 MCM clients and 1903 intakes were completed in 2018. She noted that the 27 providers are AIDS service organizations (ASO) and community-based organizations and medical institutions.

K. Carter asked about clients who do not want MCM. T. Tyler explained that people who call CSU but don't want MCM are entered into the database just the same. K. Carter asked about how many people that would be. T. Tyler noted that CSU does a lot of RW certifications and many of those are for access to dental services. The group discussed the role of RW certification card and why providers would want to see it. A guest noted that RW dental services covers things that insurance doesn't cover all necessary dental services. A. Wood-McCann explained that CSU database is not everyone in RW system, just folks who call the information line. She explained that the RW card is the system's way to ensure that PLWH are RW eligible. She noted that criteria: residency, income, HIV status, and insurance status. She explained the card helps agencies talk to each other so they know that you are RW eligible without having people to go through eligibility process at every RW provider they go to. She volunteered to talk to people about RW cards.

T. Tyler explained that there were 50 people on the MCM wait list at the time, primarily because people want a specific agency and that agency is not available. Some of those people are incarcerated and on the wait list until their release. She reviewed the priority populations: newly diagnosed, recently released persons, people experiencing homelessness, PWID and pregnant women not connected to MCM.

She reviewed the intake data. 68% of callers are identify as males. 66% identify as Black non-Hispanic. 41% are heterosexual and 42% identify as men who have sex with men. Most people who call are insured. About 20% are uninsured and CSU helps them access medical care and insurance. Housing is the most mentioned service need at 51% - housing assistance or housing. 45% of callers are in need of treatment adherence, lack insurance, lost medication, etc. 25% of callers need transportation. T. Tyler explained that CSU had recently started asking why people need transportation – do they know how to get where they need to go.

T. Tyler noted that there is a variety of grievance calls about MCM, medical providers, concerns about how to access services, clarifications about policies. She explained that CSU is not here to punish anyone but SU aims to improve services, change policies, and make services more equitable. K. Carter asked how AACO ensures that providers are following new guidelines. T. Tyler said that CSU/AACO doesn't know what they don't know. She encouraged people to advocate and let them know what is going on for them. K. Carter asked about clients waiting for 30 days for treatment or provider telling people they need MCM in order to access services. T. Tyler said that there needs to be a call in order for AACO to act on it. She also noted that CSU accepts praise too. S. Heaven asked about the grievance process. T. Tyler noted that clients logs a complaint with CSU. They work with CSU to narrow down a solution. CSU collects details about the incident and records it. That information is presented to the agency and the AACO analyst who work together towards a resolution. T. Tyler communicates the resolution to the client to see if it is acceptable. If not, then they go back to work on it. She said that clients can move to other agencies as a part of that resolution, if that is what the client wants to do.

T. Tyler noted that the 215-985-2437 works for NJ but that 800-985-2437 works for PA only. She reviewed that there are 5 social workers and a supervisor. She explained that the social workers speak English, Spanish and French.

J. Browne presented on Quality Management. She is the Ryan White Clinical Care Coordinator for AACO. She reviewed QM process: quality assurance, outcomes monitoring and evaluation (tracking outcomes for clients and system), and continuous quality improvement. She explained that all QM activities are aligned with the care continuum.

She explained that CAREWare is the database providers use to collect data and report client level data to AACO. AACO brings that data together and clean it up for duplications.

J. Browne explained that performance measures, access to care, and health disparities are areas in outcome monitoring. She added that Ambulatory care measures were updated last summer. She elaborated that the MCM measures have been developed for new model and should be introduced later this summer.

She explained that one way access to care is monitored is through 'secret shopper' calls in which AACO staff call as newly diagnosed or re-entering care to see if they can get an appointment in less than 15 days. They also check to make sure the person doesn't face barriers like being quoted a large fee or other issue. She explained that if a barrier or other problem is noted then corrective actions are taken with provider. J. Browne explained that health disparities have been run at the system level and now are being done at provider level. This will help find disparities that get washed out at the system levels. She explained that providers would do quality improvement projects after any disparities are identified. She added that providers were willing to give feedback about the process and improving how that will done.

J. Browne explained that MCM and O/AHS outcome measures are collected every other month. They loosely grouped into HRSA core measures: STI screening, women's health, behavioral and other health screenings. She reviewed that new MCM measures were in development. She explained

there are 3 oral health care measures and other service categories are reviewed for viral suppression from CARE Ware.

J. Browne explained that a strong emphasis is placed on feedback. Feedback reports include data visualization which highlight strengths and needs, benchmarking contextualizes data, and assists in prioritizing QIPs. AACO also works with providers to help them make timely and correct data entry through data validation visits.

J. Browne explained that quality improvement plans (QIP) are submitted annually for MCM and O/AHS and updated three times a year. Topics for QIPs are chosen by AACO. In 2018, viral load suppression and condom use were the focuses of QIPs. She noted that 80% had been the threshold for VL suppression, it is 85% now. QIPs are effective so it is best to focus on a few key areas. For 2013-2017, 81% of QIPS noted improvement. G. Grannan asked about how they address improvement in outcomes when providers are doing well. J. Browne noted that they do not focus on those areas where most providers are doing really well, but there is still improvement noted even in the high percentages.

J. Browne explained consumer involvement in QIPS. Providers are required to use consumer involvement like surveys and community advisory boards (CAB). AACO also has a plan for consumer involvement at the system level which was under review at the time of her presentation but can be shared in the future.

J. Browne noted that there has been marked improvement in appointment availability. She explained that corrective actions with providers who have serious issues work because they do not have the same problems over time, but those problems can/do pop up at other sites. She reported that in March 2018 61% had appointments available in 15 days or less and in September 2018 97% had appointments. J. Browne noted that as of 2017 the EMA ranks first among all large EMAs in viral suppression.

J. Browne explained that in 2019 the QIPs will focus on on VL suppression and MSM gonorrhea screening and disparities. She also noted a new version of CAREware will be released and QI in prevention services will also be increasing.

Action Item: PrEP Workgroup Report (Gus Grannan)

G. Grannan reported for the last 18 months a workgroup has been focused on PrEP delivery in Philadelphia. The group's work was collecting opinions and experiences of community and providers. With AACO the group developed some thoughts on how to include delivery of PrEP into the integrated plan. He directed the group to the report. He explained that first page explains what the workgroup did. The second page is what the group was trying to determine. Third page is the list of the ten parts of the integrated plan about PrEP. He noted that the recommendations for changes to the plan apply to these. He explained that the pages that follow are the breakdown of each of those ten activities and text from the integrated plan is included for each activity. He reviewed the structure of the plan activities. On page 5, he explained that Key Elements and Discussion refer to the integrated plan activities. G. Grannan said that the Key Elements include the data and context for those activities and the Discussion are some considerations and ideas about those activities and Key

Elements. He noted that the Prevention Committee will be looking at these activities to make sure that PrEP implementation is going according to plan.

B. Morgan elaborated that the Key Elements are information not included in the integrated plan and the Discussion is what the workgroup thought about the key elements and the integrated plan. B. Morgan explained that this report is coming from the Prevention Committee as an action item. The HIPC can table this and talk about next month or vote to approve it as presented. A decision doesn't have to be made today.

B. Rowley asked if there were any qualitative data about why gay and bisexual men might not take PrEP. C. Terrell said that National HIV Behavioral Surveillance (NHBS) collects some of that data. He noted that messaging and talking to providers would be best informed by understanding the motivations of people.

M. Cappuccilli asked why NJ and PA counties were not included in the workgroup report. C. Terrell noted that for the HIPC the prevention jurisdiction is Philadelphia only. M. Ross-Russell explained that when the activities were written in the integrated plan they were for Philadelphia. M. Ross-Russell noted that OHP staff sit on both PA and NJ HPG and collaboration happens. She explained that the blue text boxes from the integrated plan and the items in the orange are from the workgroup. The PrEP information in the report are Philadelphia specific. G. Grannan noted that the HIPC may want to think about how to communicate this to the other jurisdictions within the EMA.

Motion: By general consensus the HIPC decided to table for discussion of the PrEP Workgroup Report until July 2019 to allow for more discussion and a chance for all HIPC members to review the report. Co-chairs abstained from participation in the decision.

Discussion Items:

Priority Setting Process

N. Johns stated that one of the Planning Council's responsibilities was to prioritize services according to documented need. She noted that the Council had previously decided that they would conduct the process up to every three years, and that the group had determined that it was time to revisit their priorities. She stated that there had been several months of discussion about the process, which was similar to the process used for the past several years. She noted that the process included factors, which had traditionally drawn on data sets. She stated that it included CSU MCM Intake, consumer survey, and MMP data.

N. Johns explained that, historically, the priority setting process could be very subjective, and subject to the opinions of those in the room. She further explained that, about ten years earlier, the Planning Council had decided to shift to a more data-driven priority setting process, based on one used in New York City. She went on to say that the Planning Council had decided to add a "community voices" factor that brought community expertise and experiences back into the process.

N. Johns stated that the process always used consumer survey data, since this was an important way of assessing how Ryan White clients are receiving services. She explained that the priority setting process included a consumer survey factor, which specifically included surveys that respondents said that they needed but could not get. She stated that the next factor drew on the Medical Monitoring Project, which included people who were in HIV care. She stated that the Client Services Unit data helped address needs of clients at intake. She explained that the first three factors were all weighted at 20%, because they each captured different data of similar importance. She noted that they used scores of 1, 3, 5, and 8 to score each factor. She explained that these first three factors would be scored in advance of the meeting, because they were objective.

N. Johns explained that the community voices factor was also data-driven from other data sets and discussions, and that this would be the factor discussed at the Comprehensive Planning Committee meeting. She stated that this factor looked at whether a service was needed in order to engage, retain people in care, or to result in viral suppression.

N. Johns stated that the Comprehensive Planning Committee would engage in the priority setting process the following Thursday, and that every meeting attendee would have the opportunity to participate. She stated that everyone would receive a card with each score on it, so they would be able to vote during the meeting following a conversation about each service category. She noted that each person's vote would be counted and entered into a spreadsheet. She explained that a formula would be applied that would include each person's vote, and that each service category would receive a final score between 0 and 100. She noted that the Comprehensive Planning Committee had an entire conversation about a score of 8, and she said that they had determined that only one service category would receive an 8 for the first 3 factors, but under the Community Voices factor individuals can choose to vote * on any number of service categories.

C. Terrell observed that community voices had a higher weight than in the past. He explained that this was concerning because it was more subject to whoever was in the room than in the years past. He further explained that CPC was not a representative group, and that the EMA's federal funders had been concerned that HIPC was not representative of people who were most affected by HIV. He then stated that it was important to look at the demographics of the group who set the priorities. He went on to say that he was concerned that they were migrated away from data-driven priorities. He concluded that it was important for people to show up for the meeting on Thursday to be a part of this process.

M. Ross-Russell replied that, at the beginning, the process was entirely based on who was in the room. She stated that they then moved to a data-driven process, and that the group had found that it only included data and that there was no longer any room for community expertise. She agreed that it was important to ensure that as many people were present as possible. C. Terrell stated that he wanted the HIPC to hold themselves accountable about who is in the room, and who is not in it. He stated that they really needed to think about whether they were representing people who were not adequately represented, or were only represented by proxy. He stated that this was about racial equity as well as critical subpopulations that they were making decisions for. M. Ross-Russell stated that

OHP staff works to ensure that as much data, qualitative and quantitative data, are included in the process.

N. Johns stated that PC could vote to defer the decision-making process until later. M. Cappuccilli asked if the HIPC had to complete this before allocations, and N. Johns replied that they did not. G. Keys stated that they had always encouraged participants to focus on community needs rather than individual needs, based on what they've learned in meetings and presentations through the year. She noted that they could only work with who and what they had in the room, but they encouraged everyone to represent what they had heard and learned over the entire planning process.

C. Terrell clarified that he was encouraging everyone to ensure that they were representing the needs of those who needed the support of the Ryan White system the most. G. Grannan stated that he could bring this up directly with the drug users union. He explained that one way to ensure that people participate is to pay them. He went on to say that they were essentially asking people to act as consultants. C. Terrell explained that HIPC members were not allowed to be paid, but that AACO/OHP do this when it comes to research and activities like the NHBS. M. Ross-Russell stated that they might also need to look at other ways to reach out to people, such as going to them and documenting their needs.

S. Heaven asked the Council if they would like to move ahead with conducting the priority setting process on Thursday. **Motion: G. Keys moved, G. Thomas seconded to move forward with the priority setting process on June 20th.** Motion passed: 15 in favor, 1 opposed, 8 abstentions.

FY2018 Year End Spending Report

Tabled.

Committee Reports

Executive Committee

None.

Finance Committee

A. Edelstein reported that they reviewed the underspending report (which was tabled until July).

Nominations Committee

M. Cappuccilli encouraged everyone to stay for the social, and thanked AIDS Care group and OHP for food. He stated that they wanted people to mingle and meet each other, and there would also be an information table for guests at the front. He stated there would be a bingo game and invited everyone to relax and have some food.

Positive Committee

K. Carter reported that the next meeting would be on June 18 from 6-8pm with two speakers – Kevin Moore and ACT UP. He encouraged everyone to come and bring a friend. N. Johns asked people to RSVP so they could have enough pizza.

Comprehensive Planning Committee

No report.

Prevention Committee

L. Matus reminded those present that the week of the 27th was National Testing Day and there were a number of events in the city.

Old Business

M. Ross-Russell stated that they were inviting PA Office of Health Equity to present to the HIPC in September.

New Business

M Cappuccilli asked OHP to send the email to the whole HIPC to invite them to the priority setting meeting.

Announcements

None.

Adjournment

The meeting adjourned by general consensus at 4:36 p.m.

Respectfully submitted,

Nicole D. Johns, OHP staff

Handouts distributed at the meeting:

- Meeting agenda
- Meeting minutes for May 9, 2019
- PrEP Workgroup Report
- Prevention services handout
- Meeting calendar