

HIV Integrated Planning Council

Meeting Minutes

Thursday, May 11, 2017

2:00-4:00p.m.

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

Present: Tre Alexander, Juan Baez, Katelyn Baron, Henry Bennett, Michael Cappuccilli, Jen Chapman, Mark Coleman, Lupe Diaz, Tiffany Dominique, Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven, Gerry Keys, Sayuri Lio, Loretta Matus, Nicole Miller, Jeanette Murdock, Christine Quimby, Adam Thompson, Leroy Way, Paul Yabor

Excused: Karen Coleman, Tessa Fox, Pamela Gorman, Peter Houle, Gail Thomas, Sam Romero

Absent: Johnnie Bradley, Bikim Brown, Kevin Burns, Keith Carter, Cheryl Dennis, Abraham Mejia, Ann Ricksecker, Joseph Roderick, Carlos Sanchez, Nurit Shein, Clint Steib, James Tarver, Lorrinda Wellington

Guests: David Condoluci, Susan Santry, Maryann Andrews, Ameenah McCann-Woods, Clera King, Aviva Joffe

Staff: Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order: T. Alexander called the meeting to order at 2:10p.m.

Welcome/Introductions/Icebreaker Activity T. Alexander welcomed Integrated Planning Council members and guests. Those present introduced themselves. They then participated in an icebreaker activity.

Approval of Agenda: T. Alexander presented the agenda for approval. **Motion:** P. Yabor moved, L. Way seconded to approve the agenda. **Motion passed:** All in favor.

Recap of Previous Meeting: T. Alexander reported that, at their last meeting, the Planning Council heard a presentation from Jose Bauermeister about Creating Digital Bridges for HIV Prevention. They voted on a reallocation request and determined the name of the HIV Integrated Planning Council. They also heard standard subcommittee reports.

Approval of Planning Council Minutes (April 13, 2017): T. Alexander presented the minutes for approval. **Motion:** L. Diaz moved, L. Way seconded to approve the April 13, 2017 minutes. **Motion passed:** All in favor.

Report of Co-Chair: T. Alexander explained that the Planning Council co-chairs would be presenting brief trainings at each meeting moving forward.

J. Chapman stated that she'd be going over a review of concurrence, which was a requirement of the prevention group. She explained that the HIV Prevention Planning Group (HPG) had fulfilled this responsibility in the past.

J. Chapman provided a definition for integrated planning, as specified in the last integrated plan. She stated that the HPG, Ryan White Planning Council (RWPC), AIDS Activities Coordinating Office (AACO), and Office of HIV Planning (OHP) had worked together to develop the 2017-2021 Integrated HIV Prevention and Care Plan. She explained that the integrated Planning Council, in conjunction with AACO, would monitor the Plan and its activities over the next 5 years. She stated that Section 3 of the Plan was devoted to monitoring. She noted that the Plan was updated as needed.

J. Chapman noted that the Philadelphia EMA Integrated Plan was submitted in 2016, and the jurisdiction was awaiting feedback from the CDC and HRSA.

J. Chapman explained that concurrence referred to the planning group's agreement that the Plan had been reviewed and was being monitored appropriately. She stated that a vote to concur meant that the group agreed that the programmatic activities and resources were being allocated accurately and to the populations and areas of greatest need.

J. Chapman noted that concurrence would have to be carried out within the next several months. M. Cappuccilli asked if the integrated plan was available on the OHP website. J. Chapman said it was¹.

K. Baron stated that she'd briefly review priority setting. She explained that the resources from Ryan White were limited. She stated that people living with HIV/AIDS (PLWHA) were living much longer and healthier lives than they had when the Ryan White CARE Act was first passed. However, they had many needs that had to be fulfilled. She stated that priority setting was part of the process of determining the needs of PLWHA in the area and ensuring that they were met.

K. Baron stated that many variables should be included in setting priorities to help gauge need, like data and other sources of information. She said that other sources of funding for services outside Ryan White should be taken into account, but decisions should not be directly made based on outside funding. She stated that the Comprehensive Planning Committee (CPC) would present on their updates to the priority setting process later in today's meeting. She explained that priority setting would take into account the voices of consumers of services. She said that the Planning Council would vote on the priority setting process as updated by the CPC. She invited all members to participate in the process by attending upcoming CPC meetings.

M. Cappuccilli asked if priority setting was done at specific intervals. N. Johns stated that the Planning Council had voted to carry out priority setting at least every 3 years, or more often as needed. K. Baron noted that the consumer survey was one source of data used in priority setting. She stated that the group would be provided with handouts and visual aids at the priority setting meeting. She noted that the CPC also reviewed service category definitions. P. Yabor pointed out that the essential health benefit factor was still included in priority setting. He stated that the essential health benefits could be changing in light of the proposed American Health Care Act (AHCA), which had recently passed in the House of Representatives. K. Baron said that the Planning Council would move forward with the essential health benefit factor since the Affordable Care Act (ACA) was still law.

T. Alexander distributed a handout about Medicaid's recent decision to move several HIV drugs to non-preferred status. He noted that coverage for non-preferred drugs was not necessarily denied, but the change could present barriers to getting medication. He said he objected to the change or any regulation that restricted consumers' own choices about their medications. G. Grannan stated that advocates had worked to eliminate restrictions affecting Hepatitis C (HCV) medications. He said the advocacy had been effective. T. Alexander encouraged Planning Council members to send letters to their representatives about the change.

Report of Staff: N. Johns stated that the consumer survey was closed. She stated that 385 surveys had been received, including online responses. She said that a temporary staff member would be hired by the OHP to help with data analysis. She noted that data from the survey would be used in priority setting and allocations.

¹ <http://hivphilly.org/Documents/IntegratedPlans/2017IntegratedPlan.pdf>

Public Comment: None.

Special Presentation:

- **Treatment Update**

D. Condoluci stated that his presentation would address the challenges of providing quality medical care to PLWHA with limited funding. He said he'd be presenting a model that addressed integration and delivery of care in the face of challenges. He stated that it was important to discuss how legislation affected the quality and outcomes of treatment.

D. Condoluci said that the ACA caused changes in funding to organizations in NJ. He said that there was now more funding for Medicaid, and money had been taken away from uncompensated care. He stated that new legislation was unlikely to put money back into the service.

D. Condoluci reviewed the history of developing an HIV care model in NJ. He stated that the care model at his organization dated back to 1989. He said it operated off two primary funding mechanisms, including the Treatment Assessment Program (TAP) and the Ryan White CARE Act. He stated that, at the time the care model was developed, HIV had a high mortality rate. He said that the 1990s and 2000s led to expansion of HIV services. He noted that the Early intervention Program (EIP) replaced TAP. He added that expectations arose of integrated, multi-disciplinary care. He noted that integrated care improved HIV care and resulted in fewer emergency department and hospital visits. He said that, gradually, HIV became a chronic manageable disease.

D. Condoluci stated that the ACA had resulted in Medicaid expansion in many states, which led to more people being insured. He said that it also provided consumer protection measures. However, he added that the ACA did not pay for wrap-around services, and providers still relied on Ryan White funded services to maintain comprehensive programs. He stated that Medicaid expansion had reduced some public health funding, with an emphasis on mainstreaming HIV programs.

D. Condoluci said that his organization had worked to determine how to provide the best services they could in a rapidly changing public health environment. He stated that many organizations adopted the medical home model in primary care. He stated that value-based models replaced fee-for-service models. He noted that Accountable Care Organizations (ACOs) were developed to provide better care to Medicare beneficiaries.

D. Condoluci reported that his organization had turned toward the medical home model. He explained that patient-centered medical homes (PCMHs) aimed to improve the health of populations, provider satisfaction, and patient satisfaction, as well as eliminate waste and lower cost. He explained that the model centered around the patient and the provision of coordinated care. He stated that the joint principles of PCMHs included a personal physician, physician directed medical practice, whole person orientation, coordinated and integrated care, quality and safety, enhanced access, and payment reform. He stated that it was necessary to collect data and outcomes to improve care, which was made easier through these programs.

D. Condoluci reviewed some graphics illustrating the coordination of medical care that centered around the patient. He stated that HIV care now prioritized value over volume. He noted that health care was not the same thing as sick care. He said the same model he was describing could work for all chronic disease.

D. Condoluci explained that population health management required providers to define the population, identify care gaps, stratify risks, engage providers and patients, manage care, and measure outcomes. He said that in the true medical home model, there should be open appointments every day so patients could

enroll in the program immediately. He said that the program reduced unnecessary use of the ER, decreased patient use of retail clinics, provided continuity of care, and increased patient satisfaction.

D. Condoluci stated that, before each planning session for new patients in PCMHs, “huddles” were held with the whole team: case managers, nurses, navigators, team members, scribes, and physicians, who reviewed the list of patients and planned for those patients’ care. He said these were typically held daily, in advance of patient visits, in order to identify gaps in care and review specialist reports and labs. He noted that the process promoted more robust patient visits.

D. Condoluci stated that population health management afforded the ability to identify groups of patients by their condition and services needed. He said it helped with reaching out to patients who were not in care.

D. Condoluci said that, when patients left the medical care facility, they were provided with a summary of their visit and an aftercare plan. He said that the care team provided tools and resources to patients and tracked their goals and progress. He noted that they also discussed any barriers to their continued care after the visit.

D. Condoluci said the programs allowed for continuous quality improvement. He stated that performance measures included patient satisfaction, clinical measures, preventative measures, and access to useful and accurate data. He said that the Quality Improvement (QI) processes were very effective.

D. Condoluci stated that it was hard to predict what would happen in the future of healthcare. He said that elimination of the ACA may reduce access to care.

M. Cappuccilli asked how well the Medicare system coordinated with HIV care. D. Condoluci stated that medical home models could be supported by Medicare.

Action Item:

- **Priority Setting Process – Comprehensive Planning Committee**

A. Thompson stated that the CPC had discussed how they’d address possible future changes to healthcare policy. He said that the practice of medicine would continue to move forward as it had in the past, but the way healthcare was paid for would change. He stated that the group would have to revisit the service priorities if healthcare law changed.

A. Thompson stated that the last priority setting process used objective data sources, including the consumer survey. He said they also used an overlay of the HIV Care Continuum that took into account how many steps along the continuum each service addressed. He said that several outside data sources like the Medical Monitoring Project (MMP) were also used to gauge consumer need. He noted that all service categories that were included in essential health benefits were given lower ratings for that factor because access to these services was increased by the essential health benefits. He noted that the numbers from all these factors were combined in a spreadsheet to produce a cumulative priority ranking.

A. Thompson noted that the CPC had adjusted the care continuum diagram and other priority setting materials to reflect changes in the healthcare landscape over the past several years. He stated that the group had decided to incorporate a factor called community conscience, which would allow personal experiences to be taken into account. He noted that, for instance, syringe access programs were usually thought of in terms of substance users. However, transgender persons also used syringes to take hormones. He stated that experiences like these could be captured by community conscience. He noted that the factor looked for emerging needs that weren’t captured by data, vulnerable populations (small or unrepresented groups), personal knowledge and experiences of providers and PLWHA, and service

utilization data. He stated that service utilization data would be provided by AACO. He welcomed all participants in priority setting to bring their own data to the meetings, both quantitative and qualitative. He said that, based on all community conscience variables, the services would be designated scores of 1, 5, or 8. He stated that participants would be encouraged to make arguments supporting their scores. He said the community conscience factor could make a significant difference in rankings.

M. Cappuccilli stated that one challenge of priority setting in the past is that it was carried out for the entire EMA. He said that data often differed between regions of the EMA. A. Thompson noted that much of the data being used in the process encompassed the entire system. He said that groups that were often underrepresented in the data should be represented at the meeting. M. Cappuccilli asked if the consumer survey data would be ready for use in priority setting. N. Johns replied that some consumer survey data would be available for priority setting. She stated that all regions of the EMA were well-represented in the survey data. A. Thompson noted that there were open-ended questions on the survey that would be included in the community conscience discussion.

T. Dominique asked if MMP data was Philadelphia-specific. N. Johns stated that the MMP data used in priority setting was for Philadelphia only. A. Thompson stated that he could try to obtain MMP data from NJ. T. Dominique stated that the combination of Philadelphia and NJ MMP data would still underrepresent the PA suburbs. P. Yabor asked for more information about MMP. A. Thompson stated that MMP data collection involved chart analyses and interviews with patients. T. Alexander asked how to obtain MMP data for the PA suburban counties. B. Morgan said that MMP data for PA was statewide outside of Philadelphia. N. Johns stated that priority setting took into account the higher unmet need percentage when different sources were in conflict. A. Thompson asked if the state MMP data could be separated out by zip code. B. Morgan said that this kind of analysis was unlikely to be completed in time for priority setting. A. Thompson said he'd try to gather more information about PA statewide data. N. Johns said that OHP staff would follow up with K. Brady from AACO to see if she could help the group obtain more data for priority setting.

A. Thompson asked how long Philadelphia had been collecting MMP data. T. Dominique stated that Philadelphia had been collecting MMP data since 2007. T. Dominique stated that AACO was currently doing a lost to care data collection project. She said data may be available from this project in the next year or so. A. Thompson asked if the program was part of the Black Box project. T. Dominique replied that she did not know if it was. A. Thompson noted that the Black Box program combined multiple data sources to try and find additional data on clients who were out of care. T. Dominique stated that the data for the program was being collected through Project CoRECT, led by Crystal Lucas. A. Thompson stated that lost-to-care data would be useful in priority setting. T. Dominique noted that people who were diagnosed with HIV in Philadelphia were not traceable when they moved away.

P. Yabor asked if all CD4 and viral load counts were reportable in NJ. A. Thompson replied that only one of these needed to be reported in NJ. P. Yabor asked if there was a cutoff for viral loads that needed to be reported. A. Thompson said that all viral loads had to be reported at diagnosis. B. Morgan said that NJ had comprehensive data that provided evidence of care.

Motion: The Comprehensive Planning Committee moved to approve the priority setting process with the potential addition of data sources in the unmet need section.

Discussion of the Motion

A. Edelstein asked why the process was subject to a vote. K. Baron explained that the Planning Council needed to vote on the changes in the priority setting process.

K. Baron encouraged all to attend the Comprehensive Planning Committee meeting.

Motion passed: 17 in favor, 0 opposed, 4 abstained.

Discussion Item:

- **Bylaws**

B. Morgan said she was distributing the draft updated bylaws, which reflected proposed changes as discussed by the Executive Committee. She stated that proposed bylaws changes would be open for comment for 30 days before voting. She encouraged members to discuss any changes or amendments they'd like to make today, at the June meeting, or at the July meeting of the Planning Council.

B. Morgan noted that the name of the group had changed to the HIV Integrated Planning Council. She said the name had been changed for all mentions of the Planning Council. She said that "CDC" was appended to all references to "HRSA." She stated that Section IV referred to "elected and appointed co-chairs" to account for the new governmental co-chair.

B. Morgan said that Article I, Section 5 added concurrence to the Planning Council's responsibilities. She stated that references to PLWH had been changed to people living with or at risk for HIV. She said that language that had changed over the years e.g. "HIV infection" had been updated to current preferred language (e.g. "HIV"). She said that co-chair terms had been updated. She stated that Article III, Section 3 included a description of the governmental co-chair position.

B. Morgan stated that the updated co-chair structure was described on page 4. She said the name of the Integrated Executive Committee had been changed to the Executive Committee, and the Prevention Committee had been added.

B. Morgan said she had a few copies of the bylaws with markup in red, for anyone who wanted to get a clearer picture of the changes.

Executive Committee

No report.

Finance Committee – *A. Edelstein and D. Gana, Co-Chairs*

No report.

Needs Assessment – *G. Keys, Chair*

No report.

Positive Committee – *K. Carter, Co-Chair*

A. Boone stated that the Positive Committee had met on Monday. He said that representatives from Siloam presented about their services. He said the committee also received information about priority setting and allocations.

Nominations Committee – *M. Cappuccilli and K. Burns, Co-Chairs*

M. Cappuccilli stated that the Nominations Committee was recruiting at the Prevention Summit on June 7th. He said that A. Boone and J. Hayes presented on social media, and he encouraged all to follow the OHP Facebook page and like posts. He invited all members to join the Nominations Committee, which met before the Planning Council on Thursdays.

Comprehensive Planning Committee – *A. Thompson, Chair*

A. Thompson reiterated that priority setting would be held next Thursday.

Prevention Committee – J. Chapman, Chair

J. Chapman said that the committee met on the 4th Wednesday of every month from 2:30-4:30pm. She invited all to attend the meeting. She added that, at their last meeting, the group had discussed concurrence. She added that she'd presented information on UCHAPS, which she could also share with the Planning Council in the future. She stated that they'd discussed future presentations that the Prevention Committee would like to make to the full Planning Council regarding prevention topics (e.g. PrEP). She explained that some prevention cascades had been developed concerning HIV risk, which could be correlated with the care continuum. She said exploring these connections could help incorporate the concerns of both care and prevention in the integrated planning process.

Old Business: None.

New Business: None.

Announcements: D. Gana stated that, next Saturday, May 20th, from 11am-1pm, the LGBT Elder Initiative (LGBTEI) was giving a presentation about HIV and Hepatitis C treatments at Temple University's Center City campus. He distributed fliers about the event and asked anyone who was interested to RSVP. He stated that AIDS Education Month was in June. He said he had informational cards to pass out to the group about AIDS Education Month events.

T. Dominique stated that an HIV Vaccine Awareness Day event was being held on May 18th at the William Way Center, which would focus on transgender experiences. She said she'd send out an email flier to OHP staff for distribution.

She added that the University of Pennsylvania Center for AIDS Research (CFAR) would be holding a men's wellness fair on June 27th. She said CFAR was holding a symposium on June 26th and was accepting posters for the event.

M. Coleman stated that Sunday was Mothers' Day. He said that the Susan B. Komen Race for the Cure would be held on Sunday on the Benjamin Franklin Parkway, starting at 8am.

N. Johns recommended a podcast named "Nancy" focusing on the stories and experiences of the LGBTQ community. She said one episode, from last week, featured a long-term HIV survivor interviewing a man who was recently diagnosed with HIV.

Adjournment: Motion: L. Way moved, J. Murdock seconded to adjourn the meeting at 3:51p.m. Motion passed: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- April 13, 2017 Meeting Minutes
- Integrated Planning/Concurrence Presentation Slides
- Service Priority Setting Worksheet 2017
- Planning Council Bylaws
- OHP Calendar