Philadelphia HIV Integrated Planning Council
VIRTUAL: Comprehensive Planning Committee
Meeting Minutes of
Thursday, August 19, 2021
2:00-4:00p.m.

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

Present: Keith Carter, Debra D'Alessandro, David Gana, Pamela Gorman, Gus Grannan (Co-Chair), Desiree Surplus, Nicole Swinson

Guests: Anna Thomas-Ferraioli (AACO), Julia Scarlett (AACO), Blake Rowley

Staff: Debbie Law, Mari Ross-Russell, Sofia Moletteri, Julia Henrikson, Elijah Sumners

Call to Order/Introductions: G. Grannan called the meeting to order at 2:04 p.m. He introduced himself as the co-chair of the CPC committee. He asked that everyone continue to introduce themselves and their region of representation within the chat. He asked everyone to include something they will miss about summer.

Approval of Agenda: G. Grannan referred to the August 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, D. Gana seconded to approve the August 2021 CPC agenda. **Motion passed:** 75% in favor, 25% abstaining. The August 2021 CPC agenda was approved.

Approval of Minutes (*June 17, 2021*): G. Grannan referred to the June 2021 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the June 2021 minutes. **Motion**: K. Carter motioned, D. Gana seconded to approve the June 17, 2021 meeting minutes. **Motion passed:** 50% in favor, 50% abstaining. The June 2021 CPC minutes were approved.

Report of Co-Chair:

G. Grannan reported that they did not meet last month because of allocations. Other than that, there were some tasks from the allocations process that were assigned to CPC.

Report of Staff:

S. Moletteri reported on the upcoming open nominations process. For those wanting to apply, they should do this as soon as possible. Those whose terms expired and needed to reapply should have received an email from D. Law making them aware of this. D. D'Alessandro asked how long the terms lasted. S. Moletteri responded that it was two years.

Discussion Items:

—Assessment of Telehealth Use—

S. Moletteri explained that during the July Allocations process, participants were concerned about the use of telehealth and tasked CPC with diving into this concern. When discussing possible directives, the allocations groups suggested that, regarding the Digital Divide, they needed to look into technology and corresponding accessibility resources to help clients access telehealth services, such as assistance and continuing support services for digital literacy. According to the recipient, AACO (AIDS Activities Coordinating Office), and specifically A. McCann-Woods who was present during the allocations process, there was not enough information around the future of telehealth and even the current use, but they had predicted that halting use of telehealth once in-person visits were safe was highly unlikely. Telehealth would likely be here to stay, though it was unsure at what capacity this would be the case.

During the Allocations process, they wanted CPC to look into more documented need behind telehealth. S. Moletteri mentioned how G. Grannan suggested that those having issues with the Digital Divide would be harder to reach, especially in a virtual environment. S. Moletteri continued, noting that during the process, it was suggested that CPC look into surveying CMs (Case Managers) within the system to uncover who was lost to care and if clients felt comfortable using technology/had access to it. S. Moletteri continued to explain that OHP was asked to look into state-level data. M. Ross-Russell and C. Steib reached out to the state, but they did not seem to find enough information there. They were redirected, and OHP was still looking into this.

D. D'Alessandro wondered if CPC could begin to ask the recipient about any data they had collected and if there was a way for them to survey the CMs. In the spring of 2020, she noted that the AETC (AIDS Education and Training Center) had hosted a virtual discussion group for providers to discuss the impact of COVID. Some of the CMs found that some patients were lost to care and not answering their phone. Others were happy to reengage by phone and access needed services. She mentioned how J. Browne from AACO was on the call and mentioned how they would work on a CQI (Continuous Quality Improvement) assessment or something similar to see if hard-to-reach clients were better retained with the utilization of telehealth. Therefore, D. D'Alessandro suggested CPC ask AACO if they had done any analysis and if they could survey CMs. She said that AETC and AACO could possibly work together to facilitate a focus group with CMs if this would be impactful.

S. Moletteri said that this was discussed within the allocations process, and AACO said they had not yet collected a significant amount of data. Additionally, they said that the outcome of results/survey response rate was fairly similar, no matter who was putting out the survey (AACO or OHP). They mentioned how it was likely that AACO would be able to help distribute any surveys or materials through their listservs and advertise at Directors' Meetings. Thus far, this was the extent of the discussion around collaboration with AACO.

D. D'Alessandro said that the AETC did not have data as of yet, but they had a digital platform that would possibly help in collaboration with AACO for key informant interviews or focus groups. As opposed to a quantitative analysis, they could work on a qualitative analysis. She felt that qualitative data and focus group collection would have more nuance and group discussion to build on information and topics. K. Carter asked how they would determine specific utilization of telehealth—for example, did providers collect data on whether a client had their visit in person or via telehealth? D. D'Alessandro said collection strategy was likely not very developed and that it differed site-by-site. However, if they were to get payer data, they would have a fuller answer, since insurance likely kept track of the type of visit since it impacted reimbursement.

G. Grannan added that, coming from his own perspective, clients ran into the issue of being able to gather in groups or visit locations. As only an example, G. Grannan said that federal guidance around Buprenorphine and Methadone were consonant with CDC recommendations regarding face-to-face contact. Federally, people were given more than they would have received prior to the COVID-19 response so that they could minimize their face-to-face contact. However, this was not enacted in Philadelphia, as this was the decision and response of service providers. As far as he knew, no MAT (Medication-Assisted Treatment) service provider changed their procedure to minimize face-to-face contact. He suggested that it was worthwhile to look into RW-funded service providers (of all services) to see if providers not changing their procedures was an issue. He felt that they should not only talk to CMs but also staff that interacted with federal and state policy to see what type of guidance they received and how they followed guidance to minimize COVID-19 transmission.

D. D'Alessandro responded to G. Grannan, saying she was not familiar with Methadone programs, but she knew of FQHCs providing Buprenorphine that started to offer initial visits via telemedicine, relaxed requirements for the number of visits or substance use screenings, etc. G. Grannan said that particularly within Methadone, there was a lack of following COVID-19 guidance. D. D'Alessandro asked if there was overlap between Methadone clinics and what was RW funded. G. Grannan said he was only using Methadone as an example to acknowledge the difference between guidance and how or if it was enacted. He felt that Methadone was an especially bad response in Philadelphia and might an outlier. Still, he was curious to see how clinicians responded to and enacted new instructions.

K. Carter asked that they focus more on how many clients that RW serviced had difficulty with telehealth. G. Grannan agreed but suggested that every clinical field might have had difficulty with enacting new recommendations. He felt it worthwhile to interrogate the people who were delivering services just as much as those receiving services. He wanted to ensure that providers funded under RW were following guidance and making things as safe as possible for their clients. Some providers may have done a better job with following and enacting new instructions, but he would like to see it documented.

J. Scarlett stated that, to her knowledge, AACO did not have much qualitative data on telehealth. They performed an assessment around the COVID-19 response with providers but there were only a few questions. She added that AACO recently enacted a CAREWare subservice to capture utilization of telehealth, but this was still in its beginning stages. Start-date for data collection was staggered from provider to provider, so they did not know the exact date for when data would be universally collected. K. Carter felt this was great that they could capture this data as it rolled out. He asked how they could find out how clients used telehealth and if this could be done through a survey. He noted that most of his appointments had been telehealth and that this would continue unless an in-person visit was necessary. He liked the idea of a focus group for data collection. D. D'Alessandro said her organization had easy access to providers—not as much clients. S. Moletteri said they would document this as a suggestion as they brainstormed and built a fuller picture. This discussion would be the "bones" of a larger plan-of-action. K. Carter suggested that the shelter system was a place they could get data from individuals.

S. Moletteri directed attention to the slide titled *Telehealth: A quarter-trillion dollar post-COVID reality?* They explained that this article was from McKinsey and published on July 9, 2021. This article had a few studies from different timelines during the COVID-19 crisis. Studies found that there was around 80x more uptake in telehealth during April 2020 than February 2020. After April 2020, this leveled out to about 38x more use when comparing February 2020 to February 2021. As for a shift in finances, it was estimated that there would be a $250 billion shift of US Healthcare to virtual support. As for investments, it was predicted that investments would double in 2021 and there would be innovation within virtual health models. Though none of this was directly related to RW, S.

Moletteri explained that this was just to get an idea of the general landscape, financially, for health services.

S. Moletteri reported that the study showed that uptake in telehealth utilization depended on the service, itself. For example, Substance Use Treatment (30% uptake) and Psychiatry (50% uptake) were leading for virtual, and surgeries were the lowest in telehealth uptake. Because of this uptake, the studies predicted that hybrid models would evolve.

S. Moletteri referred to the slide titled *A breakdown of modality.* The data was up to date and as of June 14, 2021. Based on the chart presented, it was found that Psychiatry and Psychology had a majority of their appointments virtually or via telephone. For other services, depending on what type it was, there was an average of 15%-20% appointments virtually/via telephone.

K. Carter mentioned how telehealth appointments were much shorter, time-wise. His visits were around 15 minutes. In-person, his visits were closer to 45 minutes long. M. Ross-Russell explained how this was due to reimbursement. For Fees for Service under Medicaid or Medicare, visits were generally timed as 15-minute intervals due to different reimbursement rates. It was to ensure that providers were reimbursed at the same rate that they would be for in-office visits. M. Ross-Russell noted how states allowed for telehealth coverage under Medicaid/Medicare as a response to COVID-19. However, it was unsure exactly how long this coverage would continue. M. Ross-Russell added that, for telehealth, some providers may have different uptake due to the costs associated with implementation. S. Moletteri added that there were also ongoing costs for upkeep.

N. Swinson reported that she was unable to find telehealth options for CBOs since models were typically for the provider-level. She asked if there were options for reimbursements/models in place that were not exclusive to medical practices. M. Ross-Russell responded that she had only found content specific to medical providers and services. This did not include CM services, etc.

G. Grannan asked about the 15-minute intervals and whether it was included with/billed alongside provider time for keeping records, writing prescriptions, etc. M. Ross-Russell said she was unsure, but there were different categories and codes for billing. There were different codes associated with different types of activities that were part of one visit.

D. D’Alessandro said that prior to COVID-19, an organization in Philadelphia had developed a way to bill insurance for their CM on a service unit-basis, though this took a while to achieve since it did not fit their medical model. She was curious to know if it allowed them to bill for telehealth. She knew that the perinatal HIV CMs were dropping supplies off at people’s homes to individuals could remain distant. She said that they might have insight about social service billing for telehealth. M. Ross-Russell said she would ask.

K. Carter asked what they were trying to uncover regarding telehealth—provider billing, client access, etc.? He felt they needed to be more focused on the type of data they wanted to collect. M. Ross-Russell said that the initial conversation they had was based on the belief that telehealth was here to stay as part of the system. Telehealth was billable through the RW service category Ambulatory Outpatient Medical Care. Additionally, they would need to discuss next steps and consider the Digital Divide given that telehealth was here to stay.

M. Ross-Russell said, in order to craft a plan-of-action, they needed to ensure that they were looking at all of the information available to them. K. Carter suggested they look into the cost of providing people with a phone, laptop, and computer. D. D'Alessandro agreed, noting that there was also the issue around accessing internet continually.

M. Ross-Russell found out that within the state of PA's Medicaid programs, they all paid for some form of smartphone. S. Moletteri said there was a Digital Divide resource guide on the hivphilly.org website which had many resources for bridging the Digital Divide. They mentioned that, not only did the Medicaid program cover the phone, but it also covered data and other ongoing costs associated with technology.

S. Moletteri said that OHP staff could help assist with the development of questions and focal points that came from the CPC discussion. OHP staff could consolidate discussions to present to CPC so that the committee did not feel the need to come up with final language or steps. M. Ross-Russell agreed, adding that OHP staff was interpreting the information from studies and presenting it to them. S. Moletteri agreed, noting that this point of presenting such information was to generate discussion and acknowledge any concerns.

S. Moletteri moved onto the slide titled *Perceptions of telehealth have improved.* They reported that for clients, 40% surveyed in June 2021 said they would continue use of telehealth as opposed to 11% pre-COVID. To clarify, this did not mean that clients would *only* use telehealth, but they would continue to participate as needed. As for providers, as of April 2021, 84% of physicians were offering virtual care, and 57% wished to continue with it. Additionally, 58% of physicians viewed telehealth more favorably than they had before.

S. Moletteri addressed the slide titled *"Digital front doors" & more benefits listed.* They explained that "digital front doors" were supposed to make it easier for patients to research more care options, find new providers, schedule appointments, etc. Additionally, it meant patients could do online registration, bill-pay, fill out e-forms. Meanwhile, providers could offer retention and review surveys.

Another benefit of telehealth mentioned in the article included how it could be more convenient for clients. Also, those living in rural areas could have increased access to care. The article explained that some rural areas did not have Behavioral Health and specialty care access. Some counties did not have psychiatrists/psychologists. When patients were able to access providers virtually, they could go further outside their county or their rural location. The study also reported that telehealth could improve health outcomes (especially with the addition of remote monitoring) and could prove to be more affordable.

S. Moletteri next looked at the Morbidity and Mortality Weekly Report (MMWR) study titled *Trends in Telehealth Use*. The study matched trends in telehealth use to trends in COVID-19 cases. This study analyzed data from 245 health centers for 20 consecutive weeks (June 2020-November 2020). The study found that telehealth dropped as COVID-19 cases decreased and plateaued or only rose slightly during any rises in COVID-19 cases.

The study compared rural and urban areas. It found that rural areas had averaged the lowest use of telehealth. These areas had more trouble providing telehealth due to a lack of providers and partners, logistics, and broadband access. The Northeast, and especially the urban areas, had more use of telehealth as compared to the Midwest and South. In all, the study reported that 43% of health centers could provide telemedicine pre-COVID compared to 95% having ability afterwards.

As for barriers and concerns, S. Moletteri said the study listed the following: continued device and broadband support, logistics, training, and the need for *continued* flexibility for the Medicaid and Medicare telehealth reimbursement policy. The study reported that there had been additional resources to help with telemedicine, but the concern was that they may run out. The study indicated that there should be federal and local level considerations around the future of telehealth.

S. Moletteri said that both studies agreed on the following: (1) telehealth improved health outcomes, (2) telehealth was important to the future of healthcare, and (3) telehealth was beneficial to those with limited access to care.

S. Moletteri read the last slide titled *NJ and PA have both expanded telehealth coverage.* They noted that this slide explained what NJ and PA were both doing to expand telehealth coverage under CMS (Centers for Medicaid and Medicare Services). Please refer to this slide for more information.

D. D'Alessandro said that during PA's primary, there were several referenda on the ballot, two of which involved telehealth coverage. The voters decided that both would take power from the governor and give it to the state legislature around two COVID-19 related issues. She suggested that this might impact coverage for telehealth in the future.

S. Moletteri asked if there were any questions or facts that remained unanswered from the study. They asked if there was any interest in people's perceptions toward telehealth. K. Carter said telehealth was something some people with disability might already have been using, as it was more convenient. Others might have difficulty using telehealth due to hearing loss or inability to use the technology. They should keep both of these factors in mind.

G. Grannan said he was personally troubled that one of the reports that CPC looked at was from McKinsey and their forecasted quarter-trillion dollar market. He felt that they needed to ensure there were no financial burdens placed on consumers. K. Carter asked if there was a fee for COVID-19 visits and if billing was increased, comparatively. G. Grannan said there was an exteriorization of costs.

S. Moletteri asked if anyone had more input regarding the section about rural areas and telehealth. G. Grannan said these areas were simply unable to expand access. D. D'Alessandro noted how the COVID-19 response shined a light on disparities. There were issues that needed to be dealt with systemically, and some things could not be fully addressed with the RW program. K. Carter agreed, noting that there were other funding streams while RW was a payer of last resort. Other funding streams should be able to provide phone services and internet access. He also said that some individuals might be not prioritizing technology and paying associated bills, because they were more focused on rent, food, etc.

G. Grannan said the group needed to be mindful of whether they were placing money as advised under a "profit lens" or if they were actually serving people and meeting their needs. K. Carter said that health outcomes were important and that this was the focal point. They needed to ensure that they were getting clients what they needed and were working to bridge the Digital Divide.

G. Grannan mentioned how bridging the Digital Divide and providing internet/phones was easier in urban areas, but not in the rural parts of the EMA because of lack of cellular service. K. Carter said they needed to look into providers/organizations to identify whether they were providing phones and data plans to individuals. G. Grannan mentioned how the places that were actively and consistently providing phones were private and not governmentally funded. When talking to providers, he suggested asking them about their barriers related to this. He felt that the group had a pretty good idea about the barriers for certain risk models, but he was interested in hearing more from the provider perspective—were there barriers around funding, policy, etc? They needed to do what they could to remove these barriers. There were barriers on the service provision side as well. They also needed to look into addressing these once they were uncovered.

S. Moletteri said that G. Grannan's last suggestion fit into the earlier discussion for a provider focus group. G. Grannan mentioned how K. Carter was right in that people who needed services should not see telehealth as barrier. As a committee, they would have to investigate how they could communicate this.

G. Grannan asked if they had enough content to begin the work. S. Moletteri said they did.

—Consumer Survey—

S. Moletteri reported that they needed to perform another Consumer Survey, as their last survey occurred in 2017. J. Henrikson flipped to page 7 of the 2017 Consumer Survey. S. Moletteri briefly reviewed the methodology. In 2017, they stated that CPC was involved in the process, as OHP presented the committee with recommendations for changes, removals, and additions to the prior Consumer Survey, based on current policy, changes in clinical practice, and community feedback gathered at a local HIV summit earlier that summer. This year, they would not look at the 2012 questionnaire, they would instead be reviewing the 2017 version. They asked the committee if they were still comfortable with this approach to the Consumer Survey process.

M. Ross-Russell said that as part of the Consumer Survey process, OHP took into consideration the current environment and discussions within the council and committees. Lately, the committees had been discussing the lack of information around elders living with HIV. They were also discussing telehealth. There were many topics that had surfaced during the course of the year, including COVID-19, that could lend itself to a survey. She explained that the survey itself was long, which could decrease the response rate. In terms of the survey distribution, they also had to consider the "how." OHP did not have a contact list of or access to PLWH. They had to work with providers to distribute the survey. Last survey round, they distributed the survey online *and* hardcopy. Additionally, CPC would soon look at performing their Priority Setting process. She said that this was not a quick process, but it would be thorough. S. Moletteri mentioned the Literature Review that J. Henrikson had presented on about people aging with HIV. K. Carter mentioned how over 50% of PLWH within the EMA were 50+ years old.

K. Carter said that they should review the questions on the survey. Then, they could see which questions had sufficient information, take them out, and replace them with newer questions (like the telehealth questions or aging with HIV questions). This way, they could keep the survey the same length. S. Moletteri asked if this meant they wanted to review and rate the questions. D. Gana said he liked the idea of rating the questions. He asked that it be sent to the committee before their meeting so they could have more of an active discussion. K. Carter said they also needed to consider the directives during the Consumer Survey process.

M. Ross-Russell said that CPC should consider their “wish list” of what should be on the survey and look at other surveys for inspiration. M. Ross-Russell said that the creation of the survey would take time and that they also had to go through the City’s IRB.

There were no questions.

Other Business:
None.

Announcements:
D. Gana announced that the CFAR CAB Red Ribbon Committee just released the awardees for the year. Some individuals, HIPC knew well. C. Terrell was receiving an award for policy. J. Bauermeister was receiving an award for research. Philadelphia AIDS Thrift was receiving the pioneer award. The event would be on December 1, 2021, World AIDS Day.

Adjournment:
G. Grannan called for a motion to adjourn. **Motion**: D. D’Alessandro motioned, K. Carter seconded to adjourn the August 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:53 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:
- August 2021 CPC Meeting Agenda
- June 2021 CPC Meeting Minutes
- 2017 Consumer Survey