Meeting Agenda

VIRTUAL:
Thursday October 20, 2022
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(September 15, 2022)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
  - Substance Use Services in NJ Counties
  - Integrated Plan Comments (Care-Related Goals)
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next Comprehensive Planning Committee meeting is
VIRTUAL: Thursday, November 17, 2022 from 2:00 – 4:00 p.m.
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Comprehensive Planning Committee

Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, September 15, 2022
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Debra D'Alessandro, Gus Grannan (Co-Chair), Pam Gorman, Gerry Keys, Adam Williams

Guests: Peggy Neumann, Sanzida Anzuman (AACO), Blake Rowley

Staff: Beth Celeste, Sofia Moletteri, Mari Ross-Russell

Call to Order/Introductions: G. Grannan called the meeting to order at 2:10 p.m. He said the introductions were going on in the Zoom chat. He asked everyone to introduce themselves with their name, area of representation, and organization if applicable.

Approval of Agenda:
G. Grannan presented the September 2022 agenda for approval. **Motion**: K. Carter motioned, P. Gorman seconded to approve the agenda via a Zoom poll. **Motion passed**: 4 in favor, 1 abstaining.

Approval of Minutes (*August 18, 2022*) G. Grannan presented the previous meeting's minutes for approval via Zoom poll. **Motion**: K. Carter motioned, G. Keys seconded to approve the August 18, 2022 meeting minutes. **Motion passed**: 4 in favor, 1 abstaining.

Report of Chair:

No report.

Report of Staff:

M. Ross-Russell reported that there was a discussion around meeting mode: hybrid, in-person, or virtual. First, they would have an Executive Committee meeting followed by a HIPC meeting to figure out what individuals were comfortable with moving forward. They could have a discussion or put out a survey. They could also look to clinics and other places that were receiving clients in-person for guidelines for in-person meetings. She wanted to ensure that everyone was as safe as possible. She asked that people email/share materials that could help them move forward with either hybrid or in-person meetings.

She reported that they also were still entering the Consumer Surveys.

G. Grannan noted that his organization had guidelines around sex workers and COVID as well as PWID and COVID. M. Ross-Russell said they were discussing transportation reimbursements and, for example, signing a sheet. Even use of the same pen would be something to consider. They have to consider all factors, including cleaning and sharing equipment. K. Carter asked if the City or AACO had a policy in place. M. Ross-Russell said she had asked them, and AACO had a policy about their office. An office, internally, was different than managing the public/individuals coming into a space. Thus far, OHP had managed the office well, but they now needed to consider the involvement of the public to keep both them and OHP staff safe.

A. Williams asked if he should share the guidelines now or via email. M. Ross-Russell said via email so she could compile and present everything. P. Gorman said she would send something over as well.

S. Moletteri reported that the Positive Committee finished writing the Monkeypox (MPV) letter to the Philadelphia's Health Commissioner, Dr. Cheryl Bettigole. The next step would be for HIPC co-chairs and the Positive Committee co-chair to sign it. Then they would send it out.

Presentation:

—Non-Medical Case Management—

S. Moletteri said that they had talked about Non-Medical Case Management (NMCM) within Priority Setting and could not vote it a high priority since they did not have enough information. Luckily P. Neumann and P. Gorman had information on the service category and were able to present on it since they received funding for their NMCM program within the Cooper Health NJ system.

P. Gorman thanked everyone for asking her to present. She disclosed that Cooper received funding for Medical Case Management (MCM) through the RW Part A Minority AIDS Initiative. For NMCM, they received funding from the NJ Department of Health, Division of HIV, STD, and TB services. There were two different funding sources funding the two different types of Case Management.

As for the program itself, Cooper had multidisciplinary comprehensive medical and supportive care. They were a one location, one-stop-shop on the campus of Cooper University Hospital. They were located in Camden.

Regarding the NMCM model, it was integrated within a multidisciplinary chronic care model for the delivery of health and supportive services. They worked in partnership with MCM and Clinical Navigation staff to assist clients with accessing medical, social, community, legal, financial, employment, vocational, and/or other services. They focused on addressing immediate needs upon entry into care or re-engagement of care. The position supported physicians, advanced practice providers, clinical psychologists, pharmacy liaison, and other Cooper specialists when providing medical care. She noted that since everyone was available during medical appointments, specialist providers would be able to reach out to the NMCM for lapses in insurance, transportation, and other NMCM needs.

The official title for the NMCM position, she explained, was Health Coach. The way it worked for their clinic was that when a person first came in for services, the Health Coach would complete an intake/acuity assessment to determine unmet social services and health needs. Then, they completed referral and linkage for medical care, social services, and MCM. This meant assisting with applications such as housing and other application needs. The Health Coaches would complete RW Certifications on all patients to determine RW eligibility for reentry or first engagement to care. They also worked with Insurance applications since these could be complex applications which was especially important for new patients. There goal was to get individuals on insurance within the next 30-60 days. They would also assist with scheduling Specialty Care referrals that were generated from EIP Physicians for patients that did not have ongoing MCM needs.

The Health Coach would ensure that clients could get connected to Support Services such as food assistance, transportation, housing, emergency financial services (for housing, utilities, and urgent medication), community services, and dental services.

As for how Health Coaches operated with other positions, they had a "warm hand-off process." The Early Intervention Program (EIP) Navigators would do a hand-off to the Health Coach. The Health Coach would then assist with calls to AACO Client Services Unit for a Rapid Assessment Plan (RAP) to be completed for MCM services. A large part of their job and the hand-off process also included internal referral for MCM based on acuity score and considering whether the client requires additional health care and psychosocial support. During this time, the Health Coach would work to connect clients to all services needed until they could be supported by an MCM. For those who were never in or were reengaged in care, the support and referral from the Health Coach was important, as these individuals would still be supported as they waited for MCM and receive services especially if they had high viral loads or other issues they needed to deal with. Essentially, the Health Coach and MCM worked in collaboration to provide services jointly to sustain the patient rapport and comfort level with existing staff.

For their Integrated EIP Model, there was an overlap of services which required employees to work as teams. Cooper EIP had three teams comprised of staff from each delivery service from registration to discharge of visit that facilitated communication and streamlining services to avoid duplication of effort. The teams were as follows: Clinical Navigator, Health Coach, and MCM. The Clinical Navigator was most similar to Early Intervention and would visit and ensure that clients were connected to a Health Coach and able to get in the doors of the hospital. In order to ensure that everything was moving smoothly between different departments, there were daily huddles to review the patient schedule, discuss any potential concerns with care, review hospitalized patients, and identify newly diagnosed/re-engaged in care patients being navigated into medical care.

P. Gorman next looked at the differences between NMCM (Health Coaches) and MCMs. She added these slides because she saw that this was the main question from CPC. This, however, was only the way that Cooper separated out the two. They viewed NMCM as immediate and short-term assistance that was needed to access medical, social, and other services to improve access and retention to care. MCM was seen as long-term services to assure improved health care outcomes and manage HIV viral load and other health conditions.

P. Gorman next read the PCN 16-02 which stated the official service definitions of MCM and NMCM. NMCM is as follows: *NMCM Services objective is to provide coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services.* She next read the MCM definition which is as follows: *MCM Services objective is to improve health outcomes.* She added that for MCM—in addition to addressing individuals not meeting viral suppression and have other medical conditions associated with HIV—MCMs needed to track their own progress with connecting the client to services and improving their health outcomes. Since HIV could exacerbate comorbidities, it was important for them to track how well a patient had improved.

Defining CM Services, both NMCM and MCM were essentially the same. She read the full definitions from PCN 16-02. The way Cooper differentiated the two was that MCM was intensive for those that needed a lot of assistance with managing health care, both for HIV and non-HIV medical conditions. NMCM was more for initial support for those who could manage their own care and health well. If care coordination was more complex, that was when they would move clients from NMCM to MCM.

P. Gorman next looked at the service comparison activities from PC 16-02 for both NMCM and MCM. They were essentially identical, except the assessment for MCM was much more intense. P. Neumann said that for those discharged from MCM or only using NMCM, Health Coaches would check in with clients every 6 months to ensure that they still did not need the more intensive MCM support.

G. Grannan asked who was responsible for administrative responsibility of the Health Coach Program. P. Gorman said she was responsible for the grant management piece, but P. Neumann was the supervisor of the program. G. Grannan asked about the career progression ladder for the NMCM role. P. Gorman said they advocated for growth within the role, so they might be given the MCM role depending on expertise and experience. They did not require educational requirements for the Health Coach role, but if people were to receive other education, this would call for a raise or movement upward in position. Within the role itself, they tried to help people grow within and stay on if they enjoyed the work and provided good care to patients. P. Neumann said most employees had been in the role for a fair amount of time, and some people were retiring after having been there for a long amount of time. P. Gorman said the work was often rewarding.

K. Carter asked about the order of professional growth and if it went Health Navigator to NMCM to MCM. P. Gorman responded that Health Navigators started at a higher level and that if progression occurred it would be NMCM to MCM. She said it was difficult to understand the differences between the two roles and that PC16-02 also had similar language.

G. Grannan mentioned the warm hand-off and asked if medical staff was good with working with the Health Coaches and MCMs. P. Gorman said everyone worked well and cooperatively with each other. P. Neumann said she encouraged the NMCMs to interact with physicians and build rapport to ensure smooth delivery of support and services. Additionally, they ensured that everyone worked well together regardless of differences in credentials.

Discussion Items:

—Topics from 2022 Allocations—

S. Moletteri explained that the discussion items were two sides of the same coin. They would look over some topics from allocations and discuss what they would like to do with them, e.g. a small request for information, presentation, research from OHP staff, etc. There was also a topic from Priority Setting on the list. After they looked at the topics and made plans, they could put them in their meeting schedule up until February 2023.

S. Moletteri pulled up a Google Doc titled “Topics from 2022 Allocations.” Each of the topics were separated into three categories, depending on when they were brought forth: NJ Counties, PA Counties, and Philadelphia Allocations.

From NJ Counties Allocations, Substance Use Outpatient or Inpatient was funding by RW Part A. Therefore, they suggested learning more about funding and the services themselves within NJ. The next topic concerned ADAP Program/funding within NJ. The last was from Priority Setting but concerned NJ Counties. There was a quick mention during Priority Setting about transportation services in NJ Counties. S. Moletteri asked how they felt about each topic and what more they wanted to know.

P. Gorman said that NJ Counties had received SAMHSA money for substance use funding. They were full with patients receiving access to care, but there were other funding sources other than Part A that provided care and treatment for substance use. She said that Cooper specifically received a large grant from NJ for MAT and had a few locations for clinics, treatment, and methadone programs.

P. Gorman noted that for ADAP in NJ, they had an open formulary, meaning all HIV medications were available through ADAP. They also had EFA which was another route for emergent medications.

As for NJ transportation, P. Gorman said she was interested in learning more about the shortages in funding for this service. They used all of the transportation funds quickly. G. Grannan said public transportation was not good in NJ unless you lived near a line. P. Gorman reported that her organization spent through Part A transportation funding quickly. There were also many shortfalls for Medicaid transportation which they had often discussed in the HIPC. K. Carter asked how transportation in NJ affected care and appointment attendance. P. Gorman said that regarding Cooper specifically, they received additional funding support to ensure patients had access to care. If an agency only had Medicaid transportation to rely on, however, this would be a challenge. For those who were outside of the four-county area and were an agency that did not have additional resources, this would also be an issue. She noted that this came down to each agency themselves and how they could come up with workarounds to address barriers and need around transportation.

S. Moletteri asked if they would like an external presentation around NJ transportation. G. Grannan agreed, but was unsure who could offer a presentation. P. Gorman suggested they get someone from the State of NJ to discuss transportation – she suggested reaching out to the state to talk more on this.

M. Ross-Russell asked P. Gorman if LogistiCare was in NJ as well. P. Gorman said it was, but she was unsure if they switched to a different provider. M. Ross-Russell said public transportation was inaccessible. Therefore, clients had to deal with secondary means of transportations – this, of course, then depended on wait times and the providers, themselves. These secondary means of transportation (ride shares) used funds much more quickly because they were more expensive. Unfortunately, RW was a payer of last resort, so it was expected that individuals use Medicaid transportation first (since the majority of individuals served in the system received Medicaid).

K. Carter asked if each county in NJ had a different Medicaid transportation provider or if it was the same throughout the state. M. Ross-Russell did not know, so this was information they would need to find out from the State of NJ. Any conclusions from NJ Counties, M. Ross-Russell surmised, would also help with perspective on PA Counties transportation. K. Carter said that the buses in PA Counties were limited in amount and schedule.

P. Gorman said, most importantly, they had great data to demonstrate the issue with transportation by simply showing how fast they used their transportation funds. K. Carter asked if the quickly spent funds were due to COVID-19. P. Gorman responded that this had nothing to do with COVID-19 and that the system for transportation was not well organized or effective. K. Carter asked if NJ received any EHE money. P. Gorman said they did, but it was for Newark. With the last competitive grant application for state funds (HIV Neutral Grant), this opened up the door and was more in alignment with EHE.

K. Carter asked if they should also look into PA Counties for transportation. S. Moletteri said that in Delaware County, there were okay routes with nice schedules, but this was information based on a very limited area in Delaware County. M. Ross-Russell said based on what people had said about the PA Counties historically, there was likely more support for public transportation in Delaware County because of the way people traveled from this county into Philadelphia. However, for Chester, Bucks, and Montgomery Counties, the ease of transportation was lacking. To answer K. Carter's question, M. Ross-Russell said she could ask A. McCann-Woods about spending trends and see if they were having the same access issues in PA Counties. S. Moletteri said this could count as a request for information.

G. Keys said that ModivCare had replaced LogistiCare. Based on a quick search, M. Ross-Russell said that LogistiCare seemed to have changed its name to ModivCare.

S. Moletteri asked if they wanted to know more information about Substance Use. K. Carter said it sounded like NJ had other funding streams for individuals to access if they needed it. G. Grannan agreed,

noting that there was a State Department of Substance Use Care. He said they could possibly contact them and see if they had data on how many PLWH they were treating and whether they knew this number. Similar to what P. Gorman was saying, he said that people would have to go through this department for Substance Use Care funding. K. Carter asked how likely it was that they would know the amount of PLWH served. G. Grannan said he was unsure, but only the state would likely know this. M. Ross-Russell said that the state would likely have this information, but the biggest issue was dependent on whether people were funded through private insurance or Medicaid. M. Ross-Russell said there should be treatment data through SAMSHA. This was not dependent on funding—it was dependent on information from facilities and their reports back. The data should be available for public funding. S. Moletteri said they could research and present the data they could find.

S. Moletteri next noted that there was a discussion within the PA Counties Allocations process about the housing crisis and the lack of structures and available affordable housing. K. Carter said that this was such a large issue and that this would be challenging to tackle. S. Moletteri said this came up often within HIPC and that CPC recently put forth the Housing First model as a way to tackle the issue. K. Carter was unsure what more they could do about this issue since most it had to do with lack of physical structures. G. Grannan agreed. K. Carter asked to parking lot the issue.

K. Carter added that people from the counties needed to show up and report the issues with and offer feedback. G. Grannan said that those in the counties refer clients to Philadelphia for housing, though they did not offer specifics about where to go. G. Grannan agreed on parking lot for the issue. S. Moletteri agreed, saying this was a much larger discussion. When they got to it, she would also look for information.

S. Moletteri next looked at the Philadelphia Allocations. They had come up with a directive to review which services were most utilized and needed by PLWH who were 50+ years old. Since they discussed this often, she asked if they had anything to add to this topic. K. Carter asked to wait for AACO to get back to CPC by January or February to report where they were on this directive. S. Moletteri agreed, saying this would be a good report back for this directive.

—Committee Workplan from 2022-2023—

Now that they planned around the topics and what information they would like to know, S. Moletteri suggested they put dates on the calendar to decide when they would tackle each topic.

S. Moletteri suggested they look into housing after February 2023. D. D'Alessandro and G. Grannan agreed.

S. Moletteri suggested transportation be tackled in either October or November, depending on when presenters were available. K. Carter also wanted to know more about LogistiCare/ModivCare's contract. M. Ross-Russell said as far as transportation providers that accepted Medicaid, there were not many. K. Carter said coverage for rideshare services also depended on the medical need of the patient. Everyone agreed that October/November would be a good timeline for presentation on this topic.

G. Grannan asked if they had enough information on the ADAP item under NJ Allocations. S. Moletteri explained that these were just numbers HIPC had not received back from NJ in time for allocations. This would likely be a small report back. M. Ross-Russell said that the client data had since been posted online and was accessible. She could not break it down regionally, but they provided age, gender, race, housing status, insurance status, etc. state-wide. In 2020, there were 6,338 ADAP clients served in NJ State. M. Ross-Russell said ADAP could be supported by Part A, but it was a solid Part B service, meaning it was the state-funded Ryan White program.

S. Moletteri said they could also look into Substance Use in NJ during October/November depending on presenter availability. Everyone agreed.

As for the topic around aging, she suggested they look at this during January/February 2023. Everyone agreed.

Other Business:

None.

Announcements:

G. Grannan announced that Ladonna Smith—active in the HIV community in Philadelphia, past employee of FIGHT, and founder of a nonprofit in Kensington to provide shelter to women for PWID—had passed away this week. He asked that those interested in the service, yet to be scheduled, get in contact with him. Ladonna used she/they pronouns and had been the Executive Director of Serenity House.

Adjournment: G. Grannan called for a motion to adjourn. **Motion:** K. Carter motioned, G. Keys seconded to adjourn the September 2022 Comprehensive Planning meeting. **Motion passed:** all in favor. The committee adjourned at 3:47 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- September 2022 CPC Meeting Agenda
- August 2022 CPC Meeting Minutes
- Topics from Allocations 2022 Process

Department of Public Health
CITY OF PHILADELPHIA
AIDS Activities Coordinating Office

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Diagnose

Goal 1: To diagnose 95% of Persons Living with HIV (PLWH) by 2026

Objective 1: Promote routine opt-out HIV screenings and diagnostic testing in 50 healthcare and other institutional settings by 2026.

Objective 2: Maintain HIV testing services in priority non-clinical settings cited in the activities.

Objective 3: Implement novel HIV testing initiatives.

Goal 2: Eliminate Disparities in non-clinical HIV Testing

Objective 1: Increase the number of partners to address syndemics to reduce new HIV diagnoses.

Objective 2: Increase HIV testing among priority populations by 20%.

Objective 3: Enhance health equity efforts through policy and process improvements annually.

Objective 4: Evaluate HIV testing programs to address disparities in priority populations annually.

Goal 3: Strengthen the HIV workforce including collaboration with NJ and PA DOH

Objective 1: Increase the capacity of the HIV workforce to provide quality services.

Objective 2: Support efforts of funded providers to diversify their HIV workforce.

Treat

Goal 1: By 2026 95% of PLWH will be virally suppressed

Objective 1: Increase Uptake of Antiretroviral Therapy by XX % .

Objective 2: Re-engage 95% of PLWH out of care in HIV medical care.

Objective 3: Assess the needs of people aging with HIV in the jurisdiction, including long-term survivors and more recently diagnosed PLWH over 50 and identify and implement strategies to support identified needs.

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Goal 2: Increase engagement in HIV medical care to 95% among PLWH

Objective 1: Address social and structural influencers of health to reduce barriers to engagement in care for PLWDH who seek behavioral health care, housing, and supportive services.

Objective 2: Provide public-facing information on the availability of HIV treatment and supportive services for PLWH.

Goal 3: Reduce HIV-Related Disparities in HIV Outcomes

Objective 1: Address health equity disparities in Ryan White funded HIV care facilities.

Objective 2: Expand the evaluation of HIV care programs to reduce health disparities.

Objective 3: Provide training related to health equity issues and key populations to all subrecipients.

Prevent

Goal 1: Use biomedical prevention strategies to reduce new HIV diagnoses by 75%

Objective 1: 50% of people with a PrEP indication will be prescribed PrEP.

Objective 2: Ensure reliable 24/7 access to nPEP.

Objective 3: Support Perinatal Prevention Services for pregnant individuals.

Goal 2: Increasing the number of access points for evidence-based harm reduction services

Objective 1: Expand access to harm reduction supplies through novel approaches.

Objective 2: Improve SSP service delivery.

Goal 3: Reduce disparities in HIV-related prevention services in priority populations

Objective 1: Monitor local disparities along the Status-neutral Continuum.

Objective 2: Reduce HIV-related disparities in new diagnoses among priority populations.

Objective 3: Increase and support health promotion activities for HIV prevention in the communities where HIV is most heavily concentrated.

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Respond

Goal 1: Identify and investigate active HIV transmission clusters and respond to all HIV outbreaks

- Objective 1: Maintain a robust core HIV public health data system to identify outbreaks of HIV.
- Objective 2: Maintain outbreak response plans and structures to respond to outbreaks and clusters that require an escalated response.
- Objective 3: Intervene in all clusters that are identified.

Goal 2: Ensure data sharing with the PA and NJ Departments of Health

- Objective 1: Expand data sharing with PA.
- Objective 2: Implement data sharing with NJ.