MEETING AGENDA

Thursday, April 11, 2019
2:00 p.m. – 4:30 p.m.

Call to Order

Welcome and Introductions

Approval of Agenda

Approval of Minutes (*March 14, 2019)*

Report of Co-Chairs

Report of Staff

Public Comment

Presentation: Understanding Data (Briana Morgan, OHP)

Discussion Items

Allocations preparations

- Outpatient Ambulatory Medical Care – Gerry Keys
- Medical Case Management – Lupe Diaz
- Medical Transportation – Keith Carter
- Direct Emergency Financial Assistance (DEFA) – Mari Ross-Russell, OHP

Committee Reports:

- Finance Committee – Alan Edelstein & David Gana
- Nominations Committee – Michael Cappuccilli & Sam Romero
- Positive Committee – Keith Carter & Jeannette Murdock
- Comprehensive Planning Committee – TBD
- Prevention Committee – Lorett Matus & Clint Steib

Old Business

New Business

Announcements

Adjournment

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

The next HIV Integrated Planning Council meeting is scheduled for
Thursday, April 11, 2019 from 2:00 – 4:00 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107

HIV INTEGRATED PLANNING COUNCIL

Service Priority Setting Worksheet 2019

Each service category will be scored according to these factors and scales using the sources noted for each factor. For the Community Voices factor each individual will vote their conscience (as informed by EMA data and committee deliberations) and the service category scores will be tallied by the average of those scores.

Factor	Definition	Scale
Consumer Survey (20%)	Percentage of consumers who said they used or "needed but didn't get" in the last 12 months, in the 2017 Consumer Survey. The sample is geographically representative of the EMA and includes PLWH who have engaged in the RW system.	1- no mention 3- >7.5% 5- 7.6-15% 8- 15.1%
Medical Monitoring Project (20%)	Medical Monitoring Project data captures unmet service needs for PLWH in care. It is a representative sample of PLWH in HIV care. The data sample if Philadelphia only.	1 – no mention 3 – > 14% 5 - 15-44% 8 – 45%
Client Services Unit-Need at Intake (20%)	Self-reported service need to Client Services MCM intake. These individuals are re-entering or entering the RW service system. The data sample is not EMA-wide- Philadelphia and PA counties with very few NJ.	1 – no mention 3 – >25% 5 – 26-51.6% 8 – 51.7%
Community Voices (40%)	This factor seeks to quantify community experience/expertise of delivering and receiving HIV services in relationship to emergent needs and issues, vulnerable populations, community knowledge, and other EMA data.	1- this service is important to ensure engagement in care, retention in care and/or viral suppression 5- This service is needed to ensure engagement in care, retention in care, and/or viral suppression 8- This service is critical to ensure engagement in care, retention in care and viral suppression.

Philadelphia EMA HIV Integrated Planning Council
Meeting Minutes of
Thursday, March 14, 2019
2:00 p.m. – 4:30 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Michael Cappuccilli, Keith Carter, Mark Coleman, Maisaloon Dias, Lupe Diaz (Co-Chair), Tiffany Dominique, Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven (Co-Chair), Peter Houle, La'Seana Jones, Lorett Matus, Nicole Miller, Christine Quimby, Erica Randy, Joseph Roderick, Samuel Romero, Jason Simmons, Gloria Taylor, Coleman Terrell (Co-Chair), Melvin White, Jacquelyn Whitfield

Excused: Katelyn Baron, Pamela Gorman, Janice Horan, Gerry Keys, Jeanette Murdock, Terry Smith-Flores, Clint Steib, Adam Thompson, Lorrita Wellington

Absent: Henry Bennett, Johnnie Bradley, George Matthews, Nhakia Outland, Eran Sargent, Gail Thomas, Zora Wesley, Steven Zick

Guests: Chris Chu (AACO), Evette Colon-Street, Julio Jackson, Ronald Lassiter, Ameenah McCann-Woods (AACO), Faith Mole, John Oliver, Nicole Risner, Blake Rowley, Kim Wentzel

Staff: Dustin Fitzpatrick, Debbie Law, Mari Ross-Russell

Call to Order: S. Heaven called the meeting to order at 2:08 p.m. Those present then introduced themselves.

Approval of Agenda:
S. Heaven presented the agenda for approval. L. Diaz noted that the committee reports needed to be added to the agenda. **Motion:** K. Carter moved, D. Gana seconded to approve the agenda. The minutes were approved by general consensus.

Approval of Minutes:
S. Heaven presented the February 14, 2019 minutes for approval. M. Cappuccilli noted that his name had been spelled with an additional 'l' under the approval of minutes section. K. Carter noted that p. 7 stated that the next Positive Committee meeting would be on March 14, but that it was on March 11. A spelling error was also noted. **Motion:** K. Carter moved, J. Whitfield seconded to approve the February 14, 2019 minutes as amended. **Motion passed:** All in favor.

Report of Chair:
C. Terrell reported that the President's Budget had included a request of $291 million for the Ending the Epidemic initiative, but that this was countered by a 12% overall cut to the Health and Human Services (HHS) budget, a $63 million cut to Housing Opportunities for People With AIDS (HOPWA), and a $1.5 trillion cut to Medicaid over ten years. He noted that STD and viral hepatitis were level-funded. He added that most information on the Ending the Epidemic initiative had been presented via short webinars, and that he hoped there would be more

information following the 2019 National HIV Prevention Conference. He noted that he would share more information when it became available.

C. Terrell also reported that awards had been funded under the new two-tier medical case management model. He stated that they were able to expand capacity at clinical sites, and that training began in March. He noted that AACO was analyzing disparities in the 2018 client data set from providers and working on quality improvement projects (QIPs) with those providers. He stated that they were just beginning the analysis, but had found that the disparity in viral suppression among transgender persons decreased. He added that AACO had hired a staff person to manage quality improvement among funded prevention providers.

Report of Staff:
M. Ross-Russell reported that two listening sessions had been scheduled, adding that OHP was trying to make it to as many areas as possible to hear from communities about their needs. She stated that the first listening session would be held at the Media-Upper Providence Library on the evening of April 10, and that the second would be held in Bucks County on April 30. She noted that OHP had flyers available, and that staff was available to answer questions. She added that they were planning to work with New Jersey counties next.

M. Ross-Russell next reported that the next meeting of the PrEP Workgroup was scheduled for March 20 from 2 – 4 p.m., and that this may be the final meeting. She noted that any additional work would likely fold into the duties of the Prevention Committee.

M. Ross-Russell also reported that the next Planning Council training would be on reading and understanding data.

M. Ross-Russell then stated that OHP staff were working to make the allocations process easier to understand. She explained that they were requesting that several HIPC members volunteer to become "experts" on specific service categories, so that they could teach other HIPC members about those services. She noted that she would be specifically approaching some HIPC members based on their expertise, and that Finance Committee members had also volunteered for some service categories. She went on to say that HIPC meetings would then include very short presentations on two to three different service categories from the experts.

Public Comment:
None.

Discussion Items:

- **Reallocations**

  A. Edelstein stated that the recipient had presented a reallocation request at the Finance Committee meeting the previous week. He explained that, in the previous year, the recipient had seen a significant uptick in utilization for emergency financial assistance – pharmaceuticals. He further explained that, in response to this increased spending, the recipient created a fourteen-day prescription fill limitation. He noted that this resulted in no negative impact to clients, so the recipient recommended continuing this limitation. He then stated that this limitation would result in underspending in the category, and that the recipient

was requesting that the Planning Council reallocate these funds for the current fiscal year. He concluded that there would be an excess allocation of $93,585 in the Philadelphia region, and an excess allocation of $95,109 in the PA Counties region.

A. Edelstein stated that the recipient typically suggested categories to receive additional funds in an underspending request, but that the recipient had left this open-ended in this case. He went on to say that the Finance Committee had not felt comfortable making a decision as to how this funding should be reallocated, and that they were seeking a discussion and motion from the entire Planning Council. He added that these were funds for the current fiscal year.

A. Edelstein stated that they had reviewed the allocations plans from the previous summer, and that an outline of these plans was included in the meeting packets *(see – attached handout)*. He explained that the 5% increase plan in the PA Counties included allocating 50% of an increase to substance abuse services, 25% to emergency financial assistance, and 25% to food bank/home-delivered meals, while keeping all other categories at level funding. He further explained that the 5% increase budget in Philadelphia included $100,000 to psychosocial support services with proportional increases to all other service categories, based on the level funding budget. He noted that psychosocial support services were not currently funded under Part A, although they were funded under Part B. He explained that there was a current network of providers that may be able to ramp up psychosocial support services without a request for proposals (RFP) process, which is expensive and time-consuming. He noted that the Finance Committee would recommend a reallocation plan that did not require an RFP process. He concluded by commending the recipient for implementing cost-saving measures and identifying likely underspending so early in the fiscal year.

M. Coleman asked about the mayor's plans for increasing funding to address the opioid crisis. C. Terrell replied that the proposed budget had come out the previous week, and that City funds were under the purview of City Council.

Motion: M. White moved, M. Cappuccilli seconded to allocate $50,000 of the additional $93,585 in Philadelphia to psychosocial support services, with the remaining funds distributed proportionally across all other funded service categories.

Discussion on the motion:
K. Carter asked if they could make these plans EMA-wide. M. Ross-Russell explained that they try to keep the total allocation per region the same throughout the year, since the regional allocation proportions were based on the regional proportion of the HIV epidemic. She stated that Southern New Jersey was not included because they had not allocated any funds to emergency financial assistance – medications at all. She further explained that reallocation requests typically come later in the year, after overspending was projected in other categories, but that this was happening so early in the year that there were no clear categories to which funds should be reallocated. She also stated that reallocating these funds proportionally across all service categories would result in very small increases, and require the recipient to change and resend all award letters to all providers within the system. A.

Edelstein noted that this would be very labor-intensive for the recipient with little benefit to providers.

A. McCann-Woods clarified that an RFP process would be necessary if the Planning Council allocated funds to psychosocial support services, since they were not currently funded under Part A. M. White asked if the motion could be improved by reallocating the entire amount to psychosocial support services. A. Edelstein replied that this would trigger a lengthy and expensive RFP process. C. Terrell stated that there was a great deal of funding for psychosocial support services and health education/risk reduction in the Philadelphia area through state rebate dollars, and that he was not sure if there was an unmet need for the service with the existing providers. He explained that they may want to launch new programs, but that this would require an RFP process, and that this would create a delay. He noted that psychosocial support service grants tended to be smaller amounts to fund support groups.

K. Carter asked if they should take more time to think about the best use for these funds, since it was so early in the year. A. Edelstein replied that this was possible. M. Ross-Russell explained that the decisions from the previous year's allocations meetings had been included in the meeting packet because these deliberations had already been held at those meetings. She stated that the Planning Council had already discussed and approved those allocations plans.

Motion withdrawn: M. White withdrew the motion.

Motion: M. White moved, J. Whitfield to split the $93,585 between food bank/home-delivered meals and medical transportation.

Discussion on the motion:
J. Jackson stated that people were not sure where to allocate funds, and suggested that they take more time for community discussion before holding a vote. A. Edelstein replied that this could be an option.

G. Grannan stated that it would be helpful to have more input from the recipient, since the recipient would have procedural information that the Planning Council would not have. He explained that the Planning Council wanted to reallocate fund with the least friction possible. M. Ross-Russell replied that the Planning Council is responsible for allocations, and that they review data and hold discussions throughout the year to this end. She stated that the Planning Council hosts allocations meetings and votes on final allocations plans, and that the recipient then distributes the funds. She said that the recipient could provide information on categories that were underspent or overspent, but that the reallocations were ultimately the responsibility of the Planning Council. A. Edelstein stated that reallocation requests typically come later in the year, when overspending had already been identified. He also stated that reallocation requests from service categories that had been underspent typically involved reallocating funds to services that can be quickly spent and directly benefit consumers, such as food bank/home-delivered meals and medical transportation. He added that they would be

unlikely to have significantly more information next month than they had in the current month.

C. Terrell noted that the recipient had brought the reallocation request to the Planning Council without a specific recommendation because they wanted to respect the allocations plans that the Planning Council had made. He then stated that they could always put funding in food bank/home-delivered meals and medical transportation, but that the recipient anticipated underspending in medical case management due to hiring delays, so there would be additional funds available for those two categories later in the year. He stated that they could hire one case manager per region with these funds, but that this was up to the group. He went on to say that, if the Planning Council truly agreed that there was a need for psychosocial support services, then they could simply decide to do the RFP. He noted that they could always use case managers, but added that psychosocial support services had not been funded through Part A for quite some time.

A. Edelstein clarified that they could cover the cost of one case manager in Philadelphia and one in the PA Counties with the amount of funding available, and C. Terrell agreed. D. Gana noted that this had been discussed in Finance Committee, and that they would have to consider which PA county an additional case manager would be located in. C. Terrell replied that AACO had reviewed the amount of funding allocated county-by-county, and that they had discovered that there was an overallocation in Delaware County as compared to the other PA counties. He stated that AACO had shifted these funds for the current contract year. He noted that current services were being cut in Delaware County.

P. Houle stated that the new contract year had started only two weeks earlier, so they had no idea where there would be underspending or overspending. He suggested that they follow the 5% increase plan, in which they would allocate funds to psychosocial support services and spread the remaining funds proportionally across all other services in an attempt to prevent overspending. A. Edelstein clarified that the 5% increase plan allocated $100,000 to psychosocial support services, so there would be no other funds to spread proportionally across other services.

A. Edelstein asked for details about the RFP process for psychosocial support services, including whether the cost of the RFP would come out of the service dollars. C. Terrell replied that the cost of the RFP would come out of the administration line item. He noted that the RFP process would take three to six months.

After a brief discussion of process, S. Romero asked how funds would be distributed to food bank/home-delivered meals and medical transportation under the current motion. C. Terrell replied that transportation is a general fund for transportation services, so AACO would increase that fund. He stated that food bank/home-delivered meals funding would be distributed to existing providers of that service. M. Dias then asked about the length of the process under this plan. S. Heaven replied that there would be some time delay as contracts with existing providers were revised, but that it would be less time than the RFP for psychosocial services.

P. Houle asked if there had been identified needs for medical transportation and food bank/home-delivered meals. He explained that he had not remembered a discussion about these services from the allocations meetings the previous summer, and that they may be unnecessarily adding a layer of complexity to the system. M. Ross-Russell replied that she works with the Planning Council on the allocations process. She stated that underspending is often reallocated to medical transportation and food bank/home-delivered meals throughout the year. She noted that they may shift as much as $300,000 into these categories at the end of a fiscal year. She stated that conversations in the allocations meetings over the summer specifically looked at the impact of the opioid epidemic. She explained that, for example, medication-assisted treatment had come up as a specific need under substance abuse services – outpatient in both Philadelphia and the PA Counties. She further explained that the level-funding budget in Philadelphia included funds for mental health services and substance abuse services – outpatient in order to address these concerns. She went on to say that the 5% increase plan already included increases in these areas, and added funds for psychosocial support.

M. Ross-Russell then reviewed the PA Counties plans, which featured two specific categories under level funding: substance abuse services and medical transportation services. She explained that the cost of providing medical transportation had gone up in the PA Counties, and that they were facing similar issues with the opioid epidemic. She noted that they had added funding to emergency financial assistance and food bank/home-delivered meals under the 5% increase budget in the PA Counties.

A. Edelstein noted that there would likely be underspending throughout the year under any plan, and that the recipient would return to request reallocations again. He noted that these funds would likely be reallocated to services that directly benefit consumers, such as medical transportation and food bank/home-delivered meals.

In response to a question about the current allocations in Philadelphia, M. Ross-Russell stated that food bank/home-delivered meals currently had $207,658 while medical transportation currently had $12,104. She noted that this was primarily for SEPTA tokens, and that Medicaid transportation had to be used before Ryan White funds for individuals who were eligible for Medicaid.

Motion failed: 6 in favor, 12 opposed, and 6 abstentions.

Motion: P. Houle moved, G. Grannan seconded to allocate $93,585 to psychosocial support services in Philadelphia.

Discussion on the motion:
A. Edelstein noted that this would require an RFP process.

G. Grannan stated that anyone who supported reallocating funds to psychosocial support services should consider supporting funding for that service in the future. A. Edelstein asked if P. Houle would still like to make his motion. P. Houle replied that it may not be worth funding the category if it required an RFP process. C. Terrell stated that, while the RFP

would take several months, the funding could still be available going forward. He explained that if the Planning Council wanted to fund psychosocial support services long-term, then they may as well go through the RFP process now.

P. Houle stated that this would be a new category. A. Edelstein stated that this was also seen as aligned with combatting the opioid epidemic. M. Ross-Russell noted that the additional funds in the category were likely to continue, since the policy change in emergency financial assistance – medications was recommended going forward. She stated that the Planning Council could choose to make this a permanent reallocation.

J. Simmons stated that they may be setting their providers up for failure. He explained that the RFP process would be lengthy, and that providers would then still need to hire staff for their programs. He concluded that they may not be able to spend the funds in the current year. E. Colon-Street expressed concern that they did not know how much funding would be available for the next year.

K. Carter asked if they could defer this decision until later in the year, when they may have more information. A. Edelstein replied that this could be possible. S. Heaven suggested that they consider increasing staff to provide more currently-funded services.

S. Romero suggested that the Planning Council consider allocating a different percentage of funds to medical transportation and food bank/home-delivered meals.

Motion failed: 4 in favor, 13 opposed, 5 abstentions.

Motion: G. Taylor moved, G. Grannan seconded to split the $93,585 evenly between medication-assisted treatment under substance abuse – outpatient and medical case management.

K. Carter asked if they would be able to hire a medical case manager with this amount of funding. He stated that it seemed as though they would only be able to hire a part-time case manager. L. Diaz noted that they could also shift a part-time case manager to a full-time position.

J. Baez asked if this would require an RFP. C. Terrell replied that it would not, since there was already funding in both of these categories. M. Cappuccilli asked for current funding levels in these categories. M. Ross-Russell replied that medical case management currently had an allocation of $3,997,585, not including Minority AIDS Initiative (MAI) funds. She stated that substance abuse services – outpatient currently had $484,428, and that $250,000 of this was specifically designated for medication-assisted treatment.

J. Baez asked which categories could receive these additional funds without triggering an RFP process. A. Edelstein replied that any of the Part A categories that were currently funded could receive funds without an RFP. M. Ross-Russell stated that this would include ambulatory/outpatient medical care, medical case management, drug reimbursement program, mental health treatment/counseling, substance abuse services – outpatient,

emergency financial assistance, emergency financial assistance – pharmaceutical, emergency financial assistance – housing, food bank/home-delivered meals, housing assistance, referral for healthcare and supportive services, other professional services (legal services), and medical transportation.

S. Romero asked how much funding was currently allocated to emergency financial assistance – housing. M. Ross-Russell replied that this category currently had $229,113.

Motion tied: 9 in favor, 9 opposed, and 6 abstentions.

A. Edelstein noted that he and the co-chairs had voted to abstain, and asked the co-chairs if they would vote to break the tie.

M. Ross-Russell stated that the Planning Council co-chairs and A. Edelstein would change their abstentions to votes. Noting that a couple of Planning Council members had left the room, the group briefly discussed representation from different parts of the EMA. S. Romero noted that, if this motion failed, he would make a motion to allocate the full $93,585 to emergency financial assistance – housing.

A revote was called.

Motion passed: 10 in favor, 9 opposed, and 4 abstentions.

A. Edelstein noted that there were not many Planning Council members from the PA Counties present, stating that he would make a motion on behalf of the PA Counties.

Motion: A. Edelstein moved, to allocate half of the $95,109 in the PA Counties to medication-assisted treatment under substance abuse – outpatient and medical case management.

Discussion on the motion:
M. Ross-Russell noted that the PA Counties currently had $1,079,732 in medical case management and $166,536 in substance abuse services – outpatient.

Motion passed: 15 in favor, 1 opposed, 7 abstentions.

- **Allocations Materials Process**

M. Ross-Russell stated that she had covered this during the staff report. She noted that they would be providing information about service categories as the summer allocations meetings came closer. She asked anyone interested in speaking about a specific service category to contact her.

Special Presentation:

- **Roles and Responsibilities**

M. Ross-Russell stated that she would discuss roles and responsibilities of the Planning Council *(see – attached slides)*. She noted that these slides were based on materials from TARGET HIV, although she had updated and modified the slides for the Philadelphia EMA.

M. Ross-Russell defined community health planning as a deliberate effort to involve members of a geographically-defined community in an open process to improve healthcare. She then reviewed legislative requirements for Ryan White Part A HIV planning. She noted that the chief elected official (CEO) was the Mayor of Philadelphia, and that the CEO of an eligible metropolitan area (EMA) must establish an HIV health services planning council. She also defined a TGA. M. Cappuccilli asked if Southern NJ was always part of the EMA. M. Ross-Russell replied that it was not, and that the EMA originally only included the five counties in Southeastern PA. She stated that the EMA had expanded in 1997. She noted that metropolitan statistical areas were defined by the Office of Management and Budget. C. Terrell stated that there had also been discussion about including the entire Philadelphia MSA, which would have included New Castle County, Delaware and Cecil County, Maryland.

M. Ross-Russell returned to the slides with an overview of Part A planning, noting that this included a five-year integrated plan, an annual planning cycle, and involvement of people living with HIV (PLWH) and community members. She noted that the integrated plan was written in 2016 and updated in 2018. She then reviewed the core planning tasks, which include determining service needs, establishing service priorities, allocating funds, guiding the recipient, ensuring coordination of Ryan White services with other services, and assessing the administrative mechanism. She added that coordination included working with Pennsylvania and New Jersey planning bodies and health departments. She noted that the earlier discussion was an example of the recipient rapidly distributing funds, since they had come to the Planning Council as soon as the underspending was identified.

M. Ross-Russell then reviewed the Health Resources and Services Administration (HRSA)/HIV/AIDS Bureau (HAB)'s suggested principles for HIV planning. She stated that planning councils were unique, particularly because the planning council made decisions instead of advising. She also pointed out the requirement that 33% of planning council members are living with HIV. She concluded the first section with a summary.

M. Ross-Russell moved on to review the roles and responsibilities of planning councils and recipients. She noted that the legislative language and the Part A manual were both available on HRSA's website. She stated that HRSA also provides guidance, including service definitions, annual notices of funding opportunity, notices of award, contact with project officers, and training and technical assistance.

M. Ross-Russell stated that the planning council and recipient had distinct and separate roles. She explained that the planning council cannot be involved in discussions about specific service providers. She noted that there were some shared roles between the planning council

and recipient, including data distribution and working on the plan. She next displayed a roles and responsibilities matrix before reviewing a flow chart of decision-making and funds.

M. Ross-Russell next gave an overview of the formation of the planning council, noting that the membership must reflect the demographics of those most affected by the HIV epidemic. She noted that the recipient could not participate in selecting members and that the recipient could not solely chair the planning council.

M. Ross-Russell moved on to discuss the expected activities, including needs assessment, integrated/comprehensive planning, and priority setting/resource allocation. She noted that the latter category included the most important legislative responsibilities of the planning council. She stated that this included priority setting, directives/instructions to the recipient, and resource allocations. She noted that directives were very specific, and could include specific services, specific areas, or specific populations. She then discussed resources allocations, pointing out that at least 75% of funding must be allocated to core services. She added that this could only be changed if the planning council applied for a waiver.

M. Ross-Russell reviewed reallocations, noting that the planning body had just done this today. She moved on to provide an overview of coordination of services, followed by procurement and requests for proposals (RFPs). She noted that procurement was solely a recipient responsibility, and that the planning council could not be involved. She also reviewed contract monitoring, noting that this too was a recipient responsibility. She added that the legislative requirements made it nearly impossible to avoid conflicts of interest on the planning council, but that the HIPC asked providers of services to disclose their conflicts during discussions, and to recuse themselves from voting if they were the solely-funded provider in a given service category. She clarified that consumers of services that did not sit on a board or work for funded organizations did not have conflicts of interest.

M. Ross-Russell next reviewed clinical quality management, noting that this was overseen by the recipient. She then discussed cost-effectiveness and outcomes evaluation, as well as assessing the administrative mechanism. She noted that planning councils were required to have bylaws and written procedures. She stated that there were two areas in which a planning council could be grieved: by not following their own processes and by not following their allocations.

M. Ross-Russell next covered the roles of planning council support staff, which was the Office of HIV Planning for the HIPC. She stated that responsibilities included staffing meetings, providing guidance on legislation, overseeing a training program, writing documents like the integrated epidemiologic profile, serving as a liaison between the planning council and the recipient, and completing varied needs assessments. She added that communication with the recipient was very important.

M. Ross-Russell then directed those present to a nine-question quiz in their meeting packets *(see – attached handout)*. The group completed the quiz as a group.

Committee Reports:
Positive Committee — *Keith Carter and Jeanette Murdock, Co-Chairs*
K. Carter stated that they had met on Monday, and that they were planning the committee newsletter. He stated that they also went through tips on how to take better notes and ask questions during planning council meetings, and how to read an agenda.

Finance Committee — *Alan Edelstein and David Gana, Co-Chairs*
No report.

Comprehensive Planning Committee – *Tiffany Dominique and Adam Thompson, Co-Chairs*
T. Dominique reported that they had started talking about the formulary as well as data related to priority setting, including consumer survey data. She noted that they needed a new co-chair for the committee, and that they would next meet the following week. G. Grannan asked if anyone had access to the state's prescription drug monitoring program (PDMP) data, and C. Terrell replied that they did not.

Nominations Committee — *Michael Cappuccilli and Sam Romero, Co-Chairs*
S. Romero reported that the Nominations Committee had met prior to the current meeting, and that they had reviewed seventeen applications. He noted that nine of these were reapplicants, and that these were all approved. He stated that they would have sixteen applications moving forward, and that they would have orientation the next month. He added that they would continue discussing the social at their next meeting.

Prevention Committee — *Lorett Matus and Clint Steib, Co-Chairs*
L. Matus stated that the committee was continuing its review of the PrEP Workgroup Report.

Old Business:
None.

New Business:
None.

Announcements:
T. Dominique stated that the University of Pennsylvania was working on a project related to suboxone.

Adjournment:
Motion: C. Terrell moved, G. Taylor seconded to adjourn the meeting. **Motion passed:** All in favor. The meeting was adjourned at 4:29 p.m.

Respectfully submitted by,

Briana L. Morgan, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes for February 14, 2019
- Philadelphia Region and PA Counties Reallocation Request
- Decisions from the 2019 – 2020 Allocations Process
- Quiz: Test Your Knowledge of the Ryan White Legislation and the Work of the Planning Council
- Activity 2.4: Review of Roles and Responsibilities Matrix
- OHP Calendar

Activity 2.4: Review of Roles and Responsibilities Matrix[1]

HANDOUT FOR PARTICIPANTS

For each task, indicate with a checkmark the responsible entity or entities.

Task	CEO	Recipient	PC
Establishment of Planning Council/Planning Body (PC/PB)			
Appointment of PC/PB Members			
Needs Assessment			
Integrated/Comprehensive Planning			
Priority Setting			
Resource Allocations			
Directives			
Procurement of Services			
Contract Monitoring			
Coordination of Services			
Evaluation of Services			
Development of Service Standards			
Clinical Quality Management			
Assessment of the Efficiency of the Administrative Mechanism			
PC/PB Operations & Support			

[1] Roles and responsibilities that are requirements for a Part A planning council (PC) and sound practice for a Part A TGA planning body functioning like a planning council

The remaining BRFSS tables and figures describe HIV testing within the Philadelphia EMA. The first two tables describe respondents who stated that they had ever been tested for HIV (see Tables 2.13 and 2.14). The figures that follow provide the location of the respondent's last HIV test. This figures are broken out by race/ethnicity and sex and by age group and sex (Figures 2.1 – 2.4). For most demographics, private doctors or HMOs were the most common HIV testing locations. For most demographics, clinics were the second-most common testing location.

Table 2.12 Ever Tested for HIV by Sex and Age, BRFSS Respondents in the Philadelphia EMA, 2016 (n=1,905)

	Ever Tested for HIV							
	Yes		No		Don't Know/Not Sure/Refused		Total	
Sex	n	%	n	%	n	%	n	%
Male								
Age								
18 to 24	23	31%	50	67%	2	3%	75	100%
25 to 34	59	61%	37	38%	1	1%	97	100%
35 to 44	76	70%	31	28%	2	2%	109	100%
45 to 54	61	53%	52	45%	2	2%	115	100%
55 to 64	75	42%	95	54%	7	4%	177	100%
65+	47	22%	158	72%	13	6%	218	100%
Subtotal	*341*	43%	*423*	53%	*27*	3%	791	100%
Female								
Age								
18 to 24	20	43%	24	51%	3	6%	47	100%
25 to 34	88	68%	38	29%	3	2%	129	100%
35 to 44	118	78%	30	20%	4	3%	152	100%
45 to 54	97	54%	76	43%	5	3%	178	100%
55 to 64	79	33%	147	62%	13	5%	239	100%
65+	55	15%	298	81%	16	4%	369	100%
Subtotal	*457*	41%	*613*	55%	*44*	4%	1,114	100%
Total	**798**	**42%**	**1,036**	**54%**	**71**	**4%**	**1,905**	**100%**

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2016 (accessed 02/2018)
Question: "Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth."

Behavioral Risk Factor Surveillance System Survey, 2016

The CDC has used the Behavioral Risk Factor Surveillance System (BRFSS) to measure adult risk behaviors since 1984. The survey is conducted through a partnership between the CDC and all 50 states, plus Washington, D.C. and three territories. This system uses a telephone-based survey conducted by health departments. The survey has included both landline and cell phones since 2011. Survey questions focus on risk behaviors (including alcohol use), chronic diseases, and preventative health behaviors.

In this section, we have provided data on alcohol use, risky behaviors, and HIV testing behaviors for BRFSS respondents. The BRFSS provides results based on state and metropolitan statistical area (MSA). The BRFSS defines the Philadelphia MSA as the five counties in Southeastern Pennsylvania: Bucks, Chester, Delaware, and Philadelphia Counties. The BRFSS defines the Camden MSA as Burlington, Camden, and Gloucester Counties. We have combined the results for these areas to develop a profile for eight of the nine counties in the Philadelphia Eligible Metropolitan Area. Only Salem County is not included in the BRFSS results.

We grouped and analyzed the data using IBM SPSS Statistics, Version 22. There are several limitations to the BRFSS. The BRFSS survey is only conducted in English, so people who do not speak English are not included in the survey. Also, this is a telephone-based survey. Thus, the survey excludes anyone without a phone. (Note: The CDC uses post-stratification weights to address this limitation.) For more information on BRFSS and its limitations, visit the CDC's BRFSS user guide.

Demographics, Philadelphia Area BRFSS Survey, 2016

In 2016, 4,448 people in the eight-county Philadelphia area responded to the BRFSS survey. Nearly 58% of these BRFSS respondents were female. For comparison, females made up 51.7% of people of the general population in these eight counties.

Both non-Hispanic Whites and non-Hispanic Blacks were well-represented in the BRFSS results. Non-Hispanic Whites made up 62.5% of the survey respondents, as compared to 62.8% of the general population in the eight-county area. Non-Hispanic Blacks made up 21.5% of the BRFSS sample, as compared to 20.3% of the general population. Hispanics of all races were slightly undersampled (7.4% compared to 8.8% of the general population). Non-Hispanic Asians were also undersampled, making up 2.9% of the respondents compared to 5.7% of the area. Other race/ethnicity categories were too small for comparison.

In terms of age, BRFSS respondents skewed older than the general population. BRFSS respondents were also more likely to have a college degree than the general population (40.4% compared to 36.0%). Only 6.29% of BRFSS respondents over 25 had less than a high school education, compared with 10.3% of the general population aged 25 and older.

Understanding Data Worksheet – Epi Profile Example
Philadelphia EMA HIV Integrated Planning Council
Thursday, April 11, 2019

1. What does the handout tell you about the source? What are the limitations?

2. What is being counted in the table?

3. What isn't being counted (that would be helpful)?

4. What story does this table tell?

5. What surprises you about this table?

6. What new questions do you have after looking at this table?

Data Terms and Concepts Worksheet

Review the definitions below and identify the term or concept described from the list at the bottom of the next page. Put the letter of the definition/description with the term.

____ 1. Information that can be expressed in numbers, counted, or compared on a scale – such as epi data or aggregated PLWH survey data.

____ 2. Differences in access to appropriate services based on where an individual lives – such as differences in access to primary medical care for people living in an outlying county.

____ 3. A listing and description of the providers of HIV-related services in a specified geographic area, what types of services they provide, where, and to whom, including both Ryan White and non-Ryan White funded providers – a component of a comprehensive needs assessment.

____ 4. The number of cases of HIV that are present in a particular population at a specific time.

____ 5. The total group of people to be studied.

____ 6. The number of new cases of HIV in a population during a defined period of time.

____ 7. A systematic process used to collect and analyze information about the number, characteristics, and needs of PLWH in and out of care, identify current resources available to meet those needs, and determine unmet needs and service gaps.

____ 8. Information on the number and characteristics of people in a specified geographic area who are at risk for or have been diagnosed with HIV.

____ 9. Information about the use of RWHAP Part A services by service category. Includes funding levels, numbers of clients, and numbers of units.

____ 10. A defined set of people from the group being studied.

____ 11. Information that cannot easily be measured or expressed in numbers – such as narrative information from a focus group or town hall meeting.

____ 12. The estimated number of people in a specific geographic area who know they are HIV-positive but are not receiving regular HIV-related primary medical care.

List of Terms and Concepts:

A. Incidence
B. Prevalence
C. Quantitative data
D. Qualitative data
E. Needs assessment
F. Epidemiologic profile
G. Resource inventory
H. Estimate of unmet need
I. Utilization data
J. Geographic disparities
K. Population
L. Subpopulation

Adapted from: Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018.
Original materials available at: www.targetHIV.org/planning-chatt/pcs-compendium

Outpatient/Ambulatory Health Services

HRSA Service Definition

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings.
Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

*As part of Outpatient and Ambulatory Medical Care, provision of **laboratory tests** integral to the treatment of HIV infection and related complications*

Number of Clients Served, Units Provided, Expenditures, Cost per Client and 3 Year averaged Cost per Client (based on actual expenditures)

Year	2015**	2016**	2017**	2018 Projected*	2019 Projected*	2020 Projected*	3 yr avg. act. Client cost
Medical Care Clients	11,201	11,011	11,176	11,876	12,211	12,546	
Medical Care Units (Dr. visit)	39,965	38,850	35,662	44,092	44,663	45,235	
Medical Care Dollars	7,476,559	7,227,633	7,104,406				
Allocated Dollars	7,101,939	7,152,427	7,162,288				
Client Cost Medical Care	$667	$656	$636				$653

*Projections are based on the history of a service. Projections do not take into consideration federal policy changes, funding shifts, etc. that may occur in the future.
**Includes MAI

Funding by Part, and info on any other payers

	Total Part A Funds (Formula + Supp.)	MAI	Total Part B Funds (Formula + Supp. NJ)	Total Part B Funds (Formula + Supp. PA)	Total Part C EIS Funds (State & Local)	Total Part D Funds (State & Local)	Total Part F Funds
Last Year Allocation	$6,497,840	$644,407		$805,650			
Current Allocation	$6,684,543	$370,664		$836,135	$6,980,625		

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Ambulatory Health Services	242	93.8%	6.2%

Unmet need

For the purposes of this document, need is based on the response of a consumer when asked if there was a service they needed. MMP interviews patients in care and asks consumers if they need a service and if they receive it. Client services unit data identifies needs at the time of initial intake.

	2014 MMP Percent with a Need	2017 Client Services Unit Need at Intake
Ambulatory Health Services	-	26.5%

Recipient Service Considerations

Ambulatory Health Services

Part A funds 25 HIV medical care programs in the EMA. These outpatient/ambulatory care providers are located in hospitals, comprehensive services agencies, Federally Qualified Health Centers and in the City of Philadelphia Health Centers.

70 (0.6%) more clients accessed Part A HIV medical services, and the number of Part A medical visits increased by 1,215 (3.1%) in comparison to 2016. (These figures do not include MAI)

VL Suppression in the EMA has increased from 83% to 85% between 2016-17. VL Suppression in the Ryan White system significantly exceeds the National HIV/AIDS Strategy (NHAS) goal of 80% VL Suppression.

Medical Case Management, including Treatment Adherence

HRSA Service Definition

Medical Case Management, including Treatment Adherence Services

Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:

Medical Case Management services have as their objective ***improving health care outcomes*** *whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.*

Number of Clients Served, Units Provided, Expenditures, Cost per Client and 3 Year averaged Cost per Client (based on actual expenditures)

Year	2015**	2016**	2017**	2018 Projected*	2019 Projected*	2020 Projected*	3 yr avg. act. Client cost
Case Management Clients	6,081	5,999	5,886	6,070	5,981	5,892	
Case Management Units (15 min)	494,260	480,812	542,174	530,505	546,015	546,015	
Case Management Dollars	7,059,257	7,097,626	7,047,089				
Allocated Dollars	7,647,520	7,280,986	7,104,482				
Client Cost Case Management	$1,161	$1,183	$1,197				$1,180

*Projections are based on the history of a service. Projections do not take into consideration federal policy changes, funding shifts, etc. that may occur in the future.

**Includes MAI

Funding by Part, and info on any other payers

	Total Part A Funds (Formula + Supp.)	MAI	Total Part B Funds (Formula + Supp. NJ)	Total Part B Funds (Formula + Supp. PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds
Last Year Allocation	$5,853,439	$1,150,336	$440,694	$1,151,771			
Current Allocation	$5,597,829	$1,405,615		$1,717,556			

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Medical Case Management	210	89.0%	11.0%

Unmet need

For the purposes of this document, need is based on the response of a consumer when asked if there was a service they needed. MMP interviews patients in care and asks consumers if they need a service and if they receive it. Client services unit data identifies needs at the time of initial intake.

	2014 MMP Percent with a Need	2017 Client Services Unit Need at Intake
Medical Case Management	13.1	-

Recipient Service Considerations

Medical Case Management

167 (2.8%) fewer Part A clients received MCM services this year, and documented service units saw a corresponding decrease of 13,542 units (2.8%). It should be noted that this does not reflect diminished need for MCM services in the EMA, as there was an increase of 404 clients (25.9%) and 15,516 units (19.0%) funded through Part B services. (These figures do not include MAI)

Studies have shown that clients enrolled in Medical Case Management tend to be more adherent to HIV Medical Care. In 2017, 90% of new MCM clients were linked to medical care, and 80% of clients who attended a medical visit in the first half of the year then returned for a follow-up visit in the second half.

50 clients are currently on the waiting list for MCM services. There were only 15 clients waiting for MCM services at this time last year.

Documentation of service care plans improved by 7% as a result of quality improvement activities throughout the EMA.

**Approximately 2/3rds of the services previously funded under Local AIDS Pharmaceutical Assistance was funded under emergency financial assistance in 2016, in accordance with the guidance.

Funding by Part, and info on any other payers

	Total Part A Funds (Formula + Supp.)	MAI	Total Part B Funds (Formula + Supp. NJ)	Total Part B Funds (Formula + Supp. PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds)
Last Year Allocation	70,458 $1,102,399		$25,000	$472,346			
Current Allocation	$69,414 $857,688 $228,470			$415,869			

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Emergency Financial Assistance	114	39.5%	60.5%

Unmet need

For the purposes of this document, need is based on the response of a consumer when asked if there was a service they needed. MMP interviews patients in care and asks consumers if they need a service and if they receive it. Client services unit data identifies needs at the time of initial intake.

	2014 MMP Percent with a Need	2017 Client Services Unit Need at Intake
Emergency Financial Assistance (Benefits Assistance)	-	40.2%

Recipient Service Considerations

Emergency Financial Assistance

All other available community resources must be exhausted prior to applying for these funds. 74 (13.6%) fewer clients received services under EFA in comparison to the previous year, with decreased utilization of prescription services responsible for 57 of these 74 clients. This decrease in utilization was proportional to the 10.3% reduction in the amount allocated to this service.

*This service category was completely expended

Emergency Financial Assistance

HRSA Service Definition

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Direct cash payments to clients are not permitted.
It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

Number of Clients Served, Units Provided, Expenditures, Cost per Client and 3 Year averaged Cost per Client (based on actual expenditures)

Year	2015	2016**	2017**	2018 Projected*	2019 Projected*	2020 Projected*	3 yr avg. act. Client cost
EFA Clients (voucher)	76	120	103	100	106	112	
EFA Units (voucher)	76	120	103	100	106	112	
EFA Dollars (voucher)	55,803	68,604	74,162				
Allocated Dollars	70,691	71,288	70,486				
Client Cost EFA (Voucher)	$734	$572	$720				$675
EFA Clients (medication)		423	366	309	252	195	
EFA Units (meds)		741	665	589	513	437	
EFA (meds) Dollars		1,298,327	1,156,211				
Allocated Dollars		1,279,961	1,102,934				
Client Cost EFA (medication)		$3,069	$3,159				$3,114
EFA clients (HSE)							
EFA Units (HSE)							
EFA (HSE) Dollars							
EFA (Housing) Allocation Dollars							

*Projections are based on the history of a service. Projections do not take into consideration federal policy changes, funding shifts, etc. that may occur in the future.

Funding by Part, and info on any other payers

	Total Part A Funds (Formula + Supp.)	MAI	Total Part B Funds (Formula + Supp. NJ)	Total Part B Funds (Formula + Supp.t PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds
Last Year Allocation	$438,288			$115,168			
Current Allocation	$429,163		$14,000	$165,168			

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Medical Transportation Services	145	69.7%	30.3%

Unmet need

For the purposes of this document, need is based on the response of a consumer when asked if there was a service they needed. MMP interviews patients in care and asks consumers if they need a service and if they receive it. Client services unit data identifies needs at the time of initial intake.

	2014 MMP Percent with a Need	2017 Client Services Unit Need at Intake
Medical Transportation Services	11.3	22.8%

Recipient Service Considerations

Medical Transportation Services

292 (12.4%) more clients received 6,044 (21.1%) more one-way trips than in the previous year. The increases in services were primarily in Philadelphia county and New Jersey.

Medical Transportation Services

HRSA Service Definition

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:

- *Medical transportation may be provided through:*
- *Contracts with providers of transportation services*
- *Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject http://www.gsa.gov/portal/content/102886)*
- *Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle*
- *Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)*
- *Voucher or token systems*

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Number of Clients Served, Units Provided, Expenditures, Cost per Client and 3 Year averaged Cost per Client (based on actual expenditures)

Year	2015	2016	2017	2018 Projected*	2019 Projected*	2020 Projected*	3 yr avg. act. Client cost
Transportation Clients	1,980	2,359	2,651	1,491	1,392	1,294	
Transportation Units (one-way trip)	20,816	28,658	34,702	16,821	15,833	14,844	
Transportation Dollars	443,776	448,962	534,622				
Allocated Dollars	433,301	438,288	451,205				
Client Cost Transportation	$224	$190	$202				$205

*Projections are based on the history of a service. Projections do not take into consideration federal policy changes, funding shifts, etc. that may occur in the future.

HIV INTEGRATED PLANNING COUNCIL GUEST SIGN IN SHEET
April 11, 2019

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