MEETING AGENDA

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

Call to Order

Welcome and Introductions

Approval of Agenda

Approval of Minutes (*June 13, 2019)*

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

Report of Staff

Public Comment

Action Item:

- PrEP Workgroup Report (Gus Grannan)
- Service Priority Approval — Comprehensive Planning Committee

Discussion Items:

- FY 2018 Year End Spending Report (Ameenah McCann-Wood)
- Allocations Preparations
    - Mental Health Services
    - Medical Nutritional Therapy
    - Local AIDS Pharmaceutical Assistance Program
    - Referral for Health Care and Support Services

Committee Reports

- Executive Committee – Sharee Heaven & Lupe Diaz
- Finance Committee – *No report*
- Nominations Committee – Michael Cappuccilli & Sam Romero
- Positive Committee – Keith Carter & Jeannette Murdock
- Comprehensive Planning Committee – *No report*
- 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, August 8, 2019 from 2:00 – 4:30 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107

HIV INTEGRATED PLANNING COUNCIL

			Possible Score (Scale varies by factor)										
			8, 5, 3, 1										
DRAFT - DO NOT DISTRIBUTE													
Service Category			Medical Montoring Project	Consumer Survey	Client Services Unit	Community Voices					Committee Conscience	Service Category Total Score	Service Category Total Percentage
	Rank 2019	Rank 2017	20%	20%	20%	Members voting	8	5	1	score before %	40%	Calculations	
Housing Assistance	1	2	5	5	8	13	9	4	0	7.08	2.83	6.43	80.38%
Medical Case Management	2	5	5	3	8	13	13	0	0	8.00	3.20	6.40	80.00%
Dental Care	3	1	8	5	3	13	8	5	0	6.85	2.74	5.94	74.23%
Ambulatory Care	4	3	5	3	5	13	11	2	0	7.54	3.02	5.62	70.19%
Mental Health Therapy/Counseling	5	12	3	5	3	13	11	2	0	7.54	3.02	5.22	65.19%
Emergency Financial Assistance	6	14	1	8	3	14	9	5	0	6.93	2.77	5.17	64.64%
Transportation	7	4	3	5	5	14	8	5	1	6.43	2.57	5.17	64.64%
Substance Abuse Treatment (Outpatient)	8	21	3	5	3	14	9	5	0	6.93	2.77	4.97	62.14%
AIDS Drug Assistance Program (ADAP)	9	16	3	3	3	13	11	2	0	7.54	3.02	4.82	60.19%
Psychosocial Support Services	10	13	3	5	3	14	7	7	0	6.50	2.60	4.80	60.00%
Food Bank/Home-Delivered Meals	11	10	3	5	3	14	6	7	1	6.00	2.40	4.60	57.50%
Substance Abuse Treatment (Residential)	12	21	3	5	3	13	5	7	1	5.85	2.34	4.54	56.73%
Local Pharmaceutical Assistance	13	15	3	3	3	13	4	9	0	5.92	2.37	4.17	52.12%
Health Insurance Premium & Cost Sharing Assistance	14	7	1	5	3	14	3	10	1	5.36	2.14	3.94	49.29%
Case Management (non-medical)	15	5	3	1	5	13	3	7	3	4.77	1.91	3.71	46.35%
Translation & Interpretation	16	17	3	5	3	13	3	3	7	3.54	1.42	3.62	45.19%
Home Health Care	17	24	1	5	3	14	2	7	5	4.00	1.60	3.40	42.50%
Care Outreach	18	11	3	3	1	14	5	5	4	4.93	1.97	3.37	42.14%
Legal Services	19	9	1	5	3	14	1	7	6	3.50	1.40	3.20	40.00%
Information & Referral	20	20	1	1	1	14	8	4	3	6.21	2.49	3.09	38.57%
Nutritional Services	21	19	1	5	3	13	1	5	7	3.08	1.23	3.03	37.88%
Child Care Services	22	18	1	5	1	13	2	5	6	3.62	1.45	2.85	35.58%
Early Intervention Services	23	26	1	1	1	14	5	6	3	5.21	2.09	2.69	33.57%
Health Education Risk Reduction	24	8	1	1	3	14	3	6	5	4.21	1.69	2.69	33.57%
Home & Community-based Health Services	25	27	1	5	1	14	1	5	8	2.93	1.17	2.57	32.14%
Hospice Services	26	25	1	5	3	14	1	0	13	1.50	0.60	2.40	30.00%
Rehabilitation Care	27	27	1	5	1	13	0	4	9	2.23	0.89	2.29	28.65%
Day or Respite Care	28	29	1	5	1	14	1	2	11	2.07	0.83	2.23	27.86%

HIV Integrated Planning Council
Thursday, June 13, 2019
2:00 p.m. – 4:30 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

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

Excused: Janice Horan, Peter Houle, Clint Steib

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

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

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

Call to Order

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

Welcome and Introductions

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

Approval of Agenda

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

Approval of Minutes (May 9, 2019)

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

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

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

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

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

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

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

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

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

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

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

Report of Staff

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

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

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

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

Public Comment

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

Presentation: Client Services Unit Annual Update (Jessica Browne)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Action Item: PrEP Workgroup Report (Gus Grannan)

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

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

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

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

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

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

Discussion Items:

Priority Setting Process

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

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

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

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

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

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

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

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

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

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

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

FY2018 Year End Spending Report

Tabled.

Committee Reports

Executive Committee

None.

Finance Committee

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

Nominations Committee

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

Positive Committee

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

Comprehensive Planning Committee

No report.

Prevention Committee

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

Old Business

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

New Business

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

Announcements

None.

Adjournment

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

Respectfully submitted,

Nicole D. Johns, OHP staff

Handouts distributed at the meeting:

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

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
***4th* Quarter Spending as of February 28, 2019**

	Allocations	4th Quarter Allocation	Spending	Balance	% under/(over)
Philadelphia	12,573,373	12,573,373	12,595,535	(22,162)	0%
PA Counties	2,734,448	2,734,448	2,697,370	37,078	-1%
New Jersey Counties	2,174,255	2,174,255	2,294,499	(120,244)	6%
Systemwide	3,085,889	3,085,889	2,571,744	514,145	-17%
Minority AIDS Initiative	1,776,279	1,776,279	1,776,279	-	0%
MAI Systemwide	196,383	196,383	196,383	-	0%
Carryforward	7,101	7,101	7,101	-	0%
Total	22,547,728	22,547,728	22,138,911	408,817	-2%

7/11/2019

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
4th Quarter Spending as of February 28, 2019

Systemwide

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	7,055,207	7,055,207	7,362,705	(307,498)	4%
Case Management	7,003,445	7,003,445	6,956,416	47,029	-1%
Drug Reimbursement Program	497,810	497,810	357,810	140,000	-28%
Early Intervention Services	-	-	-	-	
Health Insurance Premium & Costs Sharing Assistance	-	-	-	-	
Home & Community-based Health Services	-	-	-	-	
Home Health Care	-	-	-	-	
Hospice Services	-	-	-	-	
Mental Health Therapy/Counseling	541,986	541,986	521,363	20,623	-4%
Nutritional Services	59,611	59,611	59,609	2	0%
Oral Health Care	770,275	770,275	806,350	(36,075)	5%
Substance Abuse Treatment - Outpatient	354,603	354,603	346,487	8,116	-2%
Care Outreach	-	-	-	-	
Case Management (non-Medical)	-	-	-	-	
Child Care Services	-	-	-	-	
Day or Respite Care	-	-	-	-	
Emergency Financial Assistance	69,415	69,415	85,122	(15,707)	23%
Emergency Financial Assistance/AIDS Pharma Asst.	1,086,158	1,086,158	598,150	488,008	-45%
Emergency Financial Assistance/Housing	385,663	385,663	385,585	78	0%
Food Bank/Home-Delivered Meals	334,355	334,355	538,026	(203,671)	61%
Health Education Risk Reduction	-	-	-	-	
Housing Assistance	179,145	179,145	278,368	(99,223)	55%
Referral for Health Care/Supportive Services	81,039	81,039	80,970	69	0%
Other Professional Services/Legal Services	402,393	402,393	432,393	(30,000)	7%
Psychosocial Support Services	-	-	-	-	
Rehabilitation Care	-	-	-	-	
Substance Abuse (Residential)	-	-	-	-	
Translation & Interpretation	-	-	-	-	
Transportation	444,351	444,351	561,430	(117,079)	26%
Total	19,265,456	19,265,456	19,370,784	(105,328)	1%

SYSTEMWIDE ALLOCATIONS

Allocations	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
I & R	512,425	512,425	437,238	75,187	-15%
QM Activities	538,293	538,293	333,516	204,777	-38%
Systemwide Coordination	190,598	190,598	189,185	1,413	-1%
Capacity Building	111,384	111,384	65,596	45,788	-41%
PC Support	494,154	494,154	437,998	56,156	-11%
Grantee Administration	1,435,418	1,435,418	1,304,594	130,824	-9%
			-		
Total	3,282,272	3,282,272	2,768,127	514,145	-16%
Total Service Allocations & Administrative	22,547,728	22,547,728	22,138,911	408,817	-2%

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
4th Quarter Spending as of February 28, 2019

Philadelphia

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	4,941,896	4,941,896	5,137,693	(195,797)	4%
Case Management	4,092,325	4,092,325	4,095,298	(2,973)	0%
Drug Reimbursement Program	497,810	497,810	357,810	140,000	-28%
Early Intervention Services	-	-		-	
Health Insurance Premium & Costs Sharing Assistance	-	-		-	
Home & Community-based Health Services	-	-		-	
Home Health Care	-	-		-	
Hospice Services	-	-		-	
Mental Health Therapy/Counseling	324,920	324,920	323,757	1,163	0%
Nutritional Services	-	-		-	
Oral Health Care	424,600	424,600	440,457	(15,857)	4%
Substance Abuse Treatment - Outpatient	234,428	234,428	226,312	8,116	-3%
Care Outreach	-	-		-	
Case Management (non-Medical)	-	-		-	
Child Care Services	-	-		-	
Day or Respite Care	-	-		-	
Emergency Financial Assistance	47,950	47,950	58,447	(10,497)	22%
Emergency Financial Assistance/AIDS Pharma Asst.	870,249	870,249	491,556	378,693	-44%
Emergency Financial Assistance/Housing	385,663	385,663	385,585	78	0%
Food Bank/Home-Delivered Meals	207,075	207,075	409,040	(201,965)	98%
Health Education Risk Reduction	-	-		-	
Housing Assistance	152,241	152,241	244,422	(92,181)	61%
Referral for Health Care/Supportive Services	81,039	81,039	80,970	69	0%
Other Professional Services/Legal Services	301,107	301,107	328,556	(27,449)	9%
Psychosocial Support Services	-	-		-	
Rehabilitation Care	-	-		-	
Substance Abuse (Residential)	-	-		-	
Translation & Interpretation	-	-		-	
Transportation	12,070	12,070	15,632	(3,562)	30%
Total	12,573,373	12,573,373	12,595,535	(22,162)	0%

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
4th Quarter Spending as of February 28, 2019

PA Counties

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	659,540	659,540	755,294	(95,754)	15%
Case Management	1,079,734	1,079,734	1,042,187	37,547	-3%
Drug Reimbursement Program	-	-	-	-	
Early Intervention Services	-	-	-	-	
Health Insurance Premium & Costs Sharing Assistance	-	-	-	-	
Home & Community-based Health Services	-	-	-	-	
Home Health Care	-	-	-	-	
Hospice Services	-	-	-	-	
Mental Health Therapy/Counseling	47,606	47,606	43,905	3,701	-8%
Nutritional Services	59,611	59,611	59,609	2	0%
Oral Health Care	150,162	150,162	150,159	3	0%
Substance Abuse Treatment - Outpatient	120,175	120,175	120,175	-	0%
Care Outreach	-	-	-	-	
Case Management (non-Medical)	-	-	-	-	
Child Care Services	-	-	-	-	
Day or Respite Care	-	-	-	-	
Emergency Financial Assistance	21,465	21,465	26,675	(5,210)	24%
Emergency Financial Assistance/AIDS Pharma Asst.	215,909	215,909	106,594	109,315	-51%
Emergency Financial Assistance/Housing	-	-	-	-	
Food Bank/Home-Delivered Meals	65,238	65,238	71,885	(6,647)	10%
Health Education Risk Reduction	-	-	-	-	
Housing Assistance	26,904	26,904	33,946	(7,042)	
Referral for Health Care/Supportive Services	-	-	-	-	
Other Professional Services/Legal Services	17,065	17,065	17,065	-	0%
Psychosocial Support Services	-	-	-	-	
Rehabilitation Care	-	-	-	-	
Substance Abuse (Residential)	-	-	-	-	
Translation & Interpretation	-	-	-	-	
Transportation	271,039	271,039	269,876	1,163	0%
Total	2,734,448	2,734,448	2,697,370	37,078	-1%

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
4th Quarter Spending as of February 28, 2019

New Jersey

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	1,083,107	1,083,107	1,095,185	(12,078)	1%
Case Management	425,771	425,771	417,185	8,586	-2%
Drug Reimbursement Program	-	-	-	-	
Early Intervention Services	-	-	-	-	
Health Insurance Premium & Costs Sharing Assistance	-	-	-	-	
Home & Community-based Health Services	-	-	-	-	
Home Health Care	-	-	-	-	
Hospice Services	-	-	-	-	
Mental Health Therapy/Counseling	169,460	169,460	153,701	15,759	-9%
Nutritional Services	-	-	-	-	
Oral Health Care	195,513	195,513	215,734	(20,221)	10%
Substance Abuse Treatment - Outpatient	-	-	-	-	
Care Outreach	-	-	-	-	
Case Management (non-Medical)	-	-	-	-	
Child Care Services	-	-	-	-	
Day or Respite Care	-	-	-	-	
Emergency Financial Assistance	-	-	-	-	
Emergency Financial Assistance/AIDS Pharma Asst.	-	-	-	-	
Emergency Financial Assistance/Housing	-	-	-	-	
Food Bank/Home-Delivered Meals	54,941	54,941	50,000	4,941	-9%
Health Education Risk Reduction	-	-	-	-	
Housing Assistance	-	-	-	-	
Referral for Health Care/Supportive Services	-	-	-	-	
Other Professional Services/Legal Services	84,221	84,221	86,772	(2,551)	3%
Psychosocial Support Services	-	-	-	-	
Rehabilitation Care	-	-	-	-	
Substance Abuse (Residential)	-	-	-	-	
Translation & Interpretation	-	-	-	-	
Transportation	161,242	161,242	275,922	(114,680)	71%
Total	2,174,255	2,174,255	2,294,499	(120,244)	6%

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council
4th Quarter Spending as of February 28, 2019

Minority AIDS Initiative

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	370,664	370,664	374,533	(3,869)	1%
Case Management	1,405,615	1,405,615	1,401,746	3,869	0%
Drug Reimbursement Program	-	-	-	-	
Early Intervention Services	-	-	-	-	
Health Insurance Premium & Costs Sharing Assistance	-	-	-	-	
Home & Community-based Health Services	-	-	-	-	
Home Health Care	-	-	-	-	
Hospice Services	-	-	-	-	
Mental Health Therapy/Counseling	-	-	-	-	
Nutritional Services	-	-	-	-	
Oral Health Care	-	-	-	-	
Substance Abuse Treatment - Outpatient	-	-	-	-	
Care Outreach	-	-	-	-	
Case Management (non-Medical)	-	-	-	-	
Child Care Services	-	-	-	-	
Day or Respite Care	-	-	-	-	
Emergency Financial Assistance	-	-	-	-	
Emergency Financial Assistance/AIDS Pharma Asst.	-	-	-	-	
Emergency Financial Assistance/Housing	-	-	-	-	
Food Bank/Home-Delivered Meals	-	-	-	-	
Health Education Risk Reduction	-	-	-	-	
Housing Assistance	-	-	-	-	
Referral for Health Care/Supportive Services	-	-	-	-	
Other Professional Services/Legal Services	-	-	-	-	
Psychosocial Support Services	-	-	-	-	
Rehabilitation Care	-	-	-	-	
Substance Abuse (Residential)	-	-	-	-	
Translation & Interpretation	-	-	-	-	
Transportation	-	-	-	-	
Total	1,776,279	1,776,279	1,776,279	-	0%

SYSTEMWIDE ALLOCATIONS

Allocations	Allocations	4th Quarter Allocation	Spending	Balance	% (under)/over
I & R	-	-	-	-	
QM Activities	21,624	21,624	8,957	12,667	-59%
Systemwide Coordination	-	-	-	-	
Capacity Building	-	-	-	-	
PC Support	-	-	-	-	
Grantee Administration	174,759	174,759	187,426	(12,667)	7%
Total	196,383	196,383	196,383	-	0%
Total Service Allocations & Administrative	1,972,662	1,972,662	1,972,662	-	0%

Ryan White EMA-Wide Spending
Philadelphia HIV Integrated Planning Council

Carryover

Service Categories	Allocations	4th Quarter Allocation	Spending	Balance	% under/over
AIDS Drug Assistance Program (ADAP)	-	-	-	-	
Ambulatory Care	-	-	-	-	
Case Management	-	-	-	-	
Drug Reimbursement Program	-	-	-	-	
Early Intervention Services	-	-	-	-	
Health Insurance Premium & Costs Sharing Assistance	-	-	-	-	
Home & Community-based Health Services	-	-	-	-	
Home Health Care	-	-	-	-	
Hospice Services	-	-	-	-	
Mental Health Therapy/Counseling	-	-	-	-	
Nutritional Services	-	-	-	-	
Oral Health Care	-	-	-	-	
Substance Abuse Treatment - Outpatient	-	-	-	-	
Care Outreach	-	-	-	-	
Case Management (non-Medical)	-	-	-	-	
Child Care Services	-	-	-	-	
Day or Respite Care	-	-	-	-	
Emergency Financial Assistance	-	-	-	-	
Emergency Financial Assistance/AIDS Pharma Asst.	-	-	-	-	
Emergency Financial Assistance/Housing	-	-	-	-	
Food Bank/Home-Delivered Meals	7,101	7,101	7,101	-	0%
Health Education Risk Reduction	-	-	-	-	
Housing Assistance	-	-	-	-	
Referral for Health Care/Supportive Services	-	-	-	-	
Other Professional Services/Legal Services	-	-	-	-	
Psychosocial Support Services	-	-	-	-	
Rehabilitation Care	-	-	-	-	
Substance Abuse (Residential)	-	-	-	-	
Translation & Interpretation	-	-	-	-	
Transportation	-	-	-	-	
Total	7,101	7,101	7,101	-	

Mental Health Services

HRSA Service Definition

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

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

Year	2014	2015	2016	2017 Projected*	2018 Projected	2019 Projected	3 yr avg. act. Client cost
Mental Health Clients	921	1,232	2,137	1,316	1,389	1,461	
Mental Health Units (session)	2,685	3,750	8,039	4,012	4,101	4,190	
Mental Health Dollars	240,894	399,392	551,562	376,947	387,062	397,177	
Allocated Dollars	304,024	517,136	518,789				
Client Cost Mental Health	$261	$324	$258	$286	$279	$272	$281

*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. PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds
Last Year Allocation	$518,789			$6,386			
Current Allocation	$554,895		$224,947	$76,608			

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Mental Health Services	166	75.3%	24.7%

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	2016 Client Services Unit Need at Intake
Mental Health Services	8.4%	22.7%

Grantee Service Considerations

Mental Health Services

905 (73.5%) more clients utilized mental health services with a corresponding increase of 4,289 (114.4%) mental health outpatient sessions since the previous year. These increased were due to the addition of several mental health awards at large medical programs.

Medical Nutrition Therapy

HRSA Service Definition

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals

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

Year	2014	2015	2016	2017 Projected*	2018 Projected	2019 Projected	3 yr avg. act. Client cost
Medical Nutrition Clients	340	368	328	434	478	522	
Medical Nutrition Units	726	629	611	676	657	638	
Medical Nutrition Dollars	59,123	64,172	54,160	61,464	63,454	65,445	
Allocated Dollars	54,623	59,444	59,946				
Client Cost Medical Nutrition	$174	$174	$165	$142	$133	$125	$171

*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. PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds
Last Year Allocation	$59,946			$28,208			
Current Allocation	$60,531		$40,000	$28,208			

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Medical Nutrition Therapy	157	75.2%	24.8%

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	2016 Client Services Unit Need at Intake
Medical Nutrition Therapy	1.8	22.7%

Grantee Service Considerations

Medical Nutrition Therapy

40 (10.9%) fewer clients received 18 (2.9%) fewer hours of nutrition therapy between 2015 and 2016. The average number of hours per client increased from 1.7 to 1.9.

Local AIDS Pharmaceutical Assistance Program

HRSA Service Definition

Local AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.
1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or sub-recipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary approved by the local advisory committee/board
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV primary care medications not otherwise available to the client
- Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See: Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringparta.pdf
See also: LPAP Policy Clarification Memo http://hab.hrsa.gov/manageyourgrant/files/lpapletter.pdf
See also: AIDS Drug Assistance Program Treatments and Emergency Financial Assistance

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

Year	2014	2015	2016**	2017 Projected*	2018 Projected	2019 Projected	3 yr avg. act. Client cost
Drug Reimbursement Clients	691	723	319	725	687	648	
Drug Reimbursement Units (30-day prescription)	2,730	3,795	2,111	2,488	2,361	2,234	
Drug Reimbursement Dollars	1,963,852	1,697,959	573,286	1,434,365	1,403,783	1,373,201	
Allocated Dollars	1,936,366	1,864,218	516,000				
Client Cost Drug Reimbursement	$2,842	$2,348	$1,797	$1,978	$2,043	$2,119	$2,329

*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.

**Approximately 2/3rds of these services will now be funded under emergency financial assistance, 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 (NJ)	Total Part B Funds (PA)	Total Part C EIS Funds	Total Part D Funds	Total Part F Funds
Last Year Allocation	$516,000						
Current Allocation	$505,196						

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Local AIDS Pharmaceutical Assistance	139	89.2%	10.8%

Referral for Health Care and Support Services (System-wide)

HRSA Service Definition

Referral for Health Care and Support Services

Description:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain 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, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:

Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

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

Year	2014	2015	2016	2017 Projected*	2018 Projected	2019 Projected	3 yr avg. act. Client cost
Referral for Health Care Clients	297	2,206	2,265	2,324	2,383	2,442	
Referral for Health Care Units (hotline call)	1,226	2,206	2,265	2,324	2,383	2,442	
Referral for Health Care Dollars	169,406	545,641	356,077	166,513	138,482	212,615	
Client Cost Referral for Health Care	$570	$247	$157	$72	$58	$87	
Referral for Health Care Clients		222	392	232	292	297	
Referral for Health Care Units (digital ¼ hour*)		1,511	3,576	3,230	4,491	5,351	
Referral for Health Care Dollars		63,132	133,132	203,132	273,132	343,132	
Client Cost Referral for Health Care		$284	$340	$876	$935	$1,155	

*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	$84,000 $529,704						
Current Allocation	$82,241 $520,329						

Consumer survey info 2017 n=392

	n	Used in the last 12 months	Needed but did not get (last 12 months)
Referral for Health Care and Support Services	139	89.2%	10.8%

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 (uninsured)	2016 Client Services Unit Need at Intake
Referral for Health Care and Support Services	1.8	22.7%

Grantee Service Considerations

Referral for Health Care and Support Services