Client Services Unit

Health Information Helpline

Division of HIV Health

HIV Integrated Planning Council for 5/9/2024

City of Philadelphia

Agenda

1. Mission & Responsibilities
2. Key Point of Entry: Medical Case Management Services
3. Intake Data
4. Consumer Grievance Process

CSU Mission

- Help people living with HIV and at-risk individuals understand their needs, look at possible solutions, and make informed decisions

- Advocate on behalf of those who need special support

- Reinforce clients' capacity for self-reliance and self-determination through:

  referral & linkage

  education

  collaborative planning

  problem solving

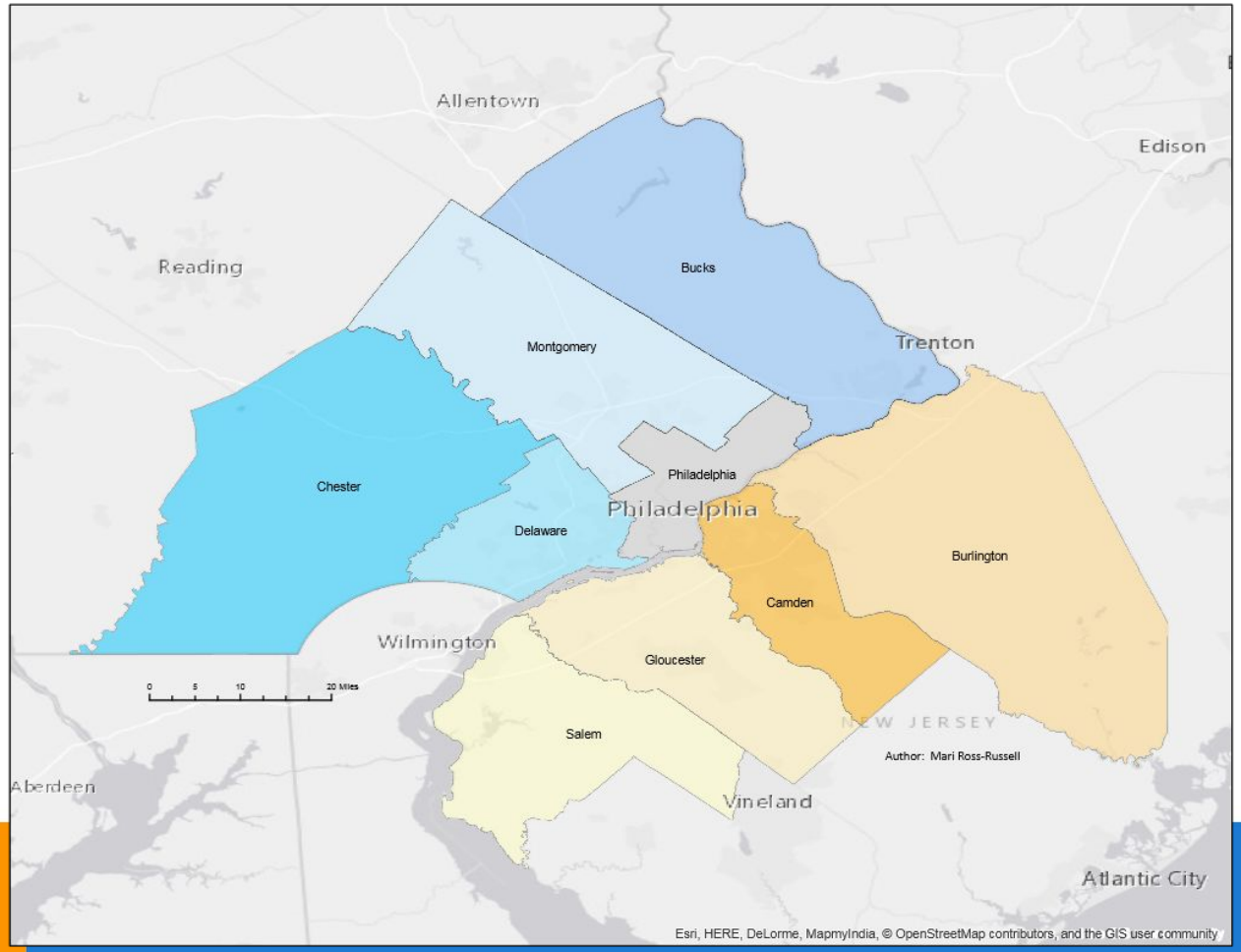
CSU Responsibilities

- Key point of entry for Medical Case Management
- Assists with scheduling medical appointments for those newly diagnosed, lost to care and relocating to the EMA
- Transitional Planning Initiative
- Assists those on waiting list and unfunded providers with RW certifications, EFAs, and emergency medications
- Provides information and referral services for all other DHH funded programs
- Processes grievances about funded services
- Assists with special DHH projects: FSP, MMP and NHBS

Medical Case Management (MCM) Services in the Philadelphia EMA

Philadelphia and Surrounding Counties:

- Bucks
- Chester
- Delaware
- Montgomery
- Burlington
- Camden
- Gloucester
- Salem



HRSA MCM Definition

- 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
- Includes all types of encounters (e.g. face-to-face, phone contact and any other forms of communication)

MCM Key Activities

- Initial assessment of service level and needs
- Development of individualized care plans
- Timely and coordinated access to medically appropriate levels of health and support services
- Continuous client monitoring to assess the efficacy of the plan
- HIV treatment adherence counseling
- Client-specific advocacy
- Assessment of client needs is ongoing
- Re-evaluation of the care plan at least every six months

MCM Services in the EMA

- Approximately $10.3 million allocated to medical case management in RW Part A, State Rebate, MAI and General Funds
- DHH funded subrecipients provided MCM services to 7,087 unduplicated PWH in CY 2023
- 1680 intakes completed through the Client Services Unit in CY 2023
- 26 MCM subrecipients funded throughout the EMA

  CBOs

  Hospital outpatient infectious disease clinics, including pediatric sites

  Stand alone HIV clinics

CSU Wait List

Approximately 15 people as of 5/9/24

- *2 being sent to MCM provider on 5/13/24*
- *2 being sent upon determination that they are patients of collocated MCM provider*
- *1 waiting for discharge from inpatient treatment program*
- *10 waiting for resolution of agency-specific issue*

Waitlist and agency openings continuously monitored by CSU Social Workers and Supervisor

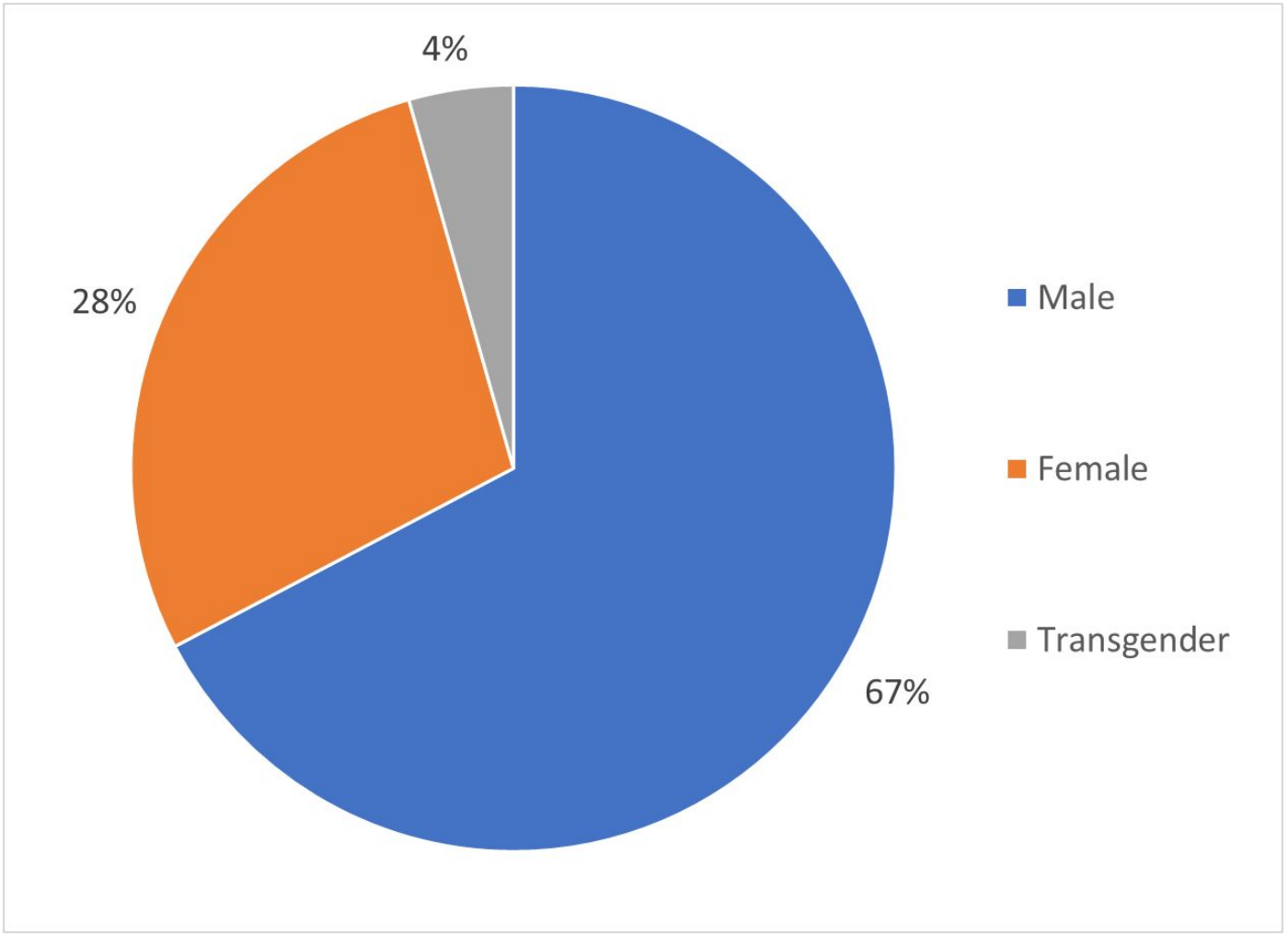
Emergencies and Priority Populations

Emergencies and other priority populations are immediately referred to MCM providers

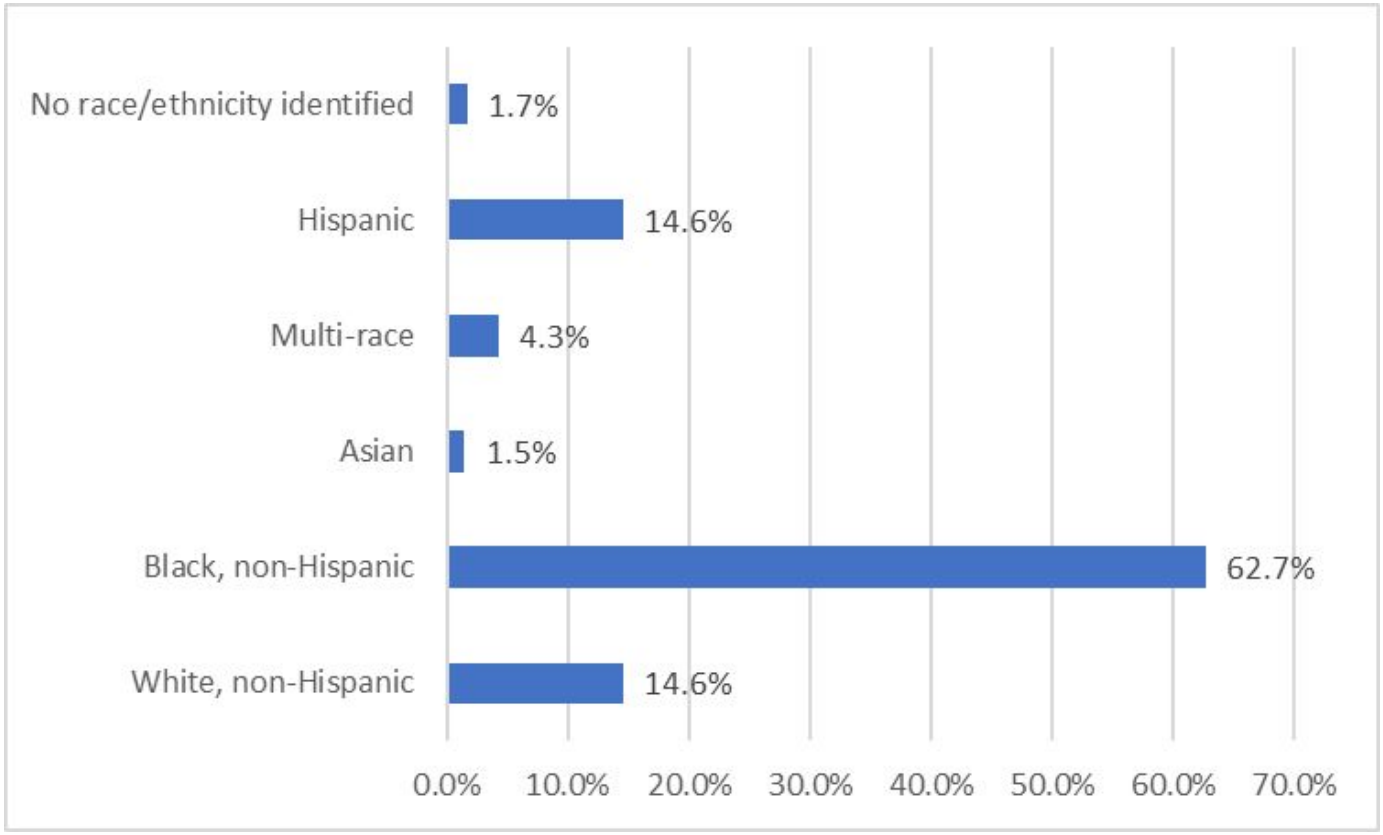
- They are pregnant and not currently in medical care
- Street homeless or in a shelter
- Recently diagnosed with HIV in the last three months
- Released from prison within the last three months (federal, state or local)
- Released from a Pennsylvania State Correctional Institution
- Actively injecting drugs
- Have been out of medical care for six months or more
- Attempted suicide within the last three months and are not receiving mental health treatment

Intake Data

2023 Intake Demographics – Gender Identity

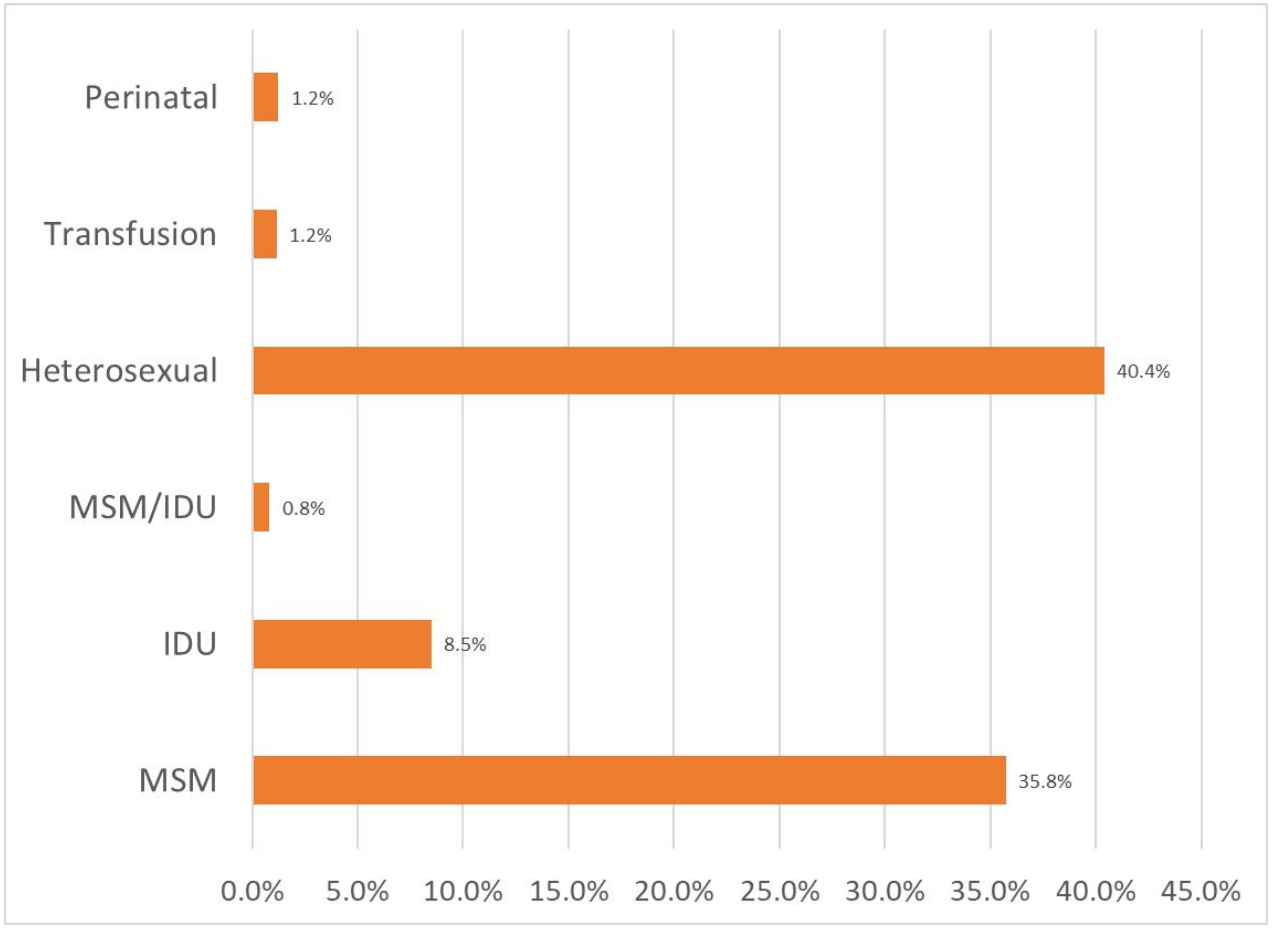


2023 Intake Demographics – Race/Ethnicity



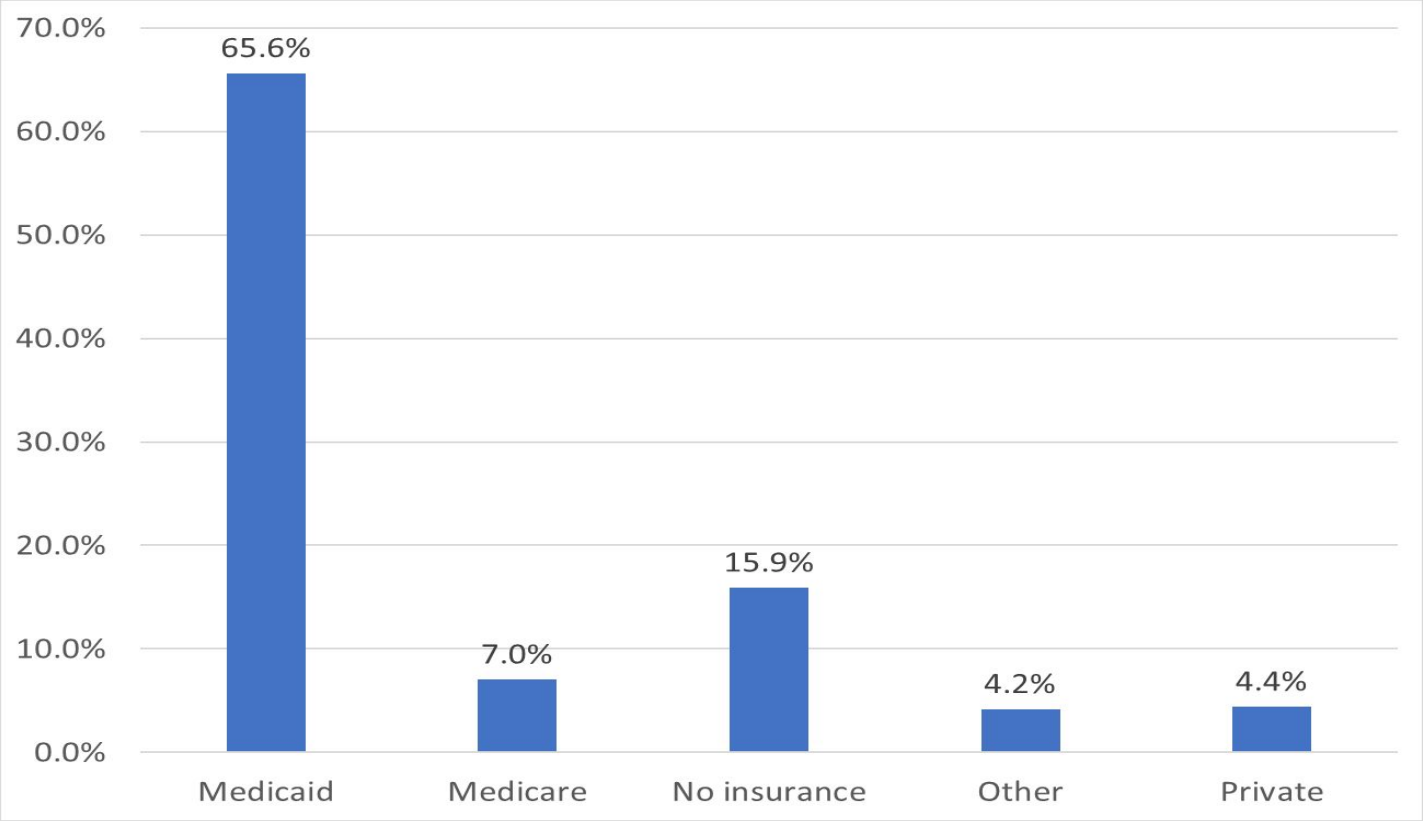
**Native Hawaiian, Pacific Islander, American Indian and Alaska Native data not included due to values <10*

2023 Intake Demographics – Risk Factor



**Hemophilia data not included due to values <10*

2023 Intake Demographics – Insurance Type



**VA or Other Military Insurance data not included due to values <10*

	Total	Male	Female	Afr. Amer. MSM	Latino MSM
Number of Intakes	1680	1128	474	518	102
Service Category					
Housing	81.7%	42.0%	17.0%	17.1%	3.0%
Food Bank/Voucher/ Home Delivered Meal	135.4%	89.5%	39.4%	33.4%	6.4%
Treatment Adherence	43.5%	22.1%	8.9%	8.4%	2.5%
Benefits Assistance	23.6%	12.7%	4.5%	4.7%	1.0%
Medical Care	23.5%	12.0%	4.8%	3.9%	1.8%
Transportation Assistance	28.9%	4.3%	1.5%	18.8%	4.0%
Medication	26.6%	13.9%	5.2%	4.9%	1.8%

Consumer Grievance Process

- Addresses grievances regarding any and all DHH funded Care and Prevention services
- Grievances can be filed anonymously
- Calls are designated as Crisis, Priority or Non-Priority
- Program Analysts work with agencies to reach agreed upon resolutions
- CSU Supervisor relays resolution to caller
- *Note: All DHH funded subrecipients must have a grievance process and must share this process with all clients*

CSU Information

Health Information Helpline
8:30 a.m. - 5:30 p.m.
Monday through Friday

215-985-2437

<u>Staffing:</u>
Manager
SW Supervisor
4 Social Workers
Currently one Social Worker vacancy

Call us for helpline cards!

Staff speak Spanish & French
(other languages including ASL are available through PDPH translation services)


Q
A

Quality Management in the EMA

Jessica Browne
Manager of Information Services
Division of HIV Health
May 9, 2024

City of Philadelphia

Quality Management (QM)

The QM process includes:

- Quality assurance
- Outcomes monitoring and evaluation
- Continuous quality improvement (QI)

The goal of the EMA's QM program is to use high quality data to continually improve access to high quality clinical HIV care

QM and the Continuum of Care

In accordance with National Goals, initiatives are being directed at all stages of the care continuum

- Diagnosis and linkage
  - CDC-funded 18-1802 and 20-2010
  - QI on prevention processes and systems
- Retention and viral suppression
  - Quality improvement projects (QIPs) in Ryan White O/AHS and MCM

The QM Process in the EMA

Collect and analyze data to assess client outcomes

- Local and HAB performance measures
- Other available data

Use data to improve client outcomes

- Provider use of CAREWare reports
- Ongoing feedback to providers
  - Benchmarking and trends
- QIPs
- Regional QM Meetings
- Technical assistance and training with providers
- Consumer input

Outcome Monitoring in the EMA

Performance Measures

- O/AHS measures focus on clinical outcomes, including VLS, retention, STI/other screenings, and women's health
- MCM measures reflect new model – broken out into Comprehensive and Standard

Access to Care

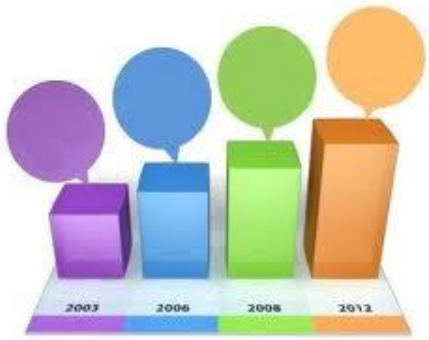
- Regular "secret shopper" calls to O/AHS providers, including feedback and corrective actions

Health disparities

- Will connect to QI to improve health equity

Performance Measures

- 24 measures for O/AHS services
- 7 measures for Comprehensive MCM, 5 measures for Standard MCM
- 3 oral health measures
- Measures for all other services and health equity data calculated from RW database
    - VL suppression
    - Retention



Monitoring and Feedback

- Strong emphasis on feedback in the EMA
- Feedback reports
  - Data visualization highlights strengths and needs
  - Benchmarking contextualizes data
  - Assists in prioritizing QIPs
- Feedback on QIPs helps to translate data into action intended to improve health outcomes

Quality Improvement Projects

- New QI coaching model rolled out in late 2021 at O/AHS programs
- Current cycle, including OAHS, MCM, and testing programs, began in spring/summer 2023
    - Training held for MCM providers in early 2023 to reintroduce them to QIPs and DHH's QI expectations
- Goal is to be more individualized and flexible
- Incorporation of different QI methodologies (e.g. Lean Six Sigma)
- Project topics based on programs' individual performance and needs
- Joint QIPs at co-located sites

QIPs Are Effective

- QIPs for O/AHS consistently result in better outcomes
- From 2013 to 2017, 81% (128/158) of QIPs for O/AHS resulted in improved outcomes
- Final outcomes for last QI cycle (2021-2022) showed the following:
    - Average improvement of 9% on measures that were focus of QIP
    - 24 out of 27 programs showed improvement on measures that were focus of QIP
    - Average improvement per measure greater at provider sites that completed QIP on that measure vs. those that did not complete a QIP on that measure

Consumers and QI

- QI principle: quality is defined by the consumer!
- DHH emphasizes consumers in the QI process
- Methods of obtaining input include:
  - Consumers on QI teams or committees
  - Obtain input from Consumer Advisory Boards during key stages of a QI process
  - Consumer focus groups
  - Client surveys to obtain client input relating to causes for low performance or proposed action steps
- Providers will be completing rapid QIP cycle on consumer involvement in fall 2024
    - Includes standardized organizational assessment

Appointment Availability

- HAB systems level performance measure assesses number of RW O/AHS programs with a waiting time of 15 or fewer business days for a RW-eligible patient to receive a medical appointment
- DHH callers present as patients who are uninsured, out of care or never linked to care, and have no income
- Provides opportunity to assess any potential barriers to care

Appointment Availability

- Overall decline since 2018
- Providers whose calls indicate serious barriers to care are given corrective action plan
- Both Spanish and English calls in recent cycles
- Barriers include inability to schedule appointment due to lack of responsiveness and/or insurance, and miscommunication of fees and other costs
- Added 4-day metric based on last year's feedback from Comprehensive Planning and Positive Committee

Viral Load Suppression

- As of December 2023, 23 out of 24 O/AHS programs in the EMA had 80% or higher VL suppression
  - 21 programs had 85% or higher VL suppression
  - 7 programs had 90% or higher VL suppression
- Mean of 88.3%, which is a 2.2% increase from December 2022

Review of 2023 QM Initiatives

Initiative	Status
Beginning QIPs at MCM and testing providers	Completed (began in spring/summer 2023)
Joint QIPs at co-located sites	Partially completed (joint QIPs being completed where possible, but there is room for growth and increased coordination)
Peer sharing network	Completed (sent out to system in April 2023)
Streamlined QM plan	Completed (final version shared with HRSA and PA Dept. of Health in summer 2023)
Increasing consumer input	Partially completed (QM work plan shared with HIPC and subcommittees in 2023; consumer input into providers' QM programs will be increased through rapid QIP cycle in 2024)

QM Initiatives in 2024

- Rapid QIP cycle to improve consumer input into providers' QM programs
- Continue to develop Lunch and Learn training series
- Finalize and publish recorded CAREWare trainings to build capacity among providers
- Work with MCM Committee to decide on future QI needs in MCM system

Quality Management Plan

Gita Krull-Aquila, Psy.D.
Quality Management Coordinator
Laura Silverman, MS, CHES
Quality Advisor
Division of HIV Health
May 9, 2024

City of Philadelphia

Agenda

- Quick overview of QM Plan
- Presentation of Work Plan
- Questions and feedback

QM Plan

- Requirement of HRSA's PCN 15-02
- Roadmap of CQM activities
- Updated annually
- DHH uses a checklist from HRSA to ensure all needed components are included in the document
- One main component is the Work Plan which covers goals, objectives, and action steps
- DHH took an extra step and noted how Work Plan objectives align with specific aspects of the NHAS, Philadelphia Integrated Plan, and Philadelphia EHE Plan

Components of QM Plan

- Generally, a QM plan will include:
  - Organizational Summary
  - Quality Statement
  - Quality Infrastructure
  - Annual Goals and Objectives
  - Participation of Stakeholders
  - Performance Measurement
  - Capacity Building
  - Evaluation of QM Program
  - Work Plan
  - Process to Update QM Plan

2024 Work Plan

- Some goals were reworked, while others are entirely new
  - New goals focus on consumer involvement and health equity

- Due to the length of the Work Plan, we will be summarizing the action steps for this presentation
  - Full Work Plan includes staff responsible, timeline, and outcome for each step

Breakdown of Work Plan

Goals	Objectives	Action Steps
Goal 1	6	42
Goal 2	7	12
Goal 3	4	19
Goal 4	4	13

Goals for 2024

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Goal 3: Ensure regional services are reflective of the needs of PWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and subrecipients' CQM programs

Goal 4: Improve capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 1: Monitor and evaluate improvements in access to and initiation of status neutral HIV treatment and care

Action steps summary:

- Collect & evaluate data (LSHS PDEs, EHE Triannuals, PDEs, PMRs, TFRs)
- Collect & evaluate iART PM data & incorporate into QIPs
- Modify public-facing EHE dashboard
- Participate in State CQI Project to improve retention in MCM services

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 2: Apply a QI perspective to review and provide feedback on Corrective Action Plans (CAPs) submitted from providers with identified issues during bi-annual DHH appointment availability calls and periodic PrEP availability calls

Action steps summary:

- O/AHS Secret Shopper Calls (incl. 1st appt. within 4 days, CAP reviews, reports)
- Linguistic info into reports
- Assist with PrEP call writeups

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 3: Re-evaluate barriers reported by patients who have been reengaged in care through Field Services and incorporate results into CQM program, including provider QI projects

Action steps summary:

- Obtain barriers to care; develop DTC feedback reports
- DTC reports to Health Equity Officer for review & QI input
- Feedback to providers (DTC & HE) for incorporation into QIPs as needed

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 4: Initiate QIPs with DHH funded Prevention, MCM, and O/AHS programs using coaching model in order to improve performance across identified areas

Action steps summary:

- Relevant training updates for ISU staff (key aspects of O/AHS, MCM and Prevention services)
- ISU hosting EvaluationWeb user group
- Assess Prevention reports and OAHS/MCM PM data for potential QIP topics
- Provide training & TA to Prevention, O/AHS & MCM providers during QIP process
- Evaluate results of QIPs, disseminate outcomes & use as guide for next cycle

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 5: Continue collaboration between DHH ISU and EHE Team around aligning CQM activities

Action steps summary:

- Ongoing meetings with EHE team to identify potential QIP areas
- Finalize EHE Evaluation Plan

Goal 1: Conduct and evaluate activities that enhance recipient and subrecipient CQM programs, including infrastructure, performance measurement, and quality improvement, in order to help meet EHE goals

Objective 6: Create and offer innovative trainings for providers to enhance their quality management skills

Action steps summary:

- Develop online CAREWare 6 training for providers
- Continue discussions regarding CAREWare centralization
- Develop new trainings for subrecipients & provide TA/resources
- Offer optional Lunch & Learns

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 1: Create a process to share O/AHS program contact information with Testing providers biannually in order to expedite linkage of newly diagnosed individuals and those lost to care

Action steps summary:

- O/AHS providers identify primary & secondary contacts for Testing providers
- O/AHS contact form distributed 2x year to Testing providers

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 2: Continue to update and share O/AHS program contact information with MCM providers biannually in order to support monitoring of treatment adherence and to improve health outcomes

Action steps summary:

- O/AHS providers identify primary & secondary contacts for MCM providers
- O/AHS contact form distributed 2x year to MCM providers

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 3: Establish and complete a process to update and share MCM provider contact information with O/AHS programs biannually in order to support linkage and retention in care

Action steps summary:

- MCM providers identify primary & secondary contacts for O/AHS providers
- MCM contact form distributed 2x year to O/AHS providers

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 4: Develop an evaluation process to measure referral of unsuppressed O/AHS clients to MCM services

Action steps summary:

- Continue to evaluate implementation schedule of PHL25 performance measure

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 5: At co-located sites, integrate O/AHS and MCM QIPs where possible to foster collaboration

Action steps summary:

- Involve both O/AHS and MCM staff in QIPs

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 6: Establish a process to improve coordination between Testing, O/AHS, and MCM services

Action steps summary:

- Reconvene MCM Workgroup
- Meet with providers to address barriers in the region

Goal 2: Develop and evaluate processes for O/AHS, MCM, and Testing providers to communicate more efficiently with each other in order to improve client engagement along the care continuum using a whole-person approach

Objective 7: Establish and help organize a peer sharing network for programs where they can learn from each other's QI work

Action steps summary:

- Update list of peer sharing network participants
- Distribute updated list to participants

Goal 3: Ensure regional services are reflective of the needs of PWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and subrecipients' CQM programs

Objective 1: Assess recipient's capacity to obtain and incorporate consumer feedback into CQM program activities

Action steps summary:

- Compile current resources of consumer feedback in place at DHH
- Outline identified resources for further QI work

Goal 3: Ensure regional services are reflective of the needs of PWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and subrecipients' CQM programs

Objective 2: Assess subrecipients' capacity to obtain and incorporate consumer feedback into QIPs

Action steps summary:

- Refine Organizational Assessment (OA)
- Use OA at start of new QIP cycle to explore providers' level of consumer involvement in CQM activities
- Distribute resources to providers on strengthening consumer involvement in CQM activities

Goal 3: Ensure regional services are reflective of the needs of PWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and subrecipients' CQM programs

Objective 3: Refine process to obtain and incorporate consumer feedback into DHH QM Plan on a regularly scheduled basis

Action steps summary:

- Present QM Plan to HIV Integrated Planning Council and subcommittees

Goal 3: Ensure regional services are reflective of the needs of PWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and subrecipients' CQM programs

Objective 4: Share and review QM Plan, including Work Plan, with key stakeholders and incorporate their feedback into both documents

Action steps summary:

- Review QM Plan and Work Plan with ISU QM team, CQM Committee, and DHH Leadership and staff

Goal 4: Improve capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities

Objective 1: Analyze and disseminate data on regional health disparities to key stakeholders including subrecipients

Action steps summary:

- Identify EMA-wide disparities and present at Annual QM Meeting

Goal 4: Improve capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities

Objective 2: Conduct evaluation of recipient and subrecipient health equity activities

Action steps summary:

- Assist Health Equity Officer with reviewing health equity related activities such as health equity plans
- Develop performance measures, evaluation process, and QIPs for health equity initiatives

Goal 4: Improve capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities

Objective 3: Develop health equity resources for subrecipients to apply to their CQM work

Action steps summary:

- Assess status of health literacy trainings for all O/AHS, MCM, and Testing providers
- Offer health literacy guide during QIPs to providers who have completed health literacy training

Goal 4: Improve capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities

Objective 4: Increase capacity of CQM staff to incorporate health equity activities into QI projects with subrecipients

Action steps summary:

- Participate in Aging and HIV training to increase knowledge and help develop QM/QI activities
- Discuss CQM health equity initiatives with Health Equity Officer

Questions or Comments

Please email
AACOISU@phila.gov
with any additional input!

Service Utilization

Jessica Browne
Manager of Information Services
Division of HIV Health
May 9, 2024

City of Philadelphia

AIDS Pharmaceutical Assistance (LPAP)

Service Definition

- Local pharmacy assistance programs
- Supplemental means of providing medication assistance

Service Utilization FY23

- Clients: 242
- Units: 997
- Unit Definition: 1 Unit = 1 30-day Prescription filled

AIDS Pharmaceutical Assistance (LPAP)

Highlights and Comparison to FY22

- 39 (+19%) additional clients
- 107 (+12%) additional 30-day Prescriptions filled.

Medical Case Management

Service Definition

- Focused on improving health outcomes in support of HIV care continuum
- Core activities include initial assessment of service needs; individualized care plan; access to health and support services; ongoing assessment of needs; treatment adherence counseling
- Implementation in EMA:
  - Two-tiered model (Comprehensive and Standard)
  - Co-located with O/AHS programs vs. Community Based Organizations

Medical Case Management

Service Utilization FY23 (Part A Only)

- Clients: 4,198
- Units: 318,815
- Unit Definition: 1 Unit = Quarter Hour

Service Utilization FY23 (MAI Only)

- Clients: 1,039
- Units: 83,423
- Unit Definition: 1 Unit = Quarter Hour

Medical Case Management

Highlights and Comparison to FY22

- Clients stayed relatively stable in FY23, with a decrease in 48 (-1%) clients receiving Part A/MAI MCM services this year
- Units increased by 9,724 units (3%)
- In 2024, 62.2% of new MCM clients were linked to medical care.

Medical Nutrition Therapy

Service Definition

- Includes nutrition assessment, screening, and evaluation; food and nutritional supplements; and nutrition education and counseling
- Individual or group settings

Service Utilization FY23

- Clients: 350
- Units: 2,557
- Unit Definition: 1 Unit = Quarter Hour

Medical Nutrition Therapy

Highlights and Comparison to FY22

- 18 (-5%) fewer clients received Nutrition Therapy
- Units increased by 142 (6%).

Mental Health Services

Service Definition

- Outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling
- Outpatient group or individual session provided by a licensed mental health professional

Service Utilization FY23

- Clients: 1,958
- Units: 17,679
- Unit Definition: 1 Unit = Quarter Hour

Mental Health Services

Highlights and Comparison to FY22

- 316 (19%) more clients
- Increase of 4,338 (33%) units since the previous year
- Most subrecipients utilize the Behavioral Health Consultant model which provides short term, decision support for mental health treatment planning

Oral Health Care

Service Definition

- Outpatient diagnostic, preventive, and therapeutic services
- Provided by dental health care professionals

Service Utilization FY23

- Clients: 1,476
- Units: 6,961
- Unit Definition: 1 Unit = 1 Visit

Oral Health Care

Highlights and Comparison to FY22

- 29 (-2%) fewer clients
- Increase of 232 (3%) dental visits

Outpatient/Ambulatory Health Services

Service Definition

- Outpatient diagnostic/therapeutic services provided by licensed healthcare provider
- Consistent with the Public Health Service guidelines

Outpatient/Ambulatory Health Services

Service Utilization FY23 (Part A Only)

- Clients: 10,627
- Units: 33,509
- Unit Definition: 1 Unit = 1 Visit

Service Utilization FY23 (MAI Only)

- Clients: 175
- Units: 797
- Unit Definition: 1 Unit = 1 Visit

Outpatient/Ambulatory Health Services

Highlights and Comparison to FY22

- Service utilization rose from the previous year
- 109 (-1%) fewer combined clients and 4,101 (14%) more medical visits
- VL Suppression in the EMA increased from 86.1% to 88.3% during this period
- Seven providers above 90% on VL Suppression (compared to 4 in 2019)

Substance Use – Outpatient

Service Definition

- Outpatient services for the treatment of drug or alcohol use disorders
- Includes screening, assessment, diagnosis and/or treatment

Service Utilization FY23

- Clients: 420
- Units: 9,657
- Unit Definition: 1 Unit = Quarter Hour

Substance Use – Outpatient

Highlights and Comparison to FY22

- 110 (36%) more clients received this service this year
- Service utilization decreased by 1,106 (-10%)

Emergency Financial Asst.

Service Definition

- Limited one-time or short-term payments for essential utilities, housing, and/or medication
- All other available community resources must be exhausted prior to applying for these funds

Service Utilization FY23

- Clients: 554
- Units: 703
- Unit Definition: 1 Unit = 1 payment, 1 filled prescription, or 1 bill/expense

Emergency Financial Asst.

Highlights and Comparison to FY22

- 78 (16%) more clients received services under EFA in FY23
- Utilization increased by 49 units (8%).

Food Bank/Home Delivered Meals

Service Definition

- Food items, hot meals, and/or voucher program to purchase food

Service Utilization FY23

- Clients: 2,318
- Units: 97,716
- Unit Definition: 1 Unit = 1 Meal, 1 Visit, or 1 Voucher

Food Bank/Home Delivered Meals

Highlights and Comparison to FY22

- Clients remained relatively stable, with 150 (7%) more clients compared to FY22.
- Number of meals increased by 10,404 (12%) meals

Housing

Service Definition

- Limited short-term assistance
- Must provide medical/supportive services OR enable client to access services
- EFA, supportive services, group housing, and legal assistance

Service Utilization FY23

- Clients: 558
- Units: 8,816
- Unit Definition: 1 Unit = Quarter Hour or 1 Payment

Housing

Highlights and Comparison to FY22

- Clients decreased by 29 clients (-5%) as compared to FY22
- Utilization decreased by 820 units (-9%)

Medical Transportation

Service Definition

- Non-emergency transportation services to core medical and support services
- Payer of last resort (must use MotivCare first)

Service Utilization FY23

- Clients: 1,332
- Units: 13,034
- Unit Definition: 1 Unit = 1 Way Trip or Round Trip

Medical Transportation

Highlights and Comparison to FY22

- 335 (-20%) fewer clients
- 453 (-3%) fewer one-way trips
- 48% decline in clients and a 65% decline in units compared to FY19

Other Professional Services

Service Definition

- Provision of legal services related to HIV
- Includes assistance with benefits, power of attorney, and living will

Service Utilization FY23

- Clients: 889
- Units: 15,777
- Unit Definition: 1 Unit = Quarter Hour

Other Professional Services

Highlights and Comparison to FY22

- 124 (16%) more clients accessed Legal Services
- Service units decreased by 2,699 (-15%)
- Largest increase in Philadelphia, while NJ and PA counties declined slightly

Referral For Health Care/ Supportive Services

Service Definition

- Directs client to needed core medical or support services
- Includes DHH CSU client intakes and help line, as well as confidential helpline and computer lab with digital health literacy classes focused on entitlements and benefits information.

Service Utilization FY23

- Clients: 1,828
- Units: 2,066
- Unit Definition: 1 Unit = Quarter Hour or 1 call

Referral For Health Care/ Supportive Services

Highlights and Comparison to FY22

- Clients utilizing these services increased by 455 (33%)
- 225 (-10%) fewer units were provided

Questions or Comments