Philadelphia HIV Integrated Planning Council
Meeting Minutes of
Thursday, May 9th, 2023
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Nicole Adams, Juan Baez, Veronica Brisco, Keith Carter, Debra D'Alessandro, Lupe Diaz, Jose DeMarco, James Ealy, Alan Edelstein, Jeffrey Haskins, Nafisah Houston, Sharee Heaven, DJ Jack, Greg Langan, Pamela Gorman, Alecia Manley, Lorett Matus, Clint Steib, Desiree Surplus, Evan Thornburg, Mary Evelyn Torres, Adam Williams, Mystkue Woods

Guests: Gita Krull-Aquila (DHH), Jessica Browne (DHH), Ameenah McCann-Woods (DHH), Laura Silverman (DHH), Patrick Mukinay, Maddison Toney (PADHH), Tahira Tyler

Excused: Michael Cappuccilli, Kenneth Dilliard-Cruz, Gus Grannan, Shane Nieves

Staff: Tiffany Dominique, Debbie Law, Sofia Moletteri, Mari Ross-Russell, Kevin Trinh

Call to Order: L. Diaz called the meeting to order at 2:07 p.m.

Introductions: L. Diaz asked everyone to introduce themselves.

Approval of Agenda: L. Diaz referred to the May 2024 HIV Integrated Planning Council (HIPC) agenda and asked for a motion to approve. **Motion:** K. Carter motioned; A. Manley seconded to approve the May 2024 HIPC agenda via a Zoom poll. **Motion passed:** 15 in favor, 3 abstained. The May 2024 HIPC agenda was approved.

Approval of Minutes (*April 14, 2024*): L. Diaz referred to the April 2024 HIPC meeting minutes and asked for a motion to approve. **Motion:** K. Carter motioned; C. Steib seconded to approve the April 2024 HIPC minutes via a Zoom poll. **Motion passed:** 15 in favor, 4 abstained. The April 2024 HIPC meeting minutes were approved.

Report of Co-Chairs:
S. Heaven reported on the HOPWA allocation. She said they had to calculate the funding since they had just received the award the day before. She expected that there was a slight decrease in funding. She said they would make this public as soon as they receive their action plan sometime in June or July. She said the funding included disaster relief for those who were impacted by Hurricane Ida.

C. Steib gave his report on the Pennsylvania State HIV Planning Group meeting that he had attended. He said they had met in Wilkes-Barre, PA in a town hall where they had met with the Wilkes-Barre Health Department and the Northeast region staff. C. Steib described his highlights from the meeting. One was that there were many immigrants from Latin countries and Ukraine. There was a workgroup update on the employment and aging workgroup. There was a discussion on updating the state's protocol for the council meetings. A stakeholder engagement plan was

presented. The state HPG called this their Conversation Cafes and looked for feedback on how they could improve their stakeholder engagement plan. There was also a presentation on HOPWA for the state. L. Diaz said her takeaway from the meeting was that mental health services could have a wait time of up to 2 - 3 years if the person requesting services needed a translator.

L. Diaz asked M. Toney for an update on the state department of HIV Health. M. Toney said she had no update but she could answer any questions by email.

Report of Staff:
M. Ross-Russell said they were still waiting for the Final Award and the date they would receive it was still being determined. They said the federal government was planning on sending the notices to the recipients within the month of May. She said once they receive the award, they would need to go into the allocations process to review and approve the plans that were created in July.

M. Ross-Russell further reported on the Harm Reduction letter. The letter was requested by HIPC members who wanted harm reduction such as syringe exchange to be supported in the city. She said they were awaiting the signature of 4 people, but she welcomed any interested HIPC members to sign the document. She said they did not ask anyone with a phila.gov email to sign the letter. The letter would be sent out the same day to the Director of the Division of HIV Health (DHH) and all the members of the Philadelphia City Council. S. Moletteri said they received a signature and were awaiting the other three. They said if the other three members had wanted to sign the letter or if anyone else wanted to replace the signatures, they would need to contact S. Moletteri. M. Ross-Russell thanked M. Cappuccilli, A. Edelstein, and C. Steib for their feedback on the letter. J. DeMarco asked if the Health Commissioner should be attached to the letter. M. Ross-Russell confirmed that the commissioner would be sent a copy of the letter.

M. Ross-Russell announced that B. Celeste had resigned from the OHP staff due to medical reasons on Friday. B. Celeste was the receptionist at OHP.

T. Dominique reminded the members that they were required to be in at least one subcommittee. She said they could contact any of the Co-chairs or OHP staff if they were interested. K. Trinh would be the staff person who would add them to the subcommittee. K. Trinh's email was Kevin@HIVPhilly.org.

Presentation:
-Client Services Unit: Health Information Helpline-
T. Tyler thanked the HIPC for inviting her to present and introduced herself as the Health Services Social Work Supervisor at DHH. She said she supervised three social workers at the time. She would be presenting about the Client Services Unit Health Information Helpline first.

She described the Client Services Unit's (CSU)'s mission. Their mission was to help people living with HIV (PLWH) understand their needs and make informed decisions. She said CSU advocates on behalf of those who need special support and they reinforce the clients' capacity for self-reliance and self-determination through referral & linkage, education, collaborative

planning, and problem solving. She then detailed the CSU responsibilities such as assisting with scheduling medical appointments for those newly diagnosed, processing grievances about funded services, and assisting with special DHH projects. T. Tyler then defined the HRSA Medical Case Management definition. It described a range of client-centered activities focused on improving health outcomes. She then listed a number of MCM key activities such as initial assessment of service level and needs, development of individualized care plans, HIV treatment adherence counseling, client-specific advocacy, ongoing needs assessment, and re-evaluation of care plan at least every 6 months.

She then said there was $10.3 million allocated to MCM in RW Part A, State Rebate, Minority AIDS Initiative (MAI), and General Funds. She said DHH funded subrecipients providing MCM services to 7,087 unduplicated PLWH in 2023. 1,680 intakes were completed through CSU in 2023 and 26 MCM subrecipients were funded throughout the EMA. As of 5/9/24, there were 15 people on CSU's waitlist. She said some agencies were understaffed and they had a limited number of people they could take on at a time. She said she expected these issues for 10 individuals on the waitlist would resolve in the next two weeks. K. Carter asked why the client couldn't see the case manager while they were in the inpatient process. T. Tyler said if the patient was in an inpatient treatment program, they should be receiving support from a social worker or case management that was built inside the program and that they didn't want to duplicate efforts.

T. Tyler said emergency and other priority populations were immediately referred to MCM providers. She listed the types of populations that would be referred to MCM providers such as those who were pregnant and not in medical care, those without housing and living on the streets, and those recently diagnosed within the last three months. In the next slide, she went over the gender demographics of the intake population: 67% of the intake was reported as male, 28% of the intake population was reported as female, and 4% were transgender. She then reviewed the demographics in terms of race and ethnicity: 63% of the population was reported as NH Black while 14.6% were reported for both NH White and the Hispanic population. She then reported the risk factors for each demographic for contracting HIV: MSM and heterosexual activity were the highest risk factors for contracting HIV. Lastly, she noted that most people had Medicaid as their insurance type.

T. Tyler then reviewed the demographics on the types of calls that they received. She revealed that the top 3 concerns that people had called for were housing, food, and treatment adherence. She said housing concerns were discussed in the most calls and had accounted for 81.7% of intakes.

K. Carter asked if seniors were referred to Philadelphia Corporation for Aging (PCA) if they had come forward with food concerns. T. Tyler replied she had personally requested her team to refer older members of the population to PCA. She said she they had been cooperating with PCA to secure benefits addressing more than food concerns such as housing and legal concerns.

The next portion of the presentation went over the Consumer Grievance Process. The grievance process was a way in which consumers could submit their concerns and frustrations regarding any and all DHH funded Care and Prevention Services. The grievances were filed anonymously and labeled either crisis, priority, or non-priority. She said the program analysts would work with

agencies to reach a solution and the CSU supervisor would relay the resolution to the caller. T. Tyler then presented the HIPC with the CSU contact information. She said their staff spoke both Spanish and French with other languages through PDPH translation services. She thanked them for their invitation and asked if there were any questions.

D. D'Alessandro asked about the volume of grievances that they receive daily. T. Tyler said the volume of consumer complaints was decreasing lately since they had made efforts to resolve grievances before they approach the stage where the consumer goes through the process. She estimated that there was one grievance in the last 5 months. K. Carter asked if they had recorded grievances sent internally through a consumer's agency. T. Tyler replied that they did not record grievances at that level. They only recorded grievances if they could not be resolved at the provider level. K. Carter said this was an opportunity for them to capture data of potential barriers that the consumer may face. A. McCann-Woods said every organization that was funded must have an internal grievance process and they must have the process permanently available. She explained that it was a process that DHH reviewed every year to ensure that everything was updated.

-Quality Management in the EMA-

J. Browne, the Manager of Information Services at DHH, next presented information about their quality management (QM) program in the EMA. She began her presentation by defining quality management as a variety of activities that result in a high-quality product or service. She said the goal of the EMA's QM program was to use high quality data to continually improve access to high quality clinical HIV care. She then spoke about the QM program and its relationship with the continuum of care. She talked about how initiatives were being directed at all stages of the care continuum such as the improvement of diagnosis and linkage to care.

She explained the QM process in the EMA. The first step in the process was to collect and analyze data to assess client outcomes. She said they received information from a variety of sources including local and HRSA HIV/AIDS Bureau (HAB) performance measures. The second step was to use data to improve client outcomes. This included technical assistance, training with providers, and feedback on where they could find more consumer input. She said there were many ways in which they measured outcomes within the EMA. Some were performance measures focused on clinical outcomes such as retention screenings and women's health. Other measures were "secret shopper" calls to test access to care. She said they also monitored health disparities and had recently presented on the topic at their annual QM meeting. J. Browne said they placed great emphasis on feedback in the EMA. Data visualization, benchmarking, and feedback on Quality Improvement Projects (QIPs) were some of the ways in which they improved health outcomes by translating data into action.

J. Browne quickly gave an overview of their new Quality Improvement coaching model that had rolled out in late 2021 at Ambulatory Health Service (O/AHS) programs. She said the current cycle had begun in Spring/Summer 2023 and included O/AHS, MCM, and testing programs. She said the goal of the QI coaching model was to make the coaching model more individualized and flexible. She said they had the opportunity to incorporate different QI methodologies to approach these goals such as Lean Six Sigma.

J. Browne said QIPs for O/AHS consistently result in better outcomes. She said from 2013 to 2017, 81% of QIPs for O/AHS resulted in improved outcomes. She then summarized the final outcomes from the last QI cycle – 2021 to 2022. She said there was an average improvement of 9% on measures that were focused on QIP and that about 24 out of 27 programs showed improvement on measures that were focused on QIP. She said the average improvement per measure was greater at provider sites that completed QIP compared to those that did not complete a QIP on that measure.

From there, J. Browne spoke about how QI related to the consumer. She emphasized the consumer's role in the QI process since the quality was defined by the consumer. She said it was required to have some input from the consumer. She then listed some ways that organizations could have consumer input. These included having consumers on QI teams/committees, Consumer Advisory Boards, and Consumer focus groups. She said providers would complete a rapid QIP cycle on consumer involvement in fall 2024. Shen then discussed how the secret shopper calls were used to assess the accessibility of programs. DHH callers would present themselves as patients who were uninsured, out of care/never linked to care, and without an income. They would see if the caller was able to receive services in a timely manner. Providers whose calls indicated serious barriers to care were given a corrective action plan. Barriers to care could include inability to schedule an appointment due to lack of responsiveness and/or insurance as well as miscommunication of fees and other costs. She said Spanish calls were more likely to have these barriers. Overall, there was a decline in outcomes based on the calls since 2018.

J. Browne provided a summary of their Viral Load Suppression data. 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, and 7 programs had 90% or higher VL suppression. The average rate was 88.3%, which marked a 2.2% increase from December 2022. J. Browne reviewed the 2023 QM Initiatives. She provided the status of each initiative they had last year. She said they had completed in Spring/Summer 2023 of starting QIPs at MCM and testing providers. She said they had partially completed creating joint QIPS at co-located sites. She said they had created a peer sharing network where providers could talk to other providers about their outcomes and findings. The next initiative discussed in 2023 was a streamlined QM plan. She said they had completed this in summer 2023 and shared it with HRSA and the PA Department of Health. DHH had wanted to increase consumer input. J. Browne said this was partially completed. She said they would be increasing consumer input into QM programs through the rapid QIP cycle in 2024.

Looking forward, she presented the QM initiatives they hoped to achieve in 2024. She mentioned before, DHH was to have a Rapid QIP cycle to improve consumer input into providers' QM programs. She said they had also hoped to continue to develop the Lunch and Learn training series. She then said they wanted to finalize and publish recorded CAREWare training to build capacity among providers. She said DHH was to work with the MCM committee to decide on future QI needs in the MCM system.

J. Browne turned to G. Krull-Aquila to review the goals and action steps of the Quality Management Plan. She started her presentation by reassuring the HIPC members that they did

not forget the feedback they had received from the last time they had presented the QM Plan. She remembered they recommended some possible consumer groups DHH could contact.

G. Krull-Aquila provided an overview of the QM Plan. The QM Plan was a part of the requirements of HRSA's PCN 15-02. It provided a roadmap of Clinical Quality Management activities and needed to be updated annually. DHH uses a checklist from HRSA to ensure all needed components were included in the document and they went even further by ensuring Work Plan Objectives aligned with specific aspects of the National HIV/AIDS Strategy (NHAS) Philadelphia Integrated Plan and Philadelphia End the Epidemic Plan. She then listed the components of the QM Plan.

Since the presentation of the QM Plan. G. Krull-Aquila stated that they had reworked some of the goals and added new ones to the plan. She said she would be summarizing the action steps for the plan due to the plan's length. There were 4 goals to the plan and each goal had objectives and action steps to accomplish the goal.

The first goal was to 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. G. Krull-Aquila said goal 2 aimed to 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. The third goal was to ensure regional services were reflective of the needs of PLWH by increasing the systematic and recurrent collection, dissemination, and use of consumer input in the recipient and the subrecipient CQM programs. The fourth goal was to improve the capacity of recipient and subrecipients to promote health equity by incorporating regional health disparity data and capacity building resources into CQM activities. G. Krull-Aquila provided information about the objectives under each goal and the action steps taken to achieve them..

J. Browne took over as the presenter to provide information about service utilization. The first service was Local Pharmaceutical Assistance Programs (LPAP). LPAP referred to local pharmacy assistance programs and was a supplemental means of providing medication assistance. There were 242 clients served by this service in FY23. 997 units were utilized where 1 unit equaled 1 30-day prescription filled. Compared to FY22, FY saw an additional 39 clients which represented an increase of 19% in clients. J. Browne said FY23 had also seen an additional 107 30-day prescriptions filled.

Medical Case Management was the next service that was reviewed. She said the part A service in FY23 had 4,198 clients with 318,815 units being used. She defined 1 unit as a quarter hour of service. For MCM - Minority AIDS Initiative (MAI), there were 1,039 clients in FY23 and 83,423 units utilized where 1 unit equaled 1 quarter of service. J. Browne noted that clients using Medical Case Management stayed relatively the same in FY23 with 48 less clients receiving Part A/MAI MCM services this year, which only represented a 1% change in clients. J. Browne said that 62.2% of new MCM clients were linked to medical care. She then reviewed the service utilization for Medical Nutrition Therapy. She said there were 350 clients in FY23 and 2,557 units used where 1 unit equals a quarter hour of service. She highlighted that there were 18 fewer

clients who received Nutrition Therapy in FY23. She noted that the number of units had increased by 142 compared to FY22.

The next service category was Mental Health Services. J. Browne said Mental Health Services had gained 316 or 19% more clients in FY23 and had an increase of 4,338 units since the previous year where 1 unit accounted for 1 quarter hour of service. She said most subrecipients utilize the Behavioral Health Consultant model which provides short term decision support for mental health treatment planning.

She then reviewed the service utilization for Oral Health Care. In comparison to utilization in FY22, FY23 saw fewer clients use Oral Health care services. There were 29 fewer clients which represented a 2% decrease. Though there was a decrease in the number of clients, there was an increase in the number of dental visits. FY23 saw an increase of 232 dental visits compared to FY22.

The next service category was Outpatient/Ambulatory Health Services. J. Browne highlighted that service utilization had risen from the previous year. Though service had risen, there were 109 fewer combined clients but 4,101 more medical visits. She reported that viral load suppression in the EMA had increased from 86.1% to 88.3% during this period. She then reported that seven providers were above 90% on viral load suppression compared to only four service providers in 2019.

J. Browne reviewed utilization for Substance Use Services. She said there were 110 more clients in FY 23 than FY22, marking a 36% increase. She said overall the service utilization had decreased by 1,106 units where 1 unit accounted for a quarter hour of service.

She then reviewed utilization for Emergency Financial Assistance (EFA). She said there were 78 more clients than the previous year and that utilization had increased by 49 units where 1 unit accounted for 1 payment or filled prescription.

Food Bank Services was the next service. J. Browne said the number of clients for this service category was relatively stable with 150 clients or an increase of 7% more clients compared to the previous year. The number of meals served had increased by 10,404 meals or 12% compared to the previous year.

The next service was Housing Services. The number of clients for this service category had decreased by 29 clients or 5% compared to the previous year in FY22. Utilization had decreased by 820 units where 1 unit represented 1 payment or quarter hour of service.

She then reported on utilization of Medical Transportation services. She reported there were 335 fewer clients compared to FY22. She said there were fewer one-way trips and that this had decreased by 453 trips in FY23. She said there was a 48% decline in clients and a 65% decline in units utilized compared to FY19.

She then reviewed utilization for Other Professional Services. She reported on 124 or 16% more clients who accessed legal services than in FY22. She said the number of service units utilized

had decreased by 2,699 units or 15% where 1 unit accounted for a quarter hour of service. They had noticed the largest increase in utilization in Philadelphia while the New Jersey and PA counties had declined slightly.

The last service category reviewed was the Referral for Health/Supportive Services. She said the number of clients using this service category had increased by 455 or 33% in FY23 compared to FY22. She said there were 225 or 10% fewer units provided in FY23 than in FY22. One unit represented 1 quarter hour of service or 1 call.

Discussion Item:
-Final Spending Report-
A. McCann-Woods would be presenting the 4th Quarter Spending Summary. She said after reconciliation of the total invoices through February 29, 2024, there was two percent in underspending out of the total overall award including MAI funds. This had amounted to $519,726. She said the underspending was due chiefly to staff vacancies throughout the EMA and at the Recipient level. She noted that the report was preliminary as they were still in the process of submitting the final expenditure report.

She began her report with the underspending in Philadelphia County. There was underspending in LPAP and Substance Abuse Services (Outpatient). She said LPAP was underspent due to decreased utilization. She stated Substance Abuse Services (Outpatient) was underspent due to vacancies. She then went over the overspending in Philadelphia. Oral Health Care, EFA, EFA-Pharma, and Other Professional Legal Services were overspent. She said Oral Health Care, EFA, and EFA-Pharma were overspent due to carryover funds being utilized first before they could use their FY23-24 funding. There was further need for investigation regarding the overspending in Other Professional Legal Services.

She then reviewed underspending in PA Counties. O/AHS and EFA-Pharma services were underspent in the PA Counties. O/AHS was underspent due to vacancies. EFA-Pharma was underspent due to lower utilization. A. McCann-Woods then reviewed overspending in the PA Counties. Food Bank was the only service that was overspent and was overspent due to higher utilization.

A. McCann-Woods moved to review the underspending in New Jersey. She said Housing Services were underspent due to decreased utilization. She reminded HIPC that there were efforts in place to learn how NJ providers were making clients aware of the service. There was no overspending to report within the New Jersey Counties.

She then moved to review the Systemwide allocations. The services under this description were Information and Referral, Quality Management, Capacity Building and Grantee Administration. She said these service categories were underspent due to vacancies. She then reviewed the spending for the MAI service categories, O/AHS and MCM. These were both underspent due to vacancies and late invoicing. A. McCann-Woods reviewed the MAI Systemwide Allocations. Quality Management was the service category within this description and was underspent due to vacancies.

Committee Reports:
-Executive Committee-
None.

-Finance Committee-
A. McCann-Woods reported that the Finance Committee reviewed the Final Spending Report.

-Nomination Committee-
None.

-Positive Committee-
K. Carter announced that the next Positive Committee would meet on May 20th at 12pm for an in person meeting. S. Moletteri said they would be serving food at the meeting. They asked the members to send them an email with any dietary restrictions they may have. They said they would send out an additional email about the meeting.

-Comprehensive Planning Committee-
S. Moletteri reported DHH had presented their Quality Management Plan at the meeting. The committee had also discussed CPC's involvement in the EHE.

-Prevention Committee-
C. Steib reported that the Prevention Committee had a presentation on Substance Use Services and the barriers/facilitators to access and retention.

Other Business:
None.

Announcements:
K. Carter reminded everyone about the Aging with HIV symposium on May 28th. He said they had registered 150 people attending the symposium. If there was no space for attendance in person, excess attendees could participate online through Zoom.

J. Haskins said Philadelphia FIGHT would be hosting the AIDS Education Month Summit on June 27th.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** K. Carter motioned, J. Haskins seconded to adjourn the HIV Integrated Planning Council meeting. **Motion passed:** Meeting adjourned at 4:01 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:
- May 2024 HIPC Agenda

- April 2024 HIPC Committee Meeting Minutes