MEETING AGENDA

VIRTUAL:
Thursday, April 13th, 2023
2:00 p.m. – 4:30 p.m.

- ♦ Call to Order
- ♦ Welcome/Introductions
- ♦ Approval of Agenda
- ♦ Approval of Minutes (March 9th, 2023)
- ♦ Report of Co-Chairs
- ♦ Report of Staff
- ♦ Presentation
  - EHE Update
- ♦ Discussion item
  - Third Quarter Spending Report
- ♦ Action Item
  - FY2021 Prevalence Data
- ♦ Committee Reports:
  - Executive Committee
  - Finance Committee – Alan Edelstein & Adam Williams
  - Nominations Committee – Michael Cappuccilli & Juan Baez
  - Positive Committee – Keith Carter
  - Comprehensive Planning Committee – Gus Grannan
  - Prevention Committee – Lorett Matus & Clint Steib
- ♦ Other Business
- ♦ Announcements
- ♦ Adjournment

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

The next HIPC meeting is
VIRTUAL: May 11th, 2023 from 2:00 – 4:30 p.m.

HIV Integrated Planning Council

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

Present: Michael Cappuccilli, Keith Carter, Debra D'alessandro, Jose Demarco, Lupe Diaz (Co-chair), Alan Edelstein, Rasheed Gonga, Pam Gorman, Gus Grannan, Jeffery Haskins, Sharee Heaven (Co-chair), DJ Jack, Gerry Keys, Shane Nieves, Erica Rand, AJ Scruggs, Desiree Surplus, Evan Thornburg (Co-chair), Adam Williams

Guests: Sanzida Anzuman (DHS), Jessica Browne (DHH), Gita Krull-Aquila (DHH), Ameenah McCann-Woods (DHH), Greg Seaney (DHH), Maddison Toney (PA Department of Health), Tahira Tyler (DHH), Maddison Toney, Mike Valentin, Kim Thomas,

Excused: Julie Hazzard, Clint Steib

Staff: Beth Celeste, 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 March 2023 HIV Integrated Planning Council agenda and asked for a motion to approve. **Motion:** K. Carter motioned; G. Keys seconded to approve the March HIV Integrated Planning Council agenda via a Zoom poll. **Motion passed:** 10 in favor, 4 abstained. The March 2023 HIV Integrated Planning Council agenda was approved.

Approval of Minutes (*February 9th, 2023*):

L. Diaz referred to the February 2023 HIV Integrated Planning Council minutes. D. D'alessandro asked to include her name as present in the attendee list. **Motion:** G. Keys motioned; K. Carter seconded to approve the amended February 2023 HIV Integrated Planning Council meeting minutes via a Zoom poll. **Motion passed:** 9 in favor, 8 abstained**.** The amended February 2023 HIPC Minutes are approved.

Report of Co-chairs:

S. Heaven gave a report on the Division of Housing and Community Development (DHCD) and the Department of Public Health's collaboration on housing initiatives to support those who were rent-burdened. She said the collaboration would not be a part of the Housing Opportunities for Persons With AIDS (HOPWA) program. S. Heaven was unsure what the format of the program

would look like but believed it would be similar to HOPWA. She said they should keep the contact information for people on the waiting list for rent assistance updated so that the Office of Homeless Services could directly make referrals to those in need.

S. Heaven also reported on eviction diversion programs. The eviction diversion programs were created during the COVID-19 pandemic. The program allowed landlords to apply for a mediation process to delay any evictions. S. Heaven said the program still existed and was evolving. She said there were upcoming programs within the city such as a collaboration with the Philly First Home program to support homebuyers.

She said the city was reviewing how rent would be calculated for subsidized housing. S. Heaven said the city was deciding between the Fair Market Standard versus Small Area Fair Market Rent (SAFMR) formula when calculating rent. She said that the decision between these two types was dependent on the situation/location. For example, in some areas, the SAFMR would actually be more expensive than the Fair Market Standard.

S. Heaven said that the DHCD hearings took place on the same day as the meeting. She said it was a public hearing regarding subsidized housing and other programs. She placed her email in the chat. She encouraged the Planning Council members to reach out to her with questions. L. Diaz thanked S. Heaven and acknowledged that housing was an important topic.

Report of Staff:

-Ground Rules-

L. Diaz turned to S. Moletteri who would be reviewing the ground rules with the Planning Council. S. Moletteri said the Planning Council had approved the ground rules in December 2019, and it had been a long time since they had reviewed the rules. She said that the rules still applied even though the meetings were now virtual. S. Moletteri asked the Planning Council members to review the rules and ask questions. She said this would be a good introduction for newer members and a refresher for existing HIPC members.

The rules were broken down into three types: meeting rules for all attendees, meeting rules for members, and violations. S. Moletteri reviewed the meeting rules for attendees first. Attendees must arrive on time. If attendees were going to be late, they should call the office phone number at 215-574-6760. S. Moletteri attendees could also contact staff members by e-mail such as S. Moletteri and K. Trinh. S. Moletteri asked the HIPC to silence their phones and avoid side conversations. S. Moletteri reminded the HIPC that the meetings were a public forum and they should respect each other. She also said HIPC members should ask questions if they need more information but to wait until they are acknowledged by the co-chair or speaker before asking aloud.

S. Moletteri reviewed the rules for members. She reminded everyone that Planning Council members serve the interests of the community and not their own interests. She added that they should also behave in a way that reflects their responsibility to the community. She said it is the responsibility of all members to abide by the rules and ensure that others follow them as well.

S. Moletteri reviewed the procedure for when the rules were not followed. The first violation would be a warning to the member with a reminder of the rules. The second violation would be a reminder of the rules with the addition of another warning that the person would be asked to leave if the behavior continued. After the third violation, the person would be required to leave the meeting.

L. Diaz asked if the violation would carry over to the next meeting. M. Ross-Russell confirmed that the violations did not carry over to the next meeting.

L. Diaz thanked S. Moletteri for reviewing the ground rules and noted that raised voices could trigger persons who experienced trauma.

Presentation:

-Quality Management, Service Utilization and Client Services Unit Presentation-

G. Seaney and T. Tyler introduced themselves as staff from the Department of HIV Health (DHH). G. Seaney went over the presentation agenda regarding the Client Services Unit (CSU). He said the presentation would cover the mission and responsibilities of CSU, key points of entry for Medical Case Management (MCM) services, intake data, and the consumer grievance process.

CSU's mission was to help people living with HIV (PLWH) and at-risk individuals understand their needs and make informed decisions about possible solutions. CSU advocates on behalf of those who need special support. They support the clients' capacity for self-reliance and determination by linking them to services such as education and collaborative planning.

G. Seaney described the CSU responsibilities. He said they were the entry point for MCM. They help assist with scheduling medical appointments for those newly diagnosed, lost to care, or relocating to the Eligible Metropolitan Area (EMA). This also includes those who were in correctional facilities. CSU helps this population get connected to care. G. Seaney said they help those on the waiting list as well as unfunded providers with Ryan White Certifications, emergency financial assistance, and emergency medications. CSU provides information and referral services for all other DHH programs. They process grievances about funded services and assist with special DHH projects.

CSU provides MCM services to Philadelphia and the surrounding counties such as Bucks, Chester, Delaware, Montgomery, Burlington, Camden, Gloucester, and Salem.

G. Seaney said the definition of MCM was the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. He said activities may be prescribed by an interdisciplinary team that includes other specialty care workers. He said that MCM includes face-to-face, phone contact, and other forms of communication.

G. Seaney listed the MCM activities. He said that the MCM key activities included an initial assessment of service level and needs, development of individualized care plans, time 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, ongoing assessment of client needs, and the re-evaluation of care plan at least every six months.

G. Seaney said that about $9.6 million was allocated to MCM through Ryan White Part A, state rebate, Minority AIDS Initiative (MAI), and general funds. DHH-funded subrecipients provided MCM services to 7,446 unique clients in 2021. G. Seaney said they completed 1,648 intakes through CSU in 2022. G. Seaney said that 25 MCM subrecipients were funded throughout the EMA such as community-based organizations, hospital outpatient, infectious disease clinics, pediatric sites and stand-alone HIV clinics.

T. Tyler introduced herself. She said that CSU had about 19 people on their waiting list as of March 8, 2023. She said that the wait list fluctuates as the day goes on. The waitlist includes those in correctional facilities. She added that the wait was monitored by her team and social workers.

She said that CSU focuses on emergencies and priority populations. T. Tyler said that these populations were immediately referred to MCM providers. The priority populations included those who were pregnant, those diagnosed with HIV in the last three months, those actively injecting drugs, those who have not been in medical care for 6 months or more, and those who had attempted suicide within the last 3 months and were not receiving mental health treatment.

T. Tyler reviewed the intake data for 2022. T. Tyler said most of the people who called CSU identified as male. They accounted for 67% of the callers. 29% of callers identified as female and 4% identified as transgender. T. Tyler reviewed the intake data on race. Black non-Hispanic callers made up the largest proportion of the callers at 62.9%. White non-Hispanic callers made up 13.7% of the callers. About 13.6% of callers identified themselves as Hispanic. About 1% of the callers identified as Asian and 4.5% of callers did not identify as race.

T. Tyler said that the 2022 Intake Data consisted of 39.7% of individuals who identified as heterosexual, and 37.1% of individuals who identified as men who have sex with men (MSM). 11.6% of individuals did not identify themselves as either.

DHH had completed 1,648 intakes for their 2022 Intake Survey. T. Tyler noted that about 54.4% of surveyed individuals had some kind of housing need. 96% of individuals surveyed had used a food bank, food voucher, or food delivered home. 33.1% of callers were related to treatment adherence. 18% of callers reached out to CSU in regards to benefits assistance. 22.2% of callers reached out in regard to medical care. Around 56.4% of callers contacted CSU regarding transportation assistance.

T. Tyler reviewed the insurance types of the intake population. While many people did not have a form of insurance, about 57% of individuals surveyed through the 2022 intake had Medicaid. 8.9% of surveyed individuals had Medicare. 12.2% of individuals did not have insurance. 6.7%

of individuals had private insurance. 11.8% of individuals did not know if they had insurance. 3.2% of individuals did not identify with the above.

G. Seaney spoke about CSU's consumer grievance process. G. Seaney explained that CSU addresses grievances regarding any DHH-funded care prevention services. These grievances were filed anonymously. The calls were designated as Crisis, Priority, or Non-priority.

G. Seaney talked about how they deemed crisis priority. He went over the consumer grievance process. Program Analysts at CSU work with agencies to reach a resolution to settle the grievance. Then the CSU supervisor relays the resolution to the caller. G. Seaney noted that all DHH-funded subrecipients must have a grievance process and must share this process with all clients.

K. Carter asked for more information on treatment adherence. T. Tyler said that their questionnaire asks the clients 3 questions. The first question asks how the client was feeling. The second question asked if the client had difficulty taking their medication on time. The third question asked how many days per week the client may have missed their medication as well as when they may have missed a dose of their medication. The three questions would create a score or index for each client with a max score of 10 being perfect adherence. The scorecard would signal that the person needs help with medication adherence. Clients could also ask for medication adherence support. DHH would then mark their scorecard with an indicator to mark that they need support. G. Seaney added that the scorecard was an initial assessment to give the agency a preview of what the situation was. G. Seaney said that the client would be meeting with the MCM to review the initial assessment.

A. Williams asked if this questionnaire was the same questionnaire as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that the case managers were required to review with their clients on a quarterly basis. G. Seaney asked A. McCann-Woods if their RAP (Rapid Assessment and Plan) survey was similar to the CAHPS survey. A. McCann-Woods answered that it was the same survey.

CSU or the Health Information Helpline was open 8:30 a.m. to 5:30 p.m. from Monday to Friday. He encouraged the council to put the CSU phone number in their contacts. The phone number was 215-985-2437. G. Seaney said he would be honored if the providers had taken their business cards. He said that if they called the number, they would be provided with the business cards. G. Seaney said that he was the manager for CSU. The agency consisted of a supervisor and 4 social workers. One of the social workers was able to speak Spanish and French, though the agency has access to all languages through its department translation services. They have many cards in Spanish and English with hours listed.

K. Carter asked if anyone in the EMA could receive services. G. Seaney said if the client was looking for case management, they could receive it anywhere in the EMA. T. Tyler said some locations offer medical care and MCM in one location. At some locations, the client must receive medical care services if they want to receive MCM. T. Tyler said that for community based organizations (CBOs), the client could receive MCM regardless of whether they receive medical care at the location.

S. Heaven asked if the slide show was publicly available. L. Diaz said it would be helpful if they could access this information. G. Seaney said would ask internally if the slide show could be made public.

J. Browne introduced herself as the Manager of Information Services at DHH. She said she was going to give an overview of the Quality Management Program at DHH. She said quality management (QM) was in service of ending the HIV epidemic with a 75% reduction in new HIV infections by 2025. They hoped to reduce new HIV infections by 90% by 2030. They planned to achieve these goals by diagnosing PLWH and delivering antiretroviral therapy (ART) as soon as possible. They aimed to remove barriers to service as well as provide preventive services such as pre-exposure prophylaxis (PrEP).

J. Browne described QM as a variety of activities that led to a high-quality product or service. She said QM consists of quality assurance, monitoring and evaluating outcomes, and continuous quality improvement. J. Browne said one of the most important aspects of QM was data. She said data helped identify what needs to be improved as well as the progress towards improvement. She said data could be numeric such as the number of people that the agency wants to virally suppress. It could also be feedback from focus groups. She said quality assurance measures if minimum quality standards were being met. One example in Philadelphia was DHH's Program Services Unit which completed chart reviews and assessed whether programs were meeting their guidelines. She said quality improvement offered the tools in which DHH could use to react to the data that they had collected and identify ways in which they could improve.

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 said in order to progress towards their goals, such as the EHE and Integrated Plan goals, quality assurance and quality improvement were implemented at all stages of the care continuum including the testing system, outpatient ambulatory, and MCM providers.

J. Browne said their primary source of data on clinical outcomes in the Ryan White system was performance measures which they collected through outpatient ambulatory care providers, MCM providers, and oral health providers. DHH receives the data from providers through a database called CAREWare. They then analyze the information to provide high-quality care for their clients. Providers can use CAREWare to look at the quality of their data. J. Browne said they had a variety of standardized feedback reports that they could send to providers once they have submitted their information into CAREWare. The reports show how the programs had compared to previous years as well as in comparison to other providers in the area.

DHH uses data in Quality Improvement Projects (QIP) to determine the topic or measure to discuss at the provider site. QIPs present the information in QM meetings. They also use data to see if developers need technical assistance. DHH presents this data in regional QM meetings which includes ambulatory and MCM providers. They also share data to determine if providers need technical assistance or capacity building from the DHH staff. This was offered on an

ongoing basis throughout the year. They also use data to determine areas that need additional input from clients.

DHH monitors different types of outcomes. The first was performance measures. They have 25 measures for their providers such as viral load suppression, retention, sexual infection screenings, and women's health. They had recently added a measure that measured whether or not clients were being prescribed ART and if it was within 96 hours of diagnosis. DHH had revamped the MCM measures to reflect the new model of care: comprehensive and standard.

J. Browne said DHH had monitored health disparities on a systems and provider level. They had briefly placed monitoring health disparities on a provider level due to COVID-19. They look forward to incorporating this aspect into their QM programs in the future. K. Carter asked if they monitor PrEP uptake.

They look at disparities on a system level and provider level. This was put on hold during COVID. K. Carter asked if they monitor PrEP uptake. J. Browne replied they received information from programs funded by the HIV Navigation Services (HNS) and data received from the CDC's evaluation survey and PrEP referrals.

G. Grannan asked if J. Browne could review the differences in non-criminalized versus criminalized populations' ability to access services. J. Browne said she did not have an answer at that moment. She said that, at least in her unit, she does not believe that they look at the clients' records of incarceration. She thanked G. Grannan for raising this issue and promised to look into it.

J. Browne explained that in 2021, DHH unveiled a new coaching model. Previously they had chosen measures of focus for all of the providers based on the needs of the system. Sometimes they would set threshold measures. For example, they would say any provider with less than 80% viral suppression would be required to do a project. Otherwise, they would base it on regional needs. The providers would then complete their projects using the Plan-Do-Study-Act approach, a type of QIP methodology. The providers would submit project information on one form and DHH would provide written feedback. J. Browne said the model had been working for a number of years, but would eventually provide diminishing returns once the easier problems had been solved.

They developed a new model that would be more flexible in terms of the topics chosen and the methodology. They had also expanded their quality improvement (QI) methodologies to include other QI ideas such as Lean Six Sigma. Their staff also took training in implementation science. J. Browne said their medical projects were able to conclude soon and they were planning to start the next QI cycle in April 2023. They looked to do joint QIPs with medical and MCM providers.

DHH found that QIP had resulted in improved outcomes. From 2013 to 2017, 81% of QIPs had resulted in improved outcomes. J. Browne said they were still analyzing their final outcomes data for their current QI cycle. She said their mid-cycle analysis showed that 79.3% of QIPs demonstrated improved outcomes. Ten QIPs had resulted in an increase of 10% or higher and 5 QIPS had resulted in an increase of 20% or higher outcomes. They found that there were greater

rates of improvement on measures in which a QIP was implemented than on measures in which a QIP was not done.

J. Browne said that consumer input was important in QI. She said quality was defined by the consumer. She explained that some teams had a client on their team for this purpose. Some other methods of obtaining input included surveys, focus groups and consumer advisory boards. DHH looked to increase consumer input priority in the coming year.

K. Carter asked if they could give an explanation of implementation science. J. Browne explained that implementation science looked to add the scientific method to program implementation or interventions.

DHH employed a "Secret-Shopper" method. J. Browne said that DHH called Ryan White funded providers posing as a new client to test the appointment availability of each location. They looked to see if the programs could provide a new client with an appointment within 15 days. They also looked to see whether there were any potential barriers that could block patient access. Examples of barriers were substantial fees or language barriers.

DHH data showed that providers were declining in their ability to confirm an appointment date for new clients since 2018. J. Browne said they measure whether providers were able to give a third appointment date. J. Browne explained that they did not want their data to be skewed by the fact that some providers were able to give a person an appointment right away if someone else had canceled their appointment. She said that providers whose calls indicate a serious barrier such as long wait times were given a corrective action plan.

J. De Marco asked how often Spanish speakers were hung up on when making appointment calls. J. Browne said there were a total of 19 Spanish language calls. About 32% or 6 callers were able to get an appointment. J. Browne said they understood that there were needed improvements in the next QI cycle. E. Thornburg said they were looking to audit and improve this process.

J. Browne reported that Philadelphia ranks best in viral load suppression among EMAs with more than 10,000 people. In 2021, 20 out of 22 adult outpatient ambulatory programs had 80% or higher viral load suppression. 11 programs had 85% or higher viral load suppression. 3 programs had 90% or higher viral load suppression. She said the 2022 data was currently being analyzed and they should have this information soon.

J. De Marco asked if there was demographic data on virally suppressed people. J. Browne replied they collect data from providers and organize this information by demographics at the provider level on an annual basis. She said this was delayed due to COVID-19. She said they used gender, race, age, ethnicity and insurance status as some of the demographic information that they had collected. J. Browne said they typically find health disparities among people who were transgender, had insurance issues, had unstable housing issues, and youth. K. Carter reminded the HIPC members that individuals with less than 200 copies of HIV per milliliter were considered virally suppressed.

J. Browne reviewed the QM initiatives in 2023. They were looking to do joint QIPs at co-located sites to help further care coordination. They were also looking to introduce a peer-sharing network. The peer-sharing networks would involve providers sharing their contact information with other providers. They want to streamline the QM plan while still providing the same level of detail.

G. Grannan asked how they were trying to place significant consumer input into every stage of the process. J. Browne said they were currently looking into the issue. She said they were wary of involving the same persons for questioning. They wanted the consumer input to feel meaningful. G. Seaney added that when a person sends in a grievance, it is a form of consumer input. He explained that a grievance sets off a chain reaction within the agency that could result in corrective action.

G. Krull-Aquila introduced herself as the Quality Management Coordinator of DHH. She thanked S. Anzuman for her work on writing the QM plan for the year. She explained that the QM plan was a required component of the QM program. She said the plan was updated annually with midyear updates as needed. The plan was written by the QM advisor and the QM Coordinator with input and review by other units if deemed necessary.

G. Krull-Aquila listed all the components of a QM plan. These components included: an organizational summary, quality statement, quality infrastructure, annual goals and objectives, participation of stakeholders, performance measurement, capacity building, evaluation of the QM program, work plan and a process to update the QM plan.

G. Krull-Aquila said the goals should be quality infrastructure, performance measurement, and continuous quality improvement. She said the goals were centered on the activities of the QM program but the activities of the QM program were in service of EHE and Integrated Plan goals.

G. Krull-Aquila referred to the overview of the 2023 goals. She said the first goal of the QM plan was to build and expand QM infrastructure and activities supporting EHE goals. The second goal was to improve coordination between adult outpatient ambulatory and MCM providers to support linkages and retention of clients in care. The third goal was to create an inclusive and streamlined QM to guide QM activities. The fourth goal was to increase capacity building at programs to support quality management activities.

G. Krull-Aquila said for each objective, they have a goal and action steps to achieve the goal. The first goal was to build and expand QM infrastructure and activities supporting EHE goals. The objectives for the first goal was to monitor and evaluate improvements in access to and initiation of status-neutral HIV treatment and care. The second objective was to apply a QI perspective to review and provide feedback on CAPs submitted from providers with identified issues during the bi-annual DHH appointment availability calls. The third objective was to re-evaluate barriers reported by patients who have been reengaged in care through Field Services and incorporate results into QM programs, including provider QI projects. The fourth objective was to initiate QIPs with DHH-funded Prevention and MCM programs using a coaching model in order to improve performance across identified areas. The fifth objective was to continue the

collaboration between DHH Information Services Unit (ISU) and EHE team around aligning QM activities including updating the EHE outcome measures for EHE re-engagement activities.

G. Krull-Aquila described the objectives for goal 2. The first objective was to continue to update and share outpatient ambulatory information with MCM providers biannually in order to support the monitoring of treatment adherence and to improve health outcomes. The second objective was to establish and complete a process to update and share MCM provider contact information with outpatient ambulatory programs bi-annually in order to support linkage and retention in care. The third objective was to develop an evaluation process to measure the referral of unsuppressed outpatient ambulatory clients to MCM services. The fourth objective was to integrate outpatient ambulatory and MCM QIPs as much as possible to foster more collaboration at co-located sites.

The third goal was to create an inclusive and streamlined QM plan to guide QM activities. G. Krull-Aquila described the objectives for this goal. The first objective was to develop a process to obtain and incorporate feedback from consumer feedback into the DHH QM plan on a regularly scheduled basis. The second objective was to work with the regional QM committee of subrecipients to obtain feedback on the DHH QM plan and amend it as needed. The third objective was to share and review the QM plan, including the work plan, with all DHH departments and incorporate their feedback into the QM plan.

The fourth goal was to increase capacity building among programs to support QM activities. G. Krull-Aquila described the objectives for this goal. The first objective was to create and offer innovative training for providers to enhance their quality management skills. The second objective was to establish and help organize a peer-sharing network for programs where they can learn from others' QI work.

G. Krull-Aquila ended her portion of the presentation with discussion questions for the committee to ponder. She asked what aspects of their services and performance they should examine. She then asked if there were gaps in their plan. Lastly, she asked if there were important concerns from the consumers from a quality point of view that they should be measuring. Due to time constraints, the HIPC was asked to consider these questions during the next portion of the presentation.

J. Browne would review the service utilization data for the fiscal year 2021. J. Browne went over the usage of AIDS Pharmaceutical Assistance (LPAP). She said the program had 222 clients with 1,216 units distributed with each unit equaling a 30-day prescription fill. She said that compared to FY20, there was a 22.1% decrease in clients in FY21. She said there were 34.7% fewer 30-day prescriptions filled in FY21 than in FY20. She added that the expenditures had increased by 54.7%. The cost per unit of service had increased from $146.59 to $347.36. This represented a 31% increase in cost per unit since FY19.

K. Carter asked J. Browne what they had meant when they said there was a decrease by 22.1% in the number of clients in FY21 compared to FY20. J. Browne explained that compared to FY20, FY21 had 63 fewer clients. K. Carter then asked if the lower utilization had been due to COVID-

19. J. Browne believed that it was due to COVID-19. A. McCann-Woods said it could be attributed to COVID-19 but they could not say definitively.

J. Browne reviewed the definition of MCM. She said in FY21, the number of clients using MCM under Ryan White Part A was 4,466. Clients used 324, 202 units of service. J. Browne said that each unit was equal to a quarter-hour. J. Browne said clients using the service under MAI numbered 1,011. They had used 74,956 units of service with one unit equaling 1 quarter hour. J. Browne said that compared to Fy20, FY21 saw an increase of 344 (6%) more clients and saw an increase of 9,810 (2.5%) units usage increase. Compared to FY20, expenditures had increased by 3.7% in FY21. J. Browne added that 87.2% of new MCM clients were linked to medical care.

J. Browne defined medical nutrition therapy as providing nutrition assessment, screening, food supplements, and education on nutrition. Education and counseling could be done in individual or group settings. J. Browne compared the FY21 data to FY20's data. She said in FY21, there were 367 clients who used 957 units of counseling and education, where 1 unit was equal to a quarter-hour.

G. Grannan asked if pharmacy price increases would affect services. J. Browne said she believed that it would.

Due to the aging population of PLWH, K. Carter asked if they should consider looking at medication delivery services to keep clients virally suppressed. J. Browne said she personally thought that was a good idea. She said the question would fit better as a group discussion topic rather than a question she could answer herself.

J. Browne returned to the topic of medical nutrition therapy. She said about 5 or 14% more clients received nutrition therapy units in FY21 than in FY20. She added that the number of units used increased by 270 which represented an increase of 39.3%. She said expenditures had stayed relatively stable with an increase of 2.9% when comparing FY21 and FY20.

J. Browne reviewed the data on mental health services as an outpatient group or individual session provided by a licensed mental health professional. She reviewed the definition of mental health services. She said mental health services dealt with outpatient psychological and psychiatric screening. She said in FY21, there were 1,593 clients who used the services. They had used 8,120 units of service where 1 unit was equal to a quarter-hour. She said in comparison to FY20, there was an increase of 150 or 10.4% more clients in FY21. She noted there was a decrease of 219 units or 2.6% since compared to FY20. She noted that expenditures had increased in FY21 by 3.2%. DHH found that most subrecipients utilized the behavioral health consultant model which provided short-term, decision support for mental health treatment planning.

J. Browne reviewed the oral health care data. She said that 1,349 clients had used the service in FY21. In the same year, clients had used 6,436 units with each unit equaling one visit to a dental health care professional. Compared to FY20, FY21 saw an additional 195 clients and an increase of 1,934 dental visits–a 43% increase to the previous year. Though the number of dental visits

had increased, the expenditures had remained consistent with a 0% change since 2020. J. Browne concluded that it was a return to normalcy in FY21.

J. Browne reviewed outpatient and ambulatory health services data. She said these services were funded under Ryan White Part A and MAI. In 2021, there were 10,888 clients served under Ryan White Part A. They received 31,036 units of care. 1 Unit of care was equal to 1 healthcare provider visit. Under MAI, 188 clients were served with 802 units of care. J. Browne reported that service utilization had remained relatively stable. About 228 or 2.1% more clients were using outpatient ambulatory services in FY21. J. Browne noted that there were 165 fewer medical visits compared to FY20. Despite fewer visits, there was an increase of about 1.3% in expenditures. She added that viral load suppression in the EMA had increased from 82% to 85% during FY21. She believed that this change had occurred due to patients returning to in-person visits.

She then reported the data on outpatient services for substance abuse. She said these services treated those who had drug or alcohol disorders. Services included screening, assessment, diagnosis, and other treatments. FY21, about 611 clients utilized this service. About 12,103 units of care were used where 1 unit represented 1 quarter-hour of service. J. Browne highlighted that 353 more clients were received in FY21. This was an increase of 136.8% from the previous year. Service utilization had increased by 898 or 8.0%. J. Browne attributed the large increase in clients due to the expansion of one hospital behavioral program.

J. Browne reviewed the emergency financial assistance data. She defined emergency finances as a one-time or short-term payment for essential services such as housing or medication. She noted that all other community resources must be used before these funds could be used. In FY21 the number of clients utilizing this service was 416. They had used 518 units of care where 1 unit of care could be defined as 1 payment or 1 filled prescription or 1 bill/ expense. She said that in FY21, 168 or 67.7% more clients had received services under emergency financial assistance compared to FY19. Service utilization had increased by 197 units of care or 61.4% compared to FY19. She noted that the most significant increase was housing assistance while the number of patients receiving medication had declined. She noted that expenditures in this category had increased by 90.9% in 2021. The cost per unit of service had risen from $1,561 to $1,847, an 18% increase.

She referred to the food bank and home-delivered meals data. She said that 2,181 clients had utilized the service in FY21. About 35,452 units of care had been utilized by the clients where 1 unit was equal to 1 meal or visit or voucher. She noted that the number of clients had remained stable in FY21 compared to FY20. There were 32 fewer clients in FY21, but this was only a 1.4% change when compared to FY20. The number of meals had increased by 2,363. About 7.1% more meals had been utilized in FY21 than in FY20. The average cost per unit of service had decreased by 30% from $20.72 to $14.50.

J. Browne reviewed the housing assistance service category. She said housing assistance is a limited short-term supportive service. She noted that the service must provide medical and supportive services or enable clients to access services. This would include emergency financial services, group housing and legal assistance. The number of clients that had used this service in

FY21 was 402. About 9,123 units of care were utilized where 1 unit equals 1 quarter hour or 1 payment. Compared to FY20, there was a decrease of 176 clients or 30.4%. Service utilization had decreased by 3,346 units or 26.8% compared to FY20. Expenditures had increased by 32.8% in FY21 compared to FY20.

Medical transportation was non-emergency transportation services to core and support services. J. Browne said clients must use the MotivCare service first before they could use this service. In FY21, there were 1,930 clients and 23, 001 units of care used where 1 unit was equal to a 1-way trip. J. Browne highlighted that the service utilization had returned to the levels seen in FY19. Compared to FY20, FY21 saw 557 more clients, an increase of 40.6%. Clients in FY21 used the service 10,816 more times. As a result, expenditures increased by 56.5%. Compared to FY19, FY21 saw a decrease of 24% in the number of clients and a 38% decrease in the number of trips.

J. Browne reviewed the data for legal services related to HIV. These services included the power of attorney and a living will. In FY21, DDH found that there were 756 clients who utilized this service. About 17,561 units of care were used where 1 unit of care was equal to 1 quarter hour. J. Browne said the number of clients had stayed relatively close in FY21 compared to FY20. There were 27 fewer clients or 3.4% in FY21 compared to FY20. The number of service units utilized had decreased in FY21 by 2,251. The decrease in the use of service was consistent across Pennsylvania and New Jersey suburban counties. J. Browne believed that this was impacted by the decision to halt the termination of federal and state public benefits in the spring of 2020 and 2021.

J. Browne referred to the data on referrals for health care and support services. She said these services directed the client to core medical or supportive services. It includes the DHH CSU client intakes and helpline as well as the confidential helpline and computer lab with digital health literacy classes focused on entitlements and benefits information. In FY21, there were 1,238 clients who had used this service. About 1,642 units of care were used during this period where 1 unit of care had equaled 1 quarter hour or 1 call. Compared to FY20, there was a small increase in the number of clients who had used the service in FY21. The number had increased by 2 or 0.2%. In FY21, the service was used 149 more times than in FY20. Expenditures had declined by 7% in FY21 compared to FY20.

M. Ross-Russell thanked the presenters and asked DHH to send the question posed by G. Krull-Aquila, and OHP would send the questions to the HIPC members. Once the questions had been answered, OHP would forward the questions back to DHH.

Action Item:

-Prevalence Data and Allocation Policy-

A. Edelstein said that HIPC had issues with the data given by the State of PA. HIPC had asked for new data to use for their allocation process. The State of PA had promised that they would send a new set of data in early March 2023. HIPC did not receive the data at that time and was promised a new set of data by the end of the month.

The EMA, that HIPC serves was a 9-county region that was divided into 3 areas for the purposes of allocation which include Philadelphia County, PA suburbs and New Jersey counties. It was decided that allocation would be based on the most recent prevalence data. HIPC was still waiting for adequate data from the State of PA. HIPC members were worried that if the data was not adequate, certain counties would not get the funding they needed.

They had decided to use an alternative method in case they were unable to obtain adequate data from the State of PA. The HIPC Bylaws had stated they would need to present the proposal in one meeting and then it would need to be voted on in the next meeting after a waiting period of 30 days. The Financial Committee had proposed using the historical average of the subregions until Dr. K. Brady deemed the data satisfactory. If they do not have reliable numbers, they would take the average of the last 10 years to allocate funds to the three subregions. Edelstein reviewed the chart included in the Recommended Policy Language document. He said that if the proposal was passed, the PA counties would receive 15.67%, NJ would receive 12.66% and Philadelphia would receive 71.67% of the allocation funds.

A. Edelstein opened the floor for questions and feedback. There were no questions or feedback to the proposal. A. Edelstein said if this proposal was accepted, it would take effect during the allocations process in the summer for the next FY. A. Edelstein said a new FY had started on March 1st, 2023 and they had to use unreliable numbers for allocations. This was approved by the Planning Body in 2022. A. Edelstein reminded the Planning Council that the fiscal year began on March 1st and ended on February 28th of the next year.

M. Ross-Russell said they were in a continuing resolution. This meant that they had a partial budget as opposed to a full budget. The federal government would attempt to keep the services active but HIPC had not received its final award. M. Ross-Russell said they should get the final award before the end of the month. Once they had received the final award, they could implement the proposal for the summer.

Motion: A. Edelstein motioned to vote on the new process in the next HIPC meeting regarding the allocation policy change to use historical averages for funding distribution, as recommended by the Finance Committee.

L. Diaz: abstained
K. Carter: in favor
E. Thornburg: abstained
A. Williams: in favor
M. Cappuccilli: in favor
D. Surplus: in favor
E. Rand: in favor
G. Keys: abstained
G. Grannan: in favor:
A. Edelstein: in favor
S. Heaven: abstained
A. Scruggs: abstained
D. D'alessandro: in favor

J. De Marco: abstained
P. Gorman: in favor
J. Haskins in favor
S. Nieves: abstained
D. Jack: abstained

Motion Passed: 10 in favor, 8 abstained. The motion to vote on the allocation policy in the next HIPC meeting was approved.

Committee Reports:

-Executive Committee-

M. Ross-Russell explained that there were two discussion topics in the last Executive Committee meeting. One was the prevalence data and the allocation policy. The Executive Committee had discussed what were the options if they did not receive adequate information from the State of PA.

The other topic was subcommittee attendance. They also discussed how the subcommittee attendance was to be handled. M. Ross-Russell said that as a Planning Body, they gave subcommittees the flexibility to govern themselves. M. Ross-Russell reminded the Planning Body that they needed to attend one subcommittee meeting and one HIPC meeting per month. K. Carter had asked if the members should be marked as present or excused in subcommittee meetings. M. Ross-Russell said they had become lax with this policy because of the transition to virtual meetings. They had decided to leave the decision on how to handle this issue to subcommittees. L. Diaz said they had also decided that if a person attended any of the subcommittee meetings during the months, it would be counted as attendance to a meeting.

-Finance Committee-

A. Edelstein announced that A. Williams was elected as co-chair. They had spent most of their time talking about allocation policy and the prevalence data.

-Nominations Committee-

None.

-Positive Committee-

K. Carter said there was a Positive Committee meeting next Monday, March 13th at 2 p.m. He encouraged everyone to attend the meeting.

-Comprehensive Planning Committee-

G. Grannan said they had met last month and discussed the PA State data. He said they were having another meeting next week on Thursday, March 16th at 2 p.m. He said they would

discuss the PA State Plan and the Philadelphia Integrated Plan. He encouraged all members to attend the meeting.

-Prevention Committee-

L. Matus was co-chair but was not able to attend due to family reasons. The Planning Council sent their sympathies.

T. Dominque said there was an opioid data update. She said she would look into and give an update on it in the next Prevention Committee meeting. T. Dominque had sent out a prevention survey to HIPC. The survey closed on March 21st. They would meet on March 22, 2023 to discuss the results. S. Moletteri sent the link to the survey to the Planning Council.

Other Business:

None.

Announcements:

K. Carter said there was an aging summit that was upcoming that would address issues regarding age.

M. Toney, from PDDH, had some updates from the PA Department of Health. She sent the information and her email to the Planning Council via Zoom chat. She said she planned to join the monthly Planning Council meetings.

She put the following updates in the chat:

> *HIV Prevention has been working with STD program to get the new ChemBio DPP HIV/Syphilis rapid test added to our menu of options*
>
> *Please see the updates below from the Monitoring & Evaluation Section:*
> *•The Division of HIV Disease's updated fee-for-service contract, PPA, is being implemented with our prevention service providers for testing and PrEP*
>
> *Please see the updates below from the Care Section:*
> - *Case Management workgroup is meeting this month to review comments from DOH regarding the MCM and non-MCM Standards they recently updated. They will then move on to reviewing and updating Program Standards.*
> - *Case Management trainings through Mid Atlantic AIDS Education Training Center (MAAETC) continue. Information and registration is available through MAAETC.*
> - *23/24 Contract Renewals have been started with all Regional grantees.*
>
> *Clinical Quality Management (CQM):*
> - *2022 Quality Improvement Project, MCM Retention in Services*

    - *Baseline: 77%, after most recent report period MCM retention is at 81%.*

HOPWA:

- *CAPER report is with DOH for final approval prior to submission to DCED and HUD*
- *Work has begun on the draft of the yearly Action Plan for DCED*
    - *Anticipated allocation for next year is a slight increase to $3,644,185*

Adjournment:

L. Diaz called for a motion to adjourn. **Motion:** K. Carter motioned, and G. Grannan seconded to adjourn the March HIV Integrated Planning Council meeting. **Motion passed:** All in favor. The meeting adjourned at 4:29 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- March 2023 Meeting Agenda
- February 2023 Minutes
- Recommended Policy Language (PDF)
- HIPC Meeting Ground Rules (PDF)

Philadelphia EMA HIV Integrated Planning Council
from the Finance Committee
Recommended Prevalence Numbers
Thursday, April 13, 2023

Preface:

The fluctuation in prevalence numbers within the Pennsylvania suburban counties is due to two reasons: (1) PLWH were recorded and counted at their address of diagnosis without updating to current address and (2) a lack of regular non-Philadelphia eHARS data cleaning.

These two issues have since been resolved: data has been cleaned and most recent addresses have been updated.

Any irregularities in surveillance reports throughout the past years reflected these two issues. Any future surveillance reports should now reflect accurate prevalence data.

Language as recommended by the Finance Committee:

The HIV Integrated Planning Council is to base the FY2023 Allocations plan on the most recent available 2021 prevalence data.

Changed 2021 percentages	2019 PLWH	PLWH%	2022-2023 level	2023-24 5%-	2023-24 5%+	2021 PLWH	PLWH%	2023-24 level	2023-24 5%-	2023-24 5%+
Philadelphia	18,798	69.43%	$12,336,801	$11,717,878	$12,953,641	18,351	66.92%	$11,890,477	$11,277,364	$12,485,001
PA	4,761	17.59%	$3,124,562	$2,967,806	$3,280,790	5,472	19.96%	$3,546,532	$3,363,661	$3,723,859
NJ	3,515	12.98%	$2,306,833	$2,191,102	$2,422,175	3,598	13.12%	$2,331,187	$2,210,983	$2,447,747
EMA	27,074	100.00%	$17,768,196	$16,876,787	$18,656,606	27,421	100.00%	$17,768,196	$16,852,008	$18,656,606
Difference current phl								($446,324)	-1059437	$148,200
Difference current Pa								$421,970	$239,099	$599,297
Difference current Nj								$24,354	-$95,850	$140,913

Other prevalence data:

Current Plan	2019 PLWH	PLWH%	2022-2023 level	2023-24 5%-	2023-24 5%+	2020 PLWH	PLWH%	2022-2023 level	2023-24 5%-	2023-24 5%+
Philadelphia	18,798	69.43%	$12,336,801	$11,717,878	$12,953,641	18,621	70.48%	$12,523,622	$11,877,862	$13,149,804
PA	4,761	17.59%	$3,124,562	$2,967,806	$3,280,790	4,248	16.08%	$2,857,008	$2,709,691	$2,999,859
NJ	3,515	12.98%	$2,306,833	$2,191,102	$2,422,175	3,550	13.44%	$2,387,566	$2,264,455	$2,506,944
EMA	27,074	100.00%	$17,768,196	$16,876,787	$18,656,606	26,419	100.00%	$17,768,196	$16,852,008	$18,656,606
Difference current phl								$186,821	-458939	$813,003
Difference current Pa								($267,554)	-$414,870	-$124,703
Difference current Nj								$80,732	-$42,379	$200,110
								($0)	-916188	$888,410

Changed 2020 percentages	2019 PLWH	PLWH%	2022-2023 level	2023-24 5%-	2023-24 5%+	2020 PLWH	PLWH%	2022-2023 level	2023-24 5%-	2023-24 5%+
Philadelphia	18,798	69.43%	$12,336,801	$11,717,878	$12,953,641	18,621	67.43%	$11,981,095	$11,363,309	$12,580,149
PA	4,761	17.59%	$3,124,562	$2,967,806	$3,280,790	5,540	20.06%	$3,564,300	$3,380,513	$3,742,515
NJ	3,515	12.98%	$2,306,833	$2,191,102	$2,422,175	3,455	12.51%	$2,222,801	$2,108,186	$2,333,941
EMA	27,074	100.00%	$17,768,196	$16,876,787	$18,656,606	27,616	100.00%	$17,768,196	$16,852,008	$18,656,606
Difference current phl								($355,706)	-973492	$243,348
Difference current Pa								$439,739	$255,951	$617,954
Difference current Nj								($84,032)	-$198,647	$27,108