PENNSYLVANIA DEPARTMENT OF HEALTH

HIV PLANNING GROUP MINUTES

Park Inn Harrisburg West, 5401 Carlisle Pike, Mechanicsburg, PA
September 17th, 2014

Members: Wesley Anderson, Jr., Alicia Beatty, Dan Campion, Principe Castro, Melissa Davis, Doyin Desalu, Wayne Fenton, Sharita Flaherty, Linda Frank, Daniel Harris, Jeffery Haskins, Michael Hellman, Ron Johnson, Shannon McElroy, Briana Morgan, Daiquiri Robinson, Tamara Robinson, Susan Rubinstein , Shubra Shetty, Pamela Smith, Richard Smith, Rob Smith, Nathan Townsend, Tony Strobel, Grace Shu, Ann Stewart Thacker, Wayne Williams, Derick Wilson, Paul Yabor

Not Present: Michael Brookins, Terrance McGeorge

Dept. of Health: John Haines, Kyle Fait, Jill Garland, , Cheryl Henne, Sara Luby, Ken McGarvey, Julia Montgomery, Benjamin Muthambi, Jon Steiner, Brad Van Nostrand, Christine Quimby

University of Pittsburgh: Brian Adams, David Givens, Daniel Hinkson, Sarah Krier, Anthony Silvestre

HRSA/CDC: Hila Berl (EGM Consulting)

Guests: Bethany Blackburn, Adam Bocek, Jeanne Caldwell, Cori Drenning, Jim Ealy, John Folby, Patricia Fonzi, Rebecca Geiser, Susan Goldy, Leah Magagnotti, Willonda McCloud, Deborah Mundore, Joe Swisher

Welcome & Introductions

[9:00am]

Chairwoman Sharita Flaherty: It is great to see so many new faces here today. If you have not filled out a new member survey here before, please do so we can track who is engaging with the committee. Please keep in mind the technology policy – cell phones on vibrate and no computers at the main table. Please make sure you've signed in.

[HPG members, staff and guests introduce themselves.]

Announcements

Membership: Membership stands at 28, and we do have an update from the subcommittee on the status of recruitment and new applications. Please invite your friends and colleagues to come these are open meetings. Our integration meetings are ongoing, and we are very grateful to still have Ms. Hila Berl with us as a contractor for the HRSA.

Travel Reimbursement: Keep your receipts and pick up the forms and talk with staff if you have questions. Lisa Petrascu is sick and is unable to attend today, but any staff can assist you. Please keep in mind it is not our staff, but staff in Travel Audits that ultimately approves these requests, so please follow the guidelines for reimbursement as closely as possible.

Jill Garland: Grant News: Our grant application was due last Friday, and I hope we will have an opportunity to talk with you more about that soon. Staffing Updates: We have selected a candidate to fill a vacant Public Health Program Administrator position, so that will put us back up to full staffing.

Julia Montgomery: In care, we are busy doing our HRSA reports; we have annual and new 2014 reports turned in now. We are anxiously awaiting the FOA to be released for the 2015 grant, so we are very excited to get started on that. We have selected a staff member to fill a vacant Public Health Program Assistant Administrator position for our section as well, so we are looking forward to her starting with us next month.

Cheryl Henne: Brad Van Nostrand is our new data specialist, and we welcome him. We have another administrative vacancy, and we are in the process of filling that now. The new agreements for pharmacies are in place, and there is *no* impact on consumers. We are very pleased about that. The new manufacturer agreement is currently out. Healthy PA is now in place and we are looking at what that means for us… right now it looks like about 24% of our members are eligible for that, and we are looking to see what that will mean for us and them.

Kyle Fait: Rob McKenna from HRSA facilitated a PA meeting to allow for HRSA to do some info gathering and have providers talk about strategies and learning opportunities. It was a very good meeting, the providers were very confident, and was a useful meeting for everyone overall.

Cheryl Henne: One final point is that we have an intern joining us, and we would like to welcome him for the coming year.

David Givens: You'll be hearing much more from us over the course of the meeting about the work we've been doing for the HPG, so for now I'll just ask everyone to please pick up

the handouts we've provided, including one on HIV and Aging in honor of HIV and Aging Awareness Day, which is today. There is also an interesting handout up from one our members via the AIDS Law Project in PA about the potential impacts of Healthy PA on HIV positive citizens.

Paul Yabor: AIDS Free PA has a new platform, and we are looking for input and would encourage all of you to embrace the idea of an AIDS Free PA.

Linda Frank: We have an upcoming conference for the AETC and a number of great speakers, and we would encourage all of you to attend. Many of the people here today will also be speaking on a panel about how to get more testing in primary care settings. I also want to highlight the AIDS and Aging day as well; we have a number of resources available.

Guest: Glad to welcome a new acting Director for the Ryan White grantee for the city of Philadelphia, as our old Director is now the Director of Health for the city.

PACT has received a significant grant to build a clinic in McKeesport to model expanding testing in primary care settings.

Chairwoman Flaherty: I call for a motion to approve the July HPG Minutes. [Called and seconded. There are no objections or abstentions.]

Director Ken McGarvey: We are reaching the culmination of our planning year, as you can see on the agenda that has been handed out. If there are no questions, we will move to reports from the committee chairs and then break out.

Subcommittee Reports

Michael Hellman: We had a teleconference last month, and the biggest thing is that we have our membership applications out, and they are also available on "www.stopHIV.com". We decided that we would review any existing applications with a score of 80 or higher and new applications in the same setting. We have a few paper copies here, and you can access them on the website or on the Box. We have four current members and anyone who wants to be a part of the nominations and recruitment workgroup: we would be happy to add you. The process is done outside of the meetings; you'll get redacted applications and we look to see how applications could fill gaps. Then we teleconference and decide. We should really need to know by tomorrow if anyone wants to join us.

Melissa Davis: Priority Setting Resource Allocation (PSRA) did not have a need to meet, but we did have many consumer meetings which were all completed. They will be finishing our prep for the priority setting, and today will be preparing for the allocation process.

Briana Morgan: Needs Assessment (NA) has been working with University of Pittsburgh focusing on rural linkage to care. We have had the University of Pittsburgh doing all of those interviews, and we kicked our feet up. We are looking forward to hearing those results today, and moving forward from there.

Director McGarvey: Very good - We will reconvene at 11am.

Needs Assessment Key Informant/Rural Linkage Presentation

Director McGarvey: Sarah Krier will now present her research on Key Informant interviews for rural linkage from the Needs Assessment group.

Questions:

Michael Hellman: You report that older married men are less likely to link – do you mean same sex or just opposite sex marriages?

Sarah Krier: Good question - I mean just men who are married to women and also having sex with men.

Linda Frank: AETC has a program to reach clinicians in rural areas and we are expanding that currently.

Paul Yabor: Nationally, we are seeing more positive diagnoses happening in hospitals, and as this presentation shows there is a big need for outreach and testing in rural areas and small clinics.

Bethany Blackburn: Telemedicine – I think this a great concept with several snags. Insurance does not yet pay for Telemedicine, and that when this happens you have to have someone like a nurse in the room with you while you're on the phone, so if there are concerns with confidentially – you already have two local people right there listening to you. Also, if you have other needs like a social worker, there is no access to any of those axillary services that you might be able to get if you can get to certain clinics. So I think it's a great thing, and we do it ourselves, but we need to keep these barriers in mind.

Derek Wilson: Are confirmatory results still given over the phone?

Sarah Krier: Not by field staff, but we do hear that it is still happening sometimes with other healthcare professionals.

Paul Yabor: It is my understanding… is a blood draw required for a confirmatory test now?

Jill Garland: That depends on the provider; it is an algorithm that does not necessarily require a blood draw. Some of our sites do and some do not require a draw. The law right now does allow for negative phone results to be given over the phone, but legally one is required to give positive confirmatory results in person.

Director Ken McGarvey: That is also changing based on the changing nature of the testing and the science. The best testing technology right now that is emerging is a finger stick, which is *technically* a blood draw.

Jill Garland: For field testing, in areas where we use blood draws, we have a new Center for Disease Control (CDC) testing algorithm. In most community and outreach sites, they are still using oral tests. We are looking to use a newer rapid test kit in those settings – waiting for that to be approved. Blood based tests are shown to be more accurate, but we also realize that an oral test is better than no test. As far as how soon, the most rapid test kit is FDA approved but we are awaiting the Clinical Laboratory Improvement Amendments (CLIA) waiver so that we can use it in these settings. It is hard to say but it should be around the New Year, excluding the state procurement process. It is extremely accurate. We have that info back at the office, and you can read that online, including indeterminate results. It is already being used in other health care settings.

Anthony Silvestre: Sarah pointed out limitations, and what we don't know about people in rural areas who don't get linked. One other thing we don't know is about people who don't get tested. That is a population that is very much lost in the Cascade. Does fear of linkage keep people from getting tested, particularly among young people? That is another question to keep in mind moving forward.

Christine Quimby: Where services are not co-located, what barriers exist to co-locating them, and what barriers have been overcome in order to have had that happen?

Sarah Krier: Barriers to creating co-located services – we don't have that data, actually. That is a great question.

Michael Hellman: There are a lot of things going on right now. In southwest PA, for instance, there is a helpful document we circulate identifying places where people can go for services, and that seems to be so much more of a problem in rural settings. So, I am very interested in keeping involved in that piece of the puzzle, and I think we need to follow that. Also, I know that some clients are very afraid of numbers. We see people who like to be related to with stages and phases rather than numbers and levels.

Chairwoman Sharita Flaherty: In terms of social factors, you see that many things are similar to national trends, but what really stood out for Pennsylvania?

Sarah Krier: The too few providers really stood out… stigma and fear related to status and presumptions about sexuality in rural areas is particularly pronounced, and confidentiality, and transportation is a big barrier.

Hila Berl: Great job Sarah, thank you. I am sure there is much more data than you can present. Things to keep in mind: One visit to a doctor should not count as linkage. 58% of people, according to one study, are lost after one visit. Treating communities of color is immensely important, and cultural competency can be a huge barrier on many fronts. The state needs to ensure that training is provided, required, and up to date. Peer models are very effective, and that is something to think about as well, though this is particularly challenging in rural settings. Just things for the HPG to keep in mind.

Derek Wilson: Now that tests are available over the counter, are there any efforts to reach out to people likely to try that?

Sarah Krier: Not that I know of.

Paul Yabor: I agree that Peer models have seen a big boom. I see where this could be applicable to HIV. It would require though, a training process to certify them and make sure they are competent. This could help ease management, and realize financial savings compared to state staffers doing all this, and promoting retention in care.

Sarah Krier: Thank you. This will be made available on the Box.

Chairwoman Sharita Flaherty: Thank you again. It is time for lunch, if you have a membership survey please turn it in. We will be in the patio room.

[Reconvene 1pm]

Priority Setting Consumer Input Sessions Presentation

Director McGarvey: David Givens will now begin our next presentation from the PSRA subcommittee on consumer input meetings for state-wide HIV care services priority setting.

Priority Setting Packet Distribution and Explanation

Chairwoman Flaherty: Thank you. Now we will ask David to move right into the next presentation as well, and while that is set up we are distributing Priority Setting packets for all HPG members.

Summaries of Workgroups

Michael Hellman: We are working on updates to membership application for next year (not this year), and development of five year recruitment plan.

Melissa Davis: We got the final details for the Priority Setting Process, and started defining the process for Resource Allocation for November.

Briana Morgan: We talked about investigating funding and pilots or promoting telemedicine and increase access to HIV specialists for rural areas. We also examined the feasibility of increasing co-location of services, as well as increasing field staff… and also the possibility of a reality show.

Chairwoman Flaherty: This concludes our business for the day. Please remember that Melissa Davis, Hila Berl and David Givens will be available in the meeting room upstairs for the next hour or so if anyone would like assistance or has any questions with the Priority Setting Packet.

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September 18th, 2014

Members Attending: Wesley Anderson, Jr., Dan Campion, Principe Castro, Melissa Davis, Doyin Desalu, Wayne Fenton, Sharita Flaherty, Daniel Harris, Jeffery Haskins, Michael Hellman, Ron Johnson, Shannon McElroy, Briana Morgan, Daiquiri Robinson, Tamara Robinson, Susan Rubinstein , Pamela Smith, Richard Smith, Rob Smith, Nathan Townsend, Shubra Shetty, Tony Strobel, Grace Shu, Ann Stewart Thacker, Wayne Williams, Paul Yabor

Members Absent: Alicia Beatty, Linda Frank, Michael Brookins, Terrance McGeorge, Derick Wilson

Dept. of Health: John Haines, Kyle Fait, Jill Garland, Cheryl Henne, Sara Luby, Ken McGarvey, Julia Montgomery, Lisa Petrascu, Jon Steiner, Christine Quimby

University of Pittsburgh: Brian Adams, David Givens, Daniel Hinkson, Anthony Silvestre

HRSA: Hila Berl

Guests: Bethany Blackburn, Jeanne Caldwell, John Folby, Patricia Fonzi, Leah Magagnotti, Shirley Murphy (PA/MA AETC), Joanne Valentino

[9:00 AM]

Introductions and Announcements

Director McGarvey: Note that HPG minutes are now available on www.stopHIV.com and are also available there in Spanish. Also, please wait for the microphone before speaking.

Michael Hellman: A couple weeks ago we learned that ALPHA Pittsburgh has received their 501c3 designation.

Jill Garland– With Lisa Petrascu and Greta out, please turn your receipts in to me, Julia, or Cheryl. If you need an envelope for receipts, let me know and I will mail you a stamped envelope.

Paul Yabor: State Bill 1164 is a Bill around Good Samaritan policies in Pennsylvania that may be coming up soon, please contact your representative if you wish to show support of that.

HPG Business

Michael Hellman: Membership and Stakeholder update: We had a lot of discussion yesterday putting together a change in protocols for representative. Our issue is making sure that we and all of us understand who you are representing. In recruiting new people we need to know what representation we have according to our guidelines. One of the things we talked about yesterday is when someone represents multiple groups, in the evaluation process, we need to be able to move towards full representation.

Susan Rubinstein: What about geography? Is that a membership guideline?

Michael Hellman: We did note that gap in representation, and that will be taken in to account, particularly for NW and NC. We are looking for six new people to fill gaps. We asked yesterday if anyone wanted to join this committee, and Shannon McElroy, Dan Campion, Wayne Williams, Daniel Hinkson, Grace Shu, Sharita Flaherty, and Nathan Townsend responded. The recruitment packet is out now, and is due October 15, 2014. We will review the applications then, and make a decision then.

Guest: What criteria - what gaps - are you looking to fill?

Michael Hellman: For areas we are particularly interested in see the application form for list.

Director Ken McGarvey: The best form of recruitment is all of you. Please share this recruitment info as best you can.

Paul Yabor: What is the scoring info?

Michael Hellman: We received from Philadelphia a scoring tool, and we pared it down a little last year. There are ten criteria points for a total of 100 points, mostly around the mission and vision of the HPG, looking at why the applicant wants to be a member. All those points are compiled for each the application, and then we teleconference to make the decision. We also keep the members who aren't ultimately picked in the pool, so that we can come back to them if a gap develops later.

Chairwoman Sharita Flaherty – It is also our job to strengthen people's applications that we recruit, so that they can have strong understanding and presentation. We can educate applicants and that helps everyone.

Michael Hellman: Absolutely. Helping people before they send their application in is a great suggestion.

Director Ken McGarvey: You must also be a resident of Pennsylvania.

Hila Berl: Are there any interviews for candidates?

Michael Hellman: No.

Question: What advice do you have for people in low paying jobs who can't take time off work or front the money to travel?

Director Ken McGarvey: It is a challenge. There are some things – like the hotel and car rental – that we pay for ahead of time, but it remains a challenge.

Anthony Silvestre: The membership committee recognizes that we will never get all voices around the table, and that is why we are taking very seriously efforts to increase other means and ways of engaging consumer groups and others in alternative forms of engagement and communication.

Jill Garland: Concurrence is a requirement of our funder – CDC– we need to submit a lot of concurrence or non-concurrence or reservations every year. We have an integrated plan from a couple of years ago, and even though we haven't changed that plan a letter is still required every year. We need to certify that the HPG concurs with the state and activities and allocations both statewide and for Philadelphia.

We had sent this letter out in July, and we did get almost all of them back via email or fax – thank you! This allowed us to submit everything as a single packet this year, which was nice. We will put this letter on the Box – it was submitted last Friday.

CDC Grant Application Walk Thru

Jill Garland: Now we are going to walk through the 2015 CDC grant application. This is year four of the five year grant cycle. We submit two reports per year, the interim progress report and the annual progress report. This IPR is a grant application as well. You have a copy of that summary. We have three categories of funding – Category A, which is core testing and prevention services; Category B, a special category for PEHTTI funding to expand routine testing in disproportionally affected communities, and Category C is very competitive funding which was awarded with the University of Pittsburgh for Project Silk. See handout for further details.

We also have a letter of agreement with the City of Philadelphia, so we can apply for up to 17% of the funding that they are eligible to apply for to provide services in the counties surrounding Philadelphia (Bucks, Chester, Delaware, and Montgomery). We also contract with Penn State for Part B. For Silk, Part C, this is the final year for Silk, and we are hoping

to use that remaining money to transition that to a community partner. We hope to take the lessons learned there to other parts of the state as well. We don't know what CDC is going to say about this part of the application, but we do have a backup plan and will be able to see the project into 2015. Are there any questions about the budget?

Alicia Beatty: Is that Category B money to Penn State competitive, or is it all a continuation?

Jill Garland: It is a continuation.

Presentation on Performance and Outcomes

Alright, now I will move into the performance evaluation. To meet performance expectations we now ensure onsite visits to providers, expanding sites, a grassroots organization working with IDUs in Lancaster, and looking at community providers that would make good outreach testers for non-healthcare settings. We have exceeded expectations in healthcare settings and between Category A and B and we consistently exceed that performance measure. We are doing very specific case management for our partner services activities, and we are routinely reviewing newly identified individuals with field staff to ensure that they are getting linked to care and getting services they need. We were falling short of some of our goals, and we are now making sure that the documentation is happening. We are excited with our condom distribution and continued momentum in integrating our planning. Areas for improvement include evaluating providers and seeing where we need to ramp up testing and where we need to scale down, as well as cleaning up our lists of who is actually providing testing. We have a robust TA schedule for peer navigation, peer support, and training on couples testing, and now we are seeing with our case specific analysis, that we are seeing HIV positive individuals with repeated STDs and HIV positive individuals who are not in care, and would like CDC technical assistance in identifying strategies for addressing these problems. For Category B, with expanded testing, we have increased our healthcare setting testing, increased by 66% in that category and exceeding target positivity rate. We are also making improvements in third party billing. For Category C, they had from January-June 299 unique accesses to the safe space: 62% are in the target population and had a 4.2% positive rate – standard sites expect 1% - and all of those were new positives, not re-tests. Another success to celebrate – an unintended outcome – is that we have had 9 individuals who previously identified as positive that have successfully been reengaged in care – a 100% success rate. They also had a personal cognitive counseling (PCC) that assisted 29 people there. The target pop is 15-29 age range – the mean age is 20 – LGTB African American individuals.

Anthony Silvestre: And one thing we find with these kids is that talking about testing is not enough. Many of these people need shelter, or other services, and that's what allows us to keep folks coming back and eventually being comfortable enough to get tested.

Jon Steiner: As far as our Category A analysis and testing, we want to emphasize that we are working very hard to address the pattern that we are seeing for the highest of the high risk folks who are clearly repeatedly infecting new partners.

Shubhra Shetty: It is kind of like hot spotting, but on an individual level. Perhaps working with University of Pittsburgh, I am sure you will see them kind of acting like a hub – an infection vector – for these problems. I will be curious to see what you find as you look more at this and what strategies you identify.

Jill Garland: Indeed, and we are looking at a way of possibly teaming up with the Sexually Transmitted Disease (STD) program to see what might work. It is in a way exciting, in that we can really make a huge difference in high impact prevention. When we started working here we couldn't even see client level data, and now we are really getting into these networks and patterns and looking forward to engaging that.

Shubhra Shetty: That would be so worthwhile! I hope that you and we can crack that nut and really deal a blow to the epidemic.

Jill Garland: The next step is getting the technical review back, and we have areas we can cut if we need to.

Bethany Blackburn: Is this budget information available anywhere?

Jill Garland: It is available on the Box, and we can send that out to the HPG and any guests; just let me know if you'd like to receive it.

[10 minute break]

Sara Luby: An identified challenge is accessing client level data for Category B what we do to combat that is through our quality team. We look at service categories – you can see that in the PSRA report yesterday – and look at how we can improve those categories. We have identified mechanisms to collect the data that can give us a better view of what's going on without increasing the burden on our providers. We also want to improve the reporting mechanism for that so we can aggregate and let consumers and providers know.

Ann Stuart Thacker: What is happening with the integration of Careware?

Julia Montgomery: We now require Provider Data Information (PDI) transfer for all providers. We have had delays to get that info from the Philadelphia region and are

working with them to get that. We should be getting data from the entire state by September. As new changes come to Careware, we are looking at networking Careware to providers, and we are not yet sure what the best method is going to be yet. We do have a secure room that only one staff member has access to for handling client specific data. We know that all PDI in the entire state are transferring into this system except for two providers.

Now we'll start our HOPWA section of the presentation – Jill Garland will start.

Questions:

Alicia Beatty: Congrats those are great numbers! How do you encourage your providers to reach that rate?

Jill Garland: We evaluate what county municipals are doing to meet deliverables, and while we don't want anyone turned away from testing, we do expect them to reach and focus on targeted populations. For fee-for-service providers, we want to see if they are reaching the targeted population. They don't have deliverables but they do have caps per six months. If they are doing very well, we will give them green light to continue work, but ones falling short we can't keep expanding that both for our performance measures and not utilizing resources optimally. We also have healthcare settings where we are expanding testing.

Susan Rubinstein: For condom distribution, is that the number that you are sending to distributors or the number they hand out?

Jill Garland: When providers order from us, it serves as a data collection point. We don't collect client level data for that, so they just tell us who their targeted distribution population is.

Nathan Townsend – is there training for new Housing Opportunities for Persons with AIDS (HOPWA) administrators?

Joanne Valentino: Housing Urban Development (HUD) is trying to get away from that face to face, it is more about reading the manual, which is pretty big, and it is our hope that the regional providers are training their staff.

Grace Shu: What is your name? Where did you say you are from? Governor Corbett went a few days ago to open a low income house in Philadelphia. Is this your house?

Joanne Valentino: Most likely not. It is likely the economic development program, which is different.

Paul Yabor: Some states use Medicaid funds to offer housing, is Pennsylvania looking into that?

Joanne Valentino: We do not have a very large waiting list, but I do know that HUD HOPWA encourages folks to use other funding streams before us.

Julia Montgomery: And if it's in Philadelphia they manage their own funds, so we don't really have any control over that.

David Givens: Does HOPWA have a way to target homeless youth? We know that LGBT youth are about 5% of the US population but 40% of all homeless youth – one of the most vulnerable populations. I see that the few homeless people you have listed here are all older veterans.

Joanne Valentino: We don't get funding for outreach, but we hope that regions are doing what they can.

Question: Does the Special Pharmaceutical Benefit Program (SPBP) cover medications that come from across state lines?

Cheryl Henne: Yes... as long as it's an enrolled pharmacy in our system.

Paul Yabor: With SPBP access, it is my understanding that the three page application went to a ten page application. There are concerns that this discourages and frustrates people.

Cheryl Henne: We have talked about this before, and I'm glad we are continuing to address these concerns. First of all, we increased the font size, as it was very cramped and difficult for people to read and fill out. We also went to one sided vs two sided applications because folks were faxing only half of the application back! Additionally, we added the consent forms directly into the application, which is a lot of literature but really only requires a single signature. So in that sense it's a useful consolidation of material they need anyway. The consent allows us to talk to people on an enrollee's behalf, and we also merged the form's instructions into the packet – they were two packets before. We did add some - I think two - additional questions that HRSA now requires us to collect. Magellan does not own our application – we own the policy and creation of this application. Magellan just collects it. We did present this new document here with the committee early this year, you may recall, and vetted it through many experts, consumers, and providers. We recognize that this does seem to be an additional burden on some consumers, but we have seen a significant overall reduction in errors on our applications. I should note though that we don't consider this to be a static finished document at any time, and always welcome feedback on improvements.

Paul Yabor: Thank you so much. This will really help me with talking to people. In the previous pharmacy contract for SPBP there was that loophole that reimbursed for drugs at

a higher rate than what they were purchased. Some organizations used these funds for prevention, is there going to be any steps to remedy that loss of funding?

Cheryl Henne: This was never a way to provide prevention, though it was being used for that. We are required to buy our drugs at cost. We can't negotiate that, and these are federal requirements that we cannot change, so there is nothing left there for us to 'share' back to these organizations.

Ann Stuart Thacker: Do you anticipate the Healthy Pennsylvania impacting you?

Cheryl Henne: Certainly. We have looked at that. About 24% of our clients will be eligible for Healthy PA. That's as far as we've gotten with that – does it mean that they will be dis-enrolled? Wrapped around? We haven't been able to ascertain the benefits or other implications of Healthy PA.

Shubhra Shetty: I have gone to many national meetings where people talk about huge wait lists and people not getting medications or care, so thank you for that and don't change things too much! I know that there are new treatments for co-infections like Hepatitis C that are very effective but very expensive. How does that work, and are recent immigrants enrollments barriers?

Cheryl Henne: We look at PA residency, not US citizenship, so that should not be a barrier. As to the first question, it is a very contentious issue that we are looking at and there are good arguments on both sides, particularly related to cost-benefit ratios, so we are ongoing with our evaluation of what to do about that.

Susan Rubinstein: So it looks like SPBP will be gaining additional income?

Cheryl Henne: We really don't know because we don't know what proportion of our claims are 340B. So it could go up or down, mainly it's that now we will know who is doing what. We have no financial projections at this time. Early evidence suggests most pharmacies are not submitting claims at the 340B rate – the majority are commercial rates. If that's true we expect things to remain mostly the same.

Paul Yabor: Are your SPBP Advisory meetings open to the public? And what is the 340B drug reimbursement rate?

Cheryl Henne: Yes – 10AM here on October 30, 2014 for the SPBP Advisory Council. The reimbursement rate for 340B is basically at acquisition costs. We otherwise reimburse at acquisition costs plus seven percent for the dispensing fee.

Director McGarvey: Ok, now subcommittee will meet with the time remaining.

[Lunch at noon]

Subcommittee Reports

Michael Hellman: Most of our groups' work we discussed this morning. In addition, we are reviewing the orientation for new members, and are asking for all the segments that groups will need to know from our different divisions – SPBP, Care, Prevention, HPCP, etc. We have a conference call set up to review those orientation outlines. Finally, please do invite folks to apply to the HPG.

Melissa Davis: We agreed on the final setup for the Priority Setting process as well as the details for the Resource Allocation process which will both happen in November. Our subcommittee will be getting an email from me about the outline of our discussion and then a conference call if needed. Otherwise we are on track for a successful Priority Setting and Resource Allocation process.

Briana Morgan: We came up with a lot of work for the Needs Assessment Committee to do. We talked about the informant interviews, and will investigate further co-infections in rural areas. We are also looking more at Part B providers and whether they are even interested in testing there. We are looking at telemedicine or nontraditional partnering for HIV prevention, and red carpet system linkage programs. We are going to be looking for staff levels, and University of Pittsburgh is going to look deeper into the data to see why some of the linkages are taking so long – 3-4 weeks in certain cases. We will have a lot to talk about in November.

Shubhra Shetty: Should we be inviting the best candidates for the HPG or all possible people?

Michael Hellman: Invite everyone – remember this is a cue system not a one-time shot.

Guest: Is there any way to make the guest seating more comfortable? We look to the side all day and have nothing to write on.

Chairwoman Sharita Flaherty: We can look into that.

Paul Yabor: Can you describe member attendance requirements and inviting guests a little more?

Michael Hellman: If a member cannot commit to attend 75% of the meetings, then that really isn't helping anyone, and if they know they aren't able to personally attend enough then… honestly they probably shouldn't apply. That is why we keep attendance for members – if you don't personally attend you may be asked to leave. But keep in mind that anyone can apply at any time, so if that person's situation changes, they can apply then!

Director McGarvey: As far as guests go, anyone is – by law – welcome to join us for meetings, but we cannot guarantee that they get lunch if our attendance is over the total number of people the hotel is contracted to provide for.

Michael Hellman: When people apply, we send out a letter that we have received the application, and now in November we will send out letters that make clear that if people are not accepted at this time they may be in the future.

Melissa Davis: We will cover conflict of interest at and before the next meeting.

Christine Quimby: Does the HPG consider low income status?

Michael Hellman: We do ask if a consumer receives Ryan White services. So that does generally and in an appropriate way address that concern.

David Givens: All members who received a Priority Setting Packet yesterday have returned them.

[Motion to adjourn called and seconded at 1:23 PM]