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3 Meeting Minutes
4 **NEEDS ASSESSMENT COMMITTEE**
5 Lee Hildebrand, DSW, Chair
6

7 March 28, 2012
8 Federation of Protestant Welfare Agencies
9 281 Park Avenue South, Conference Room A
10 3:00 pm – 5:00 pm
11

12 **Members Present:** Angela Aidala, PhD, Randall Bruce, Guillermo Garcia-
13 Goldwyn, Lee Hildebrand, DSW, Natalie Humphrey, PhD, Jennifer Irwin,
14 Frank Machlica, Tamella McCowen, Jan Carl Park, Glen Phillip, Robert
15 Steptoe, Marcy Thompson, Ricardo Vanegas-Plata, DDS
16

17 **Members Absent:** Martin Bruner, Terri Faulkner, Graham Harriman, Sabina
18 Hirshfield, PhD, Rebecca Kim, Julie Lehane, PhD, Don McVinney, Freddy
19 Molano, MD, Ariel Negron
20

21 **NYC DOHMH Staff Present:** Stephanie Chamberlin, JoAnn Hilger, Rafael
22 Molina, Nina Rothschild, DrPH
23

24 **Public Health Solutions Staff Present:** Julie Cohen, Derek Coursen
25

26 **Others Present:** Felicia Carroll, Billy Fields
27

28 **Material Distributed:**
29

- 30 • Agenda
- 31 • Minutes from the February 29, 2012 NA Committee Meeting
- 32 • Executive Summary of the Comprehensive Plan for HIV/AIDS Services
33 in the New York EMA 2012-2015
- 34 • Guidance from HRSA for the Comprehensive Plan
- 35 • Planning Council Calendar for April 2012
36

37 **Welcome/Introductions/Moment of Silence/Review of the Meeting**
38 **Packet/Review of the Minutes:** Dr. Lee Hildebrand welcomed meeting
39 participants. Committee members introduced themselves and observed a
40 moment of silence. Nina Rothschild reviewed the contents of the meeting

1 packet. The minutes from the February NA Committee meeting were
2 accepted and will be posted on the Planning Council website at nyhiv.org.
3

4 **Comprehensive Plan:** Committee members devoted the entire meeting to
5 discussion of the draft of the Comprehensive Plan for HIV/AIDS Services in the
6 New York Eligible Metropolitan Area for 2012-2015 (Comprehensive Plan).
7 Meeting participants raised a number of issues and provided suggestions as
8 follows:
9

- 10 • Dr. Natalie Humphrey requested additional information on foreign-born
11 populations in the section on disproportionately impacted populations.
12 Are foreign-born individuals accessing services at the rate they should
13 be? What about language issues and the cultural competency of
14 providers? Derek Coursen of Public Health Solutions noted that the
15 collection of data on immigration status in AIRS has been optional. Data
16 on country of origin, race, and ethnicity is not complete for the
17 population receiving Ryan White services, and making statements
18 about immigration is therefore problematic. Stephanie Chamberlin
19 noted that data on immigration status is collected in eSHARE but is not
20 mandatory. Ms. Chamberlin also noted that eSHARE requires the
21 interviewer to ask about country of birth, but the client can decline to
22 answer. With eSHARE, don't yet have a lot of information at the present
23 time but will have a lot of information in coming years. JoAnn Hilger
24 commented that we don't want to know too much about immigration
25 status lest that information create a barrier to receipt of services. If an
26 additional source of information becomes available between now and
27 the due date for the Comp Plan, we can add it.
28
- 29 • Marcy Thompson asked whether the comp plan draft provides sufficient
30 information about housing and whether we fall short of the optimal goal
31 for housing. The goal, as stated on p. 37, is to increase the number of
32 Ryan White clients with permanent housing to 86% by 2015. From
33 where does this number come? This number is from the goals and
34 objectives of the Centers for Disease Control's Enhanced
35 Comprehensive HIV Prevention Plan (ECHPP). JoAnn Hilger and Jan
36 Carl Park responded that the job of the Planning Council is to make
37 adjustments to allocations in order to arrive at the goal, but the non-
38 core social support services (including housing) are capped at 25% of
39 our portfolio – without a waiver from HRSA, we cannot devote a
40 significantly larger chunk of our award to housing. Mr. Park also noted
41 that our ability to house PLWHA also depends on other funding streams
42 including the HIV/AIDS Services Administration (HASA) and Housing
43 Opportunities for People with AIDS (HOPWA). A matrix of partnerships
44 enables us to come up with resources to address the situation. During a
45 presentation in April on the third year of implementation of the

1 Comprehensive Plan for HIV/AIDS Services in the New York EMA 2009-
2 2012, we will learn about successes to date in housing PLWHA and
3 whether our goals may be achievable.
4

- 5 • Guillermo Garcia Goldwyn asked about the source of the estimate that
6 21% of infected individuals do not know that they are HIV-positive. Ms.
7 Hilger responded that 21% is the CDC estimate.
8
- 9 • Lee Hildebrand asked about the graph for Objective 2A (To increase
10 the proportion of newly diagnosed individuals who enter into primary
11 care within three months of HIV diagnosis, by the end of 2013) on p. 68:
12 why the shift from 81% linked (actual plan data) to 80% (projected plan
13 data)? Stephanie Chamberlin responded that the percentages are
14 susceptible to a small denominator and are slightly deceiving and that
15 80% is consistent with the New York City target.
16
- 17 • Dr. Hildebrand asked about the graph on p. 69 for Objective 3A (To
18 increase retention in HIV care and treatment, by the end of 2013)
19 showing actual data of 60% retained in care in 2009 and a projection
20 that 80% will be retained in 2013. Is this consistent with a small
21 denominator? Ms. Chamberlin responded that this is set to be
22 consistent with Ryan White data. We hope to see an increase based on
23 program effectiveness and also from improved data collection. We can
24 add material to the footnotes to clarify this and other, similar points.
25 We should also add a footnote explaining why some goals are for 2013
26 and others are for 2014.
27
- 28 • Dr. Hildebrand inquired about the graph for Objective 3B (To increase
29 the proportion of clients who have an optimal level of ART adherence,
30 by the end of 2013) on p. 71: why does the graph show a decrease,
31 when the objective calls for an increase? Ms. Chamberlin responded
32 that the graph presents CHAIN data and MMP data and that we strive
33 for ART adherence that is in between the percentage adherence shown
34 in CHAIN and in MMP data.
35
- 36 • Lee Hildebrand asked about the intended audience for the
37 Comprehensive Plan. Nina Rothschild responded that the audience will
38 be our HRSA Project Officer, Kerry Hill, and the Planning Council.
39
- 40 • Dr. Hildebrand requested that the graphs appear in color in order to
41 increase readability. The final version of the graphs will, indeed, be
42 printed in color.
43
44

- 1 • Dr. Angela Aidala noted that some CHAIN data is missing from the
2 graphs but that the CHAIN team can run the data now and provide it to
3 the Research and Evaluation Unit to be added to the Comp Plan.
4
- 5 • Robert Steptoe asked whether the rollout of Medicaid health homes will
6 have an impact on this document. Jan Carl Park responded that we will
7 know more in a year. For now, we will stay the course, recognize that
8 we will continue to have unanswered questions for quite a while, and
9 eventually may need to make adjustments in the provision of services –
10 but factoring these changes into our goals is difficult at the present
11 time.
12
- 13 • Dr. Natalie Humphrey inquired about the questions we are asking and
14 the documents at which we are looking in order to have answers to
15 some of these questions in a year. JoAnn Hilger noted that the Planning
16 Council asked for Objective 5B (To create a working group comprised
17 of City, State, provider and consumer representatives to take a
18 leadership role in adapting to Medicaid redesign and health care
19 reform and to report back to the Planning Council) and that this
20 objective does not have conventional data. We do, however, have a
21 matrix including every service category which we are monitoring to
22 see the impact of program and policy changes on care and treatment.
23 This matrix can be included as part of the Comprehensive Plan.
24
- 25 • Lee Hildebrand expressed concern about some of the language on p.
26 27 when we discuss systemic barriers to treatment and care,
27 particularly when the text refers to “marginalizing the role of
28 community based organizations in providing services to hard-to-reach
29 populations who may not seek mainstream care in licensed facilities.”
30 She asked whether we can express concern about losses to the EMA
31 because of increasing medicalization of services and a potentially
32 diminished role for CBOs. Nina Rothschild agreed to add a caveat
33 recognizing the value of the psychosocial support services provided by
34 CBOs. Dr. Angela Aidala commented that the value of support services
35 is clear in the National HIV/AIDS Strategy and that we can add a
36 stronger supporting voice acknowledging the remarkable work of the
37 CBOs.
38
- 39 • Dr. Hildebrand noted that p. 48 refers to many objectives from Healthy
40 People 2020 but omits objective 8. What happened to objective 8? Ms.
41 Hilger responded that objective 8 concerns perinatal transmission, and
42 prevention of perinatal transmission is not a focus of our work in
43 treatment and care services. We have almost no cases of perinatal
44 transmission in the EMA. Dr. Aidala recommended adding a note

1 stating that we had a very small number of cases and are aiming for no
2 cases of perinatal transmission.

- 3
- 4 • Jennifer Irwin called attention to the discussion of barriers to treatment
5 and care for women of color on p. 23, noting that information could be
6 added specific to young women of color. Nina Rothschild agreed to
7 follow up with Ms. Irwin to obtain additional information on this topic.
8
- 9 • Ms. Chamberlin called attention to the section entitled Using Data to
10 Monitor Progress on p. 63, asking whether the discussion of a time
11 frame needs more clarity. Committee members agreed that the
12 sentence stating that not all objectives require the same time frame
13 should be bolded.
14
- 15 • Dr. Hildebrand expressed some confusion about the tables on pp. 81-
16 85. Ms. Chamberlin responded that the indicators are the differences
17 between groups (socio-demographic differences in delayed diagnosis,
18 socio-demographic differences in prompt linkage to HIV/AIDS care
19 following HIV diagnosis, socio-demographic differences in retention in
20 primary care). Dr. Aidala noted that wide differences exist between
21 groups with regard to concurrent diagnosis. Can we do something
22 about age-based disparities? Can we include a target? Ms.
23 Chamberlin noted that there is no one-to-one correlation between the
24 National HIV/AIDS Strategy and our indicators. Dr. Aidala suggested
25 adding text explaining why we are looking for differences regarding
26 age. We could state that if the differences are below 20%, we want to
27 keep them that way; if they are above 20%, we want to reduce them to
28 20%.
29
- 30 • Jan Carl Park asked why we are suddenly using tables on pp. 81-85,
31 rather than graphs. Ms. Chamberlin responded that we would need
32 eight graphs per objective – a number that soon becomes unwieldy.
33 She volunteered to add a footnote stating that the information is only
34 presented in a graph when that graph would convey information and
35 also to state in the text that we want to keep groups already below 20%
36 where they are and to remove disparities when they exist. In addition,
37 she agreed to speak to the minimum threshold in the text and
38 mentioned the possibility of removing language about reduction in
39 differences (given that we don't want just a reduction in differences but,
40 rather, an overall improvement). Dr. Aidala recommended not
41 changing the language about the reduction in differences but adding
42 language about bringing everyone up. Ms. Hilger inquired whether we
43 are setting ourselves up to fail with this approach. Ms. Chamberlin
44 contacted Dr. Mary Irvine, who noted that if we are making the change,
45 it has to be a focus – otherwise, the project becomes unmanageable

1 and unwieldy. Dr. Irvine commented that if we say that 20% or below is
2 our goal, we will fail with some groups. We are seeing gradual
3 improvement on indicators, but we won't see 20% among all groups.
4 Philosophically, this raises the question of whether we are more
5 interested in equity or in overall improvement. Dr. Aidala noted that all
6 groups are similar except for the older folks and that we may fail
7 regarding seniors. Randall Bruce expressed concern, asking whether
8 we are working to put everyone on the same level. If older folks have
9 greater disparities, we should target them for reductions in disparities.
10 Ms. Chamberlin noted that the data is there and that we can look at it
11 either way. We do need to keep in mind that some groups will have a
12 bigger jump than others. We are now stating that we want to ensure
13 that everyone goes to a certain level. Nina Rothschild commented that
14 as a planning tool, the new data on bringing everyone up to a certain
15 level may be more useful – it should provide a more straightforward
16 picture of areas where we are succeeding and areas where we need to
17 focus increased attention.

18
19 **Next Steps:** Needs Assessment Committee members will have an opportunity
20 for a final read of the revised document and a vote in April.

21
22 **Adjournment:** The meeting was adjourned. 7