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Meeting Minutes

NEEDS ASSESSMENT COMMITTEE

2009-2012 Comprehensive Plan Work Group

Jennifer Irwin, Chair

Wednesday, September 24, 2008

40 Worth Street, Conference Room 1502B

10:00 am - 12:00 pm

Members Present: Jennifer Irwin, Rebecca Kim, Lenore Hildebrand, DSW, Rosemary Lopez, Frank Machlica, Jan Carl Park, Ricardo Vanegas-Plata, DDS

Members Absent: Angela Aidala, PhD, Soraya Elcock, JoAnn Hilger, Fabienne Laraque, MD, MPH, Juana Leandry-Torres, Julie Lehane, PhD, Luis Freddy Molano, MD, Roberta Scheinmann (alt. for Mary Ann Chiasson, DrPH), Howard Schwartz, JD

DOHMH Staff Present: David Klotz, Rafael Molina, Nina Rothschild, DrPH, Anthony Santella, DrPH, Jessica Wahlstrom, Darryl Wong

Others Present: Victor Benadava, Guillermo Garcia-Goldwyn

Materials Distributed: Agenda; minutes from the joint meeting of the Needs Assessment and Integration of Care Committees on July 15, 2008; HRSA guidance on the comprehensive plan for 2009-2012; presentation on 2009-12 Comprehensive Strategic Plan for HIV/AIDS Services; comprehensive plan vision and guiding principles; list of Planning Council Committee accomplishments in 2007-08.

Welcome/Introductions: Jennifer Irwin welcomed everyone. Members introduced themselves. Ms. Irwin noted that this gathering is not a formal meeting of the Needs Assessment Committee but, rather, will provide an opportunity for members to discuss the orientation for new Needs Assessment Committee members in October and review the requirements for the 2009-2012 comprehensive plan.

1 **Review of the Meeting Packet:** Dr. Rothschild reviewed the contents of the
2 meeting packet.

3
4 **Review of the Minutes:** The review of the minutes from the July meeting was
5 tabled because this was not a full Needs Assessment Committee meeting but,
6 rather, a working group.

7
8 **Brainstorming Session for Upcoming New Member Committee**

9 **Orientation:** Needs Assessment Committee members were asked for
10 feedback on the content of orientation and on the materials to be distributed.
11 The discussion focused primarily on two components of the orientation: the
12 role of the Committees in the context of the full Planning Council and the role
13 of Committee members versus alternate members.

- 14
15 • Rosemary Lopez asked for an explanation of how the Committee work
16 fits into the bigger picture of the work of the Planning Council as a
17 whole. She expressed interest in gaining more of an understanding of
18 how each Committee functions and how the different committees link to
19 each other, including both their similarities and their differences. What
20 does it mean to be a Planning Council member versus a Committee
21 member? What is the length of term of membership?
22
23 • Ms. Lopez also asked about the role of alternates. Jan Carl Park noted
24 that members can send an alternate to participate on their behalf, and
25 the alternate can serve as a proxy vote. Dr. Hildebrand asked whether
26 alternates have to meet the same criteria as full Committee members,
27 to which Mr. Park responded that alternates should meet similar
28 demographics or occupations (e.g., a worker from a CBO). He also
29 noted that alternates can be viewed as future Planning Council
30 members, in which case they are receiving advance training for their
31 future roles and may have a smoother transition into full PC
32 participation. The Needs Assessment Committee has approximately 20
33 official members who should be broadly representative of the
34 community.

35
36 Dr. Anthony Santella listed several possible components of the orientation:

- 37
38 • Information on the Planning Council process
39 • A work plan
40 • A timeline for the planning process as a whole
41 • A timeline for the work of the Committee
42 • Contact information for other Needs Assessment Committee members
43 • Bylaws
44 • Annotated Guide to Data Sources
45 • A policy statement on attendance

1 Dr. Hildebrand noted that the administrator for the CDC-funded Prevention
2 Planning Group sends out announcements about events and job openings and
3 asked whether the Planning Council ever sends out similar material. Mr. Park
4 noted that staff of the Planning Council occasionally forward material sent by
5 our national partners – for example, notice about an action in which the
6 recipient can engage such as contacting a politician to advocate for passage
7 of a bill – but such announcements are limited. Members generally
8 expressed relief at not being deluged by a large number of announcements
9 about community events, job postings, fundraising activities, etc. Most
10 members already receive these types of announcements via email, and
11 members are free to announce these activities during public comment
12 periods and request that staff make printed copies of announcements
13 available during meetings. Generally, communication to Planning Council
14 members relates specifically to Planning Council business. Mr. Wong noted
15 one exception, namely, Planning Council staff recently sent out mail to try to
16 engage 12 consumers for an upcoming panel on Medicaid reform.

17
18 Mr. Garcia-Goldwyn asked about attendance and absences from Committee
19 meetings. Mr. Park responded that Planning Council staff will track
20 attendance more diligently this year, work with people to encourage
21 involvement, and replace members who cannot become more involved. If a
22 member does not attend a meeting, his or her voice is not heard.

23
24 **Comprehensive Plan 2009-2012 -- HRSA Guidance and Goals and**
25 **Objectives:** Mr. Park reminded Committee members that the previous
26 comprehensive plan expired in 2008. Dr. Santella noted that the Needs
27 Assessment Committee (NAC) will work in collaboration with the Integration
28 of Care Committee (IOC), helping to craft and approve goals and objectives
29 and an evaluation for the new comprehensive plan. He noted that the vision
30 statement for the plan distributed at today's meeting was based on previous
31 work from the old plan and on current work by NYC DOHMH staff. DOHMH
32 staff has also added guiding principles to the vision statement in order to be
33 more specific. After the submission of DOHMH's application to HRSA for
34 funding for FY09 Ryan White services (due Sept. 29th), DOHMH staff and Tri-
35 County staff will collaborate with the grant writer to more fully develop the
36 comprehensive plan.

37
38 Mr. Park noted that the old comprehensive plan didn't discuss reviewing and
39 monitoring progress on goals and asked how DOHMH and the Planning
40 Council would monitor achievement of the new plan's goals. Dr. Santella
41 responded that progress would be measured on a quarterly basis but that the
42 NAC would discuss measurement during its next meeting when Dr. Mary
43 Irvine could attend.

44

1 Dr. Lee Hildebrand commented on the absence of a section on best practices.
2 Dr. Santella responded by pointing to planning principle #2 calling for
3 evidence-based interventions relying on both qualitative and quantitative
4 data. Dr. Vanegas-Plata remarked that we are trying to make a strategic plan
5 simple and recommended incorporating an acknowledgement of where we
6 have not achieved our goals – a matrix of opportunities and weaknesses. Ms.
7 Irwin suggested acknowledging that DOHMH did not formally report out on
8 progress on the goals of the previous plan to the Planning Council. Dr.
9 Santella suggested starting the next NAC meeting with sharing the needs
10 assessment that informed the previous comprehensive strategic plan.

11
12 Dr. Santella discussed the ways in which the different Planning Council
13 Committees could contribute to the plan. If IOC, for example, is discussing a
14 model of care such as medical case management, IOC may ask the NAC for
15 data on medical case management. Similarly, the Priority Setting and
16 Resource Allocation Committee (PSRA) may need data from NAC about
17 service categories. Data Day is an example of the provision of information to
18 PSRA Committee members so that they can make more informed decisions
19 about the allocation and distribution of resources. Victor Benadava expressed
20 interest in having more consumer input into the comprehensive plan.

21
22 NA Committee members moved into a discussion of the five goals for the plan
23 and the accompanying objectives but tabled a discussion of the action steps.

- 24
25 • Goal #1 calls for increasing the number of individuals who know their
26 HIV status via increased testing and outreach activities. Dr. Vanegas-
27 Plata stated that he does not support rapid testing because the plan
28 doesn't address the problem of stigma accompanying an HIV-positive
29 diagnosis. A reduction in stigma, however, cannot be measured, and
30 we cannot wait years for the problem to resolve. Jan Park reminded the
31 group that the comprehensive plan deals only with Ryan White Part A
32 programs and that the Prevention wing of the Bureau of HIV/AIDS
33 Prevention and Control is funding anti-stigma interventions. Darryl
34 Wong suggested augmenting the guiding principles for the
35 comprehensive plan, distributed as part of today's packet, to address
36 stigma directly.
- 37
38 • Goal #2 calls for promoting early entry into HIV care and continuity and
39 coordination of care for enhanced medical and general health
40 outcomes. Ms. Irwin remarked on the accompanying need to increase
41 capacity to provide care. In the past year, testing has increased by
42 30%, and the new case management model being developed by NYC
43 DOHMH will support any influx of newly-identified HIV-positive
44 individuals. Dr. Vanegas-Plata again expressed concern that people
45 would be diagnosed but avoid care because of denial and stigma.

- 1 • Goal #3 calls for promoting optimal management of HIV infection with a
2 resulting increase in stability and self-sufficiency. All Ryan White Part
3 A treatment adherence clients will be in medical case management,
4 and the combination of services should enhance stability and self-
5 sufficiency. Mr. Park inquired about how specific goals would be
6 measured: would they specify that treatment adherence rates would
7 improve from X% to Y%? Dr. Santella responded that we would need
8 to establish baseline numbers using research and evaluation data from
9 AIRS. Objective #3A in Goal #3 calls for increasing medication
10 adherence to 95%, and 95% is from the published literature. We
11 should, however, be conservative with our numbers. Dr. Lee
12 Hildebrand commented that we are looking at clinical measures
13 specific to HIV but that HIV-infected individuals are dying of other
14 causes. She suggested working to improve medication literacy as a
15 component of adherence.
16
- 17 • Goal #4 calls for reducing HIV/AIDS health disparities by ensuring that
18 patients have full access to the continuum of HIV/AIDS care. Objective
19 #4B calls for a reduction in the age-adjusted death rate between
20 gender groups. The language of the objective does not make clear
21 whether transgender individuals are included in these groups.
22 Rebecca Kim asked whether we can use some measure other than
23 death rates to measure reduction in disparities. One possibility is to
24 look at disparities in service utilization. Dr. Rothschild noted that
25 Objective #4C calls for reducing death rates between racial groups
26 and suggested augmenting the objective to call for reducing death
27 rates between racial and ethnic groups in order to capture differences
28 between Hispanic and non-Hispanic groups.
29
- 30 • Goal #5 calls for ensuring the provision of high-quality and cost-
31 effective HIV/AIDS services. Members discussed the formation of a
32 quality sub-committee of the Needs Assessment Committee to examine
33 quality-related issues. The Bureau of HIV/AIDS Prevention and Control
34 is currently talking with the NYSDOH AIDS Institute about improving
35 and expanding the quality management learning networks.
36

37 Dr. Hildebrand commented on the vision, guiding principles, and goals,
38 noting that they are driven by a medical model but that a medical model
39 doesn't necessarily apply to recent immigrants who do not want to be in care
40 for cultural reasons. Dr. Santella noted that the NA Committee and DOHMH as
41 a whole will ensure that priority populations including immigrants are
42 captured in the comprehensive plan. Dr. Santella also remarked that the NA
43 Committee would tweak the document as a whole and flesh out the action
44 steps.
45

- 1 **Adjournment:** The NA Committee adjourned and agreed to meet again on
- 2 October 21st from 2:00-5:00.

DRAFT