HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting of the

EXECUTIVE COMMITTEE

Thursday, January 17, 2013, 3:00-5:00pm
DOHMH, 2 Gotham Center, 42-09 28th Street, Conference Room 19-27,
Long Island City, NY

MINUTES

Members Present: Jan Carl Park (Governmental Co-Chair), Dorella Walters (Community Co-Chair), Robert Cordero (Finance Chair), Victor Alvarez, Victor Benadava, Randall Bruce (Consumer-At- Large), John-Anthony Eddie, Marya Gilborn, Graham Harriman, Lee Hildebrand, DSW, Tom Petro, Sam Rivera, Charles Shorter
Members Not Present: Nancy Cataldi, Gregory Cruz, Gerald DeYounge, Sharen Duke, Joan Edwards
Staff Present: Planning Council: David Klotz, Rafael Molina, Nina Rothschild, DrPH, Darryl Wong, NYCDOHMH: Anna Thomas, Jacqueline Rurangirwa, Public Health Solutions: Rachel Miller

Agenda Item #1: Welcome & Introductions

Jan Park, Governmental Co-Chair, opened the meeting, followed by member introductions. A moment of silence was observed and Jan Park, Governmental Co-Chair, Jan announced that Sam Rivera has been appointed as Co-Chair of the Priority Setting/Resource Allocation Committee and Randall Bruce has been elected as Consumer At Large of the Consumers Committee. Jan noted that our NYCDOHMH colleague, JoAnn Hilger, Ryan White Grant Administrator, has been struggling with late stage cancer and is in hospice care. Darryl Wong reviewed the meeting agenda and meeting materials.

Agenda Item #2: Review of Minutes

The minutes were distributed to members electronically for review and comments. The minutes were approved as presented.

Agenda Item #3: Integration of Care Committee

On behalf of the Integration of Care Committee, Charles Shorter reported that members have engaged in a portfolio planning exercise and decided to develop three service categories during the current community planning cycle: health education/risk reduction, non-medical case management, supportive counseling and family stabilization services.

Health Education and Risk Reduction (HE/RR) currently consists of The Positive Life Workshop (TPLW) which is a peer-led, self-management workshop for newly diagnosed PLWHA and PLWHA who are returning to care after an absence. TPLW works with PLWH to enhance self-management skills, learn to engage with the health care system, adhere to treatment, and change risky behaviors. The focus is client-centered with motivated and engaged participants dealing with biological, psychological, and social co-factors of the illness.

The current plan is to reorganize the program and locate it in the community through an initial train-the-trainer format, increase the registration and retention of participants and eventually make the workshop available in Spanish. Locating the program in the community will reduce costs. IOC Committee members

have heard from peers who have become leaders of the workshops, examined some evaluation data, reviewed program cost information, and are examining and revising a draft service directive formulated by Planning Council and Grantee staff. The timeline for deliverables is for IOC members plan to finish their work on the service directive at the next meeting (February 6th) and vote on forwarding it to the Executive Committee and then to the full Planning Council for voting. IOC members will then move on to non-medical case management at the February 20th meeting.

Agenda Item #4: Priority Setting & Resource Allocation Committee

Marya Gilborn, Co-Chair, reported that sequestration has been postponed for two months pending further Congressional negotiations. All scenarios (0%, 4%, 8%, 12%) show Tri-County's percentage stable at 4.71% of the award and Quality Management at $3M. HRSA gives the grantee sole discretion over QM funds, which are capped at either 5% of the grant award or $3M, whichever is less (this amount is not included in the 10% grant administration funds). As QM was reduced by over $400,000 in 2011 due to the elimination of the MAI portion of QM funding, the amount is staying stable. The spending plans show QM separate from administration because they are reported separately to HRSA.

The State has agreed to accept an upfront reduction of $2,768,244 (the same amount as previous years), to be restored through reprogramming during the year. The State is accepting a risk that the full amount may not be available. ADAP Director Christine Rivera will present data on the program at the next PSRA meeting, including the State's cost containment plan for ADAP should there be a reduction in funding.

All spending scenarios distributed show reductions based on the preliminary spending plan approved for the application with uncommitted funds re-allocated to enhance Food & Nutrition (FNS), Housing and Supportive Counseling (SCF), and with additional uncommitted funds from Harm Reduction remaining in that category. Thus, the proportionate reductions are based on the enhanced amounts. Other options includes applying proportionate reductions, or offsetting larger reductions by not reallocating the uncommitted funds that have been designated to enhance the FNS, Housing and SCF categories. Different methodologies might be appropriate for different levels of funding cuts. If the former option were used, in an 8% reduction scenario, the amount reduced in Supportive Counseling would be roughly equivalent to the amount that it would have been enhanced, which means essentially no change in funding.

It was acknowledged that the longer it takes for the EMA to receive the award, the harder it is for contractors to implement the new funding amounts, as any cuts will be retroactive to the beginning of the fiscal year (March 1, 2013).

Agenda Item #5: Needs Assessment Committee

Lee Hildebrand, Co-Chair of the Needs Assessment Committee acknowledged that in the past, the Planning Council designated the standard special populations, including young MSM of color, women of color, LGBT, etc. The HRSA guidance for the grant application, however, does not confine the Planning Council to these traditional designations; rather, it allows the Council latitude in making the selection. A new methodology was proposed, using the treatment cascade.

Each bar of the treatment cascade chart is a special population, i.e., PLWHA who are tested and diagnosed but not linked to care, linked to care but not retained in care, retained in care but not on ARVs, on ARVs but without a suppressed viral load, etc. Designating each of these groups as a special population allows us to focus on what we need to do -- the concrete steps we need to take.

At the same time as we are designating special populations, we want to craft a comprehensive needs assessment. HRSA advocates doing a needs assessment every three years, looking at epi data, adding data on new populations, and looking at the impact of changes – for example, medical progress – on the lives of members of the HIV/AIDS community.

Needs assessment tasks include identifying unmet need, identifying existing services, determining discrepancies between unmet needs and existing services, and examining needs of providers and the care system. The various steps involved in developing a needs assessment are as follows: Step 1: Understand the purpose of the project and determine the level of the assessment (e.g., state, community, or neighborhood); Step 2: Determine whether the data you need exists or can be produced; Step 3: Design methodology; Step 4: Collect and analyze data; Step 5: Prepare a report to summarize the needs assessment; and Step 6: Disseminate findings

Upcoming presentations that will inform and become part of the needs assessment include service needs and utilization (CHAIN) in February, the client satisfaction survey (REU) in March, delayers and dropouts (CHAIN) in April, update on the Comprehensive Plan for HIV/AIDS Services in the NY EMA in May.
The final product due in July 2013. The audience for the plan will be HRSA, Planning Council, Needs Assessment Committee, Grantee and the City, the HIV/AIDS community, and the public.

Questions to consider when designing and conducting the needs assessment include:

- What are we going to do about the approximately 60% of PLWH in the treatment cascade who are lost to care?
- What are the factors that produced these outcomes in the treatment cascade (linked to care but not retained, retained in care but not on ARVs, etc.)? Can we look at the treatment cascade and at barriers to care and arrive at a designation of special populations as an end product of the needs assessment?
- PLWHA who participate in the client satisfaction survey are, by definition, clients – and, therefore, do not provide us with complete information about barriers to care. Can we obtain a fuller understanding of barriers to care by looking at people who are not in care?
- What is the impact of syndemics – diseases co-occurring within a population and potentially exacerbating each other – on access to and retention in care?

Agenda Item #6: Consumer Committee

On behalf of the Consumer Committee, Victor Benedava reported that the committee, acting as the local CAB for the CDC Medical Monitoring Project (MMP), is reviewing the questions in the local survey and will communicate their concerns regarding HIV criminalization to the NYCDOHMH MMP Principal Investigators.

The NYC treatment cascade and continuum will be used as the framework for the borough-based listening sessions to be conducted in the Spring 2013. The cascade begins with the number of estimated HIV-infected, HIV diagnosed, those ever linked to care, those retained in care, those presumed ever started on ART and those with suppressed viral load (< 400 copies/mL). It was noted that the NYC model uses surveillance data throughout because NYC has an alternative to MMP (but CDC does not, as not all jurisdictions have reporting of all HIV related laboratory tests).

Utilizing the NYC Treatment Cascade to frame questions regarding *current barriers and necessary actions to remove or minimize these barriers* will be useful in articulating and describing the *disparities in engagement and retention in care* that prevent PLWHAs from moving along the continuum of engagement in HIV care. In particular,

- What are the most important barriers to *testing* for the estimated 18,000+ persons who are infected but not diagnosed?
- Once people are diagnosed, what are the most important barriers for the estimated 15,300 persons who are diagnosed but not linked to care?
- What are the barriers to *obtaining needed services/being linked to care* for the estimated 24,000+ linked to care but NOT retained in care?
- What are the barriers to *being retained in care* for the estimated 7,000+ persons retained in care, but not started on ART?
- What are the barriers to *treatment adherence to help the estimated 12,000+ PLWHAs who have started ART therapy but have not reached not viral suppression.*

Agenda Item #7: Rules & Membership Committee

John-Anthony Eddie, Co-Chair of the Rules & Membership Committee, reported that the Committee has been distributing applications for Planning Council Committee Appointments, which should be returned to NYCDOHMH by February 11. Members have been asked to actively promote Committee participation among the networks and communities in which they are involved. Victor Benedava and Randall Bruce of the Consumer Committee, agreed to do so.

Agenda Item #8: Policy Committee

On behalf of the Policy Committee, Nina Rothschild reported that Committee members reviewed and discussed a presentation on change agents, looking at the impact of implementation of the ACA and Medicaid reform on PLWHA in NYC. Between 110,000 and 440,000 New Yorkers may become enrolled in Medicaid or in insurance exchanges. An estimated 7% to 8% (1,540 – 1,760) of the current Part A patient population in NYC (22,000) will become eligible for Medicaid.

Service categories potentially impacted include oral health, medical case management, substance abuse, home care, and early intervention services. The potential areas of growth for Part A-funded programs include food and nutrition, housing, legal, and supportive counseling and family stabilization services.

This year, the Planning Council will issue new service directives for health education/risk reduction, supportive counseling and family stabilization services, and non-medical case management in anticipation of growing need for these services.

Next year, the Council will reshape medical case management and outpatient substance use services. The Council has applied for a waiver of the usual 75%/25% core medical/non-core social support services allocation because of Medicaid reform and the ACA. NYS Medicaid Program has implemented Health Homes, which are similar to Part A-funded medical case management (care coordination) programs. The target enrollment for Health Homes is close to 45,000 but is not as robust as the State would like. The Planning Council commissioned the Manatt Report to better understand what Medicaid reform looks like for individual service categories and may request an update. Upcoming meetings will focus on criminalization of HIV Transmission (presentation by Council member Adrian Guzman, JD, of the Center for HIV Law and Policy on 1/28/13). However, the policy Committee and Planning Council will probably not be able to take formal action on the topic because it involves legislation. As the purpose of presentation is informational, Committee members can take action as individuals or as staff of their own agencies; ensuring continuity of care for PLWHAs during the implementation of the ACA and Medicaid Redesign in NYS in February; an overview of CBOs' transition to health homes in March and routine updates on federal, state, and local HIV/AIDS policy issues on an ongoing basis.

Agenda Item #9: Grantee Report

Graham Harriman, Interim Director of the Care and Treatment Program announced that Public Health Solutions is processing contractual renewals and that New York's HRSA Project Officer will be visiting New York in March. The program has submitted its report on the 2011-12 Minority AIDS Initiative (MAI). Jacqueline Rurigirawa, Director of Quality Management, was introduced to the Committee and will present a report on Part A Quality Management to the Planning Council in February.

Jan Park shared a letter from the Planning Council acknowledging JoAnn Hilger's contributions to the NY EMA and was joined by other Committee members in honoring her many years of intelligent, compassionate and committed work on behalf of the EMA and PLWHAs locally & nationally.

Agenda Item #10: Public Comment

There was no public comment

Agenda Item #11: Adjournment

There being no further business, the meeting was adjourned at 5:10PM