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 19, 2012, 3:00-5:00pm
DOHMH, 2 Gotham Center, 42-09 28th Street, Conference Room 8-25
Long Island City, NY

MINUTES

Members Present: Jan Carl Park (Governmental Co-Chair), Dorella Walters (Community Co-Chair), Victor Alvarez, Victor Benadava, Felicia Carroll (Consumer-At- Large), Nancy Cataldi, Robert Cordero (Finance Chair), Gregory Cruz, John Anthony Eddie, Marya Gilborn, Graham Harriman, Lee Hildebrand, Tom Petro, Allan Vergara
Members Not Present: Joan Edwards, Charles Shorter
Staff Present: Stephanie Chamberlin, Mary Irvine, PhD., JoAnn Hilger, David Klotz, Rafael Molina, Nina Rothschild, DrPH, Darryl Wong
Public Health Solutions: Rachel Miller
Parliamentarian: Joan Corbisiero, PRP

Agenda Item #1: Welcome & Introductions

Dorella Walters, Community Co-Chair, opened the meeting with Jan Park, Governmental Co-Chair.

Agenda Item #2 : Review of 12/15/11 Minutes

The minutes were distributed to members electronically for review and comments. The motion was made to approve the minutes, as presented; the motion passed.

Agenda Item #3: 2012-2015 Comprehensive Strategic Plan for HIV/AIDS Services

Lee Hildebrand, Chair of the Needs Assessment Committee introduced the 2012-15 Comprehensive Strategic Plan, noting that robust discussion resulted from this presentation earlier in the month at the Needs Assessment Committee.

Nina Rothschild, Planning Council staff liaison to the Comprehensive Plan Committee, began by reviewing the general timeline of the preparation of the plan. After comments are incorporated from January through March, the Planning Council will be given the opportunity in April to review the entire comprehensive plan, including the narrative, before the final plan is submitted to HRSA in May.

Each of the plan's goals were reviewed, with objectives articulated and indicators identified for both the entire NY EMA and the Ryan White funded contracts, due to different data sources. Indicators include increasing the number of HIV tests, increasing the proportion of people linked to care, achievement of greater treatment adherence and improved immunological markers.

- **Goal 1:** Increase the number of individuals who are aware of their HIV status.

- *Objective 1a:* To ensure expanded access to voluntary HIV rapid testing across health care and social service provider settings, by the end of 2013.
- *Objective 1b:* To decrease delayed diagnosis of HIV by the end of 2014.

- **Goal 2:** Promote early entry into HIV care.
  - *Objective 2:* To increase the proportion of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis by the end of 2013.

- **Goal 3:** Promote optimal management of HIV infection.
  - *Objective 3a:* To increase retention in HIV care and treatment, by the end of 2013
  - *Objective 3b:* To increase the proportion of clients who have an optimal level of ART adherence, by the end of 2013.
  - *Objective 3c:* To increase viral suppression by the end of 2014
  - *Objective 3d:* To improve immunological health, by the end of 2014.
  - *Objective 3e:* To decrease reliance on acute care by the end of 2014.

- **Goal 4:** Reduce HIV/AIDS health disparities.
  - *Objective 4a:* To reduce (and then maintain below significance) socio-demographic differences in delayed diagnosis of HIV by the end of 2014.
  - *Objective 4b:* To reduce (and then maintain below significance) socio-demographic differences in prompt linkage to HIV/AIDS care following HIV diagnosis by the end of 2013.
  - *Objective 4c:* To reduce (and then maintain below significance) socio-demographic differences in retention in primary medical care by the end of 2013.

- **Goal 5:** Ensure that the EMA has a robust plan for the cost-effective delivery of HIV services.
  - *Objective 5a:* To respond to changes in HIV service delivery as a result of the implementation of the Affordable Care Act and the redesigned New York State Medicaid program
  - *Objective 5b:* To coordinate HIV services across funding streams in the NY EMA.
  - *Objective 5c:* To conduct and report on economic evaluation analyses of Ryan White Part A services.

Stephanie Chamberlin of the Research Evaluation Unit of NYCDOHMH noted that the Strategic Plan has been developed to insure alignment with the National HIV/AIDS Strategy (NHAS) and in certain cases, targets have been set beyond levels projected in the NHAS.

ACTION: A motion was made, seconded and passed to accept the plan as presented

Agenda Item #4: Substance Use Directive – Discussion

Jan Park introduced the discussion of the changes to the Harm Reduction/Recovery Readiness/Relapse Prevention service model promulgated by the implementation of HRSA's monitoring standards, which limit Ryan White services to HIV-positive individuals and require contactors to provide evidence of application for Medicaid certification for qualifying services and clients. Harm reduction contractors will not be reimbursed for low threshold services for HIV– or status unknown clients; however, HIV testing is excluded. Rates and payment points have been standardized to align with rates in other Part A testing programs.

Contractors will have the option of adding evidence-based practices (EBIs) and/or interventions to the contract. NYCDOHMH and Public Health Solutions will offer options for providers to implement optional EBIs and/or practices into existing programs as part of the contract renewal process. Available evidence-based practices include 1) motivational interviewing, conducted as part of current individual, family and

group AOD counseling, 2) Health Living Project, a 3 module, 15 session intervention designed to improve physical, mental and sexual quality of life, 3) Seeking Safety, a flexible, present-focused therapy to help people attain safety and 4) Therapeutic Education System, an internet-based intervention of 65 interactive modules.

It was noted that despite approval of the prior service model by the Integration of Care Committee and the full Planning Council last year, external changes beyond the control of the Planning Council have mandated a re-tooling of this service model. While contractors' budgets will not be reduced if optional interventions are elected to be offered, one service provider reported that many clients' cases will need to be terminated and that the short time period in which to do so may prove to be challenging.

Agenda Item #5: Planning Council Update

- Jan Park reported on the recent CAEAR Coalition meeting, at which core/non-core waiver issues were discussed.
- The January 26, 2012 Planning Council agenda was reviewed and approved.
- Robert Cordero inquired as to the status of the NY EMA's decision to either move forward or not with the HRSA core services waiver. It was suggested that this discussion occur in a special session, to be arranged according to CTH and Planning Council staff availability.
- Rachel Miller of Public Health Solutions reminded the Committee that there are openings in the PHS Community Advisory Group.

Agenda Item #6: Public Comment

There was no public comment.

There being no further business, the meeting was adjourned at 5:15pm.