HIV Health and Human Services Planning Council

EXECUTIVE COMMITTEE

January 8, 2004
2:05-5:00pm
Friend's House, 130 E. 25th Street

M I N U T E S

Members Present: F. Oldham, Jr. (Governmental Co-chair), N. Nagy (Community Co-chair), S. Hemraj (Finance Officer), R. Abadia, S. Abramowitz, PhD, J. Brown, R. Chavez, H. Cruz, B. L. Curry, S. Halperin, J. Hilger, R. Johnson (for D. Ng), H. Melore, T. Petro, J. Pressley, E. Santiago, P. Stabile, T. Troia, M. Wainberg, MD

Members Absent: M. Barnes, G. Brown, MD, R. Busan, T. Hamilton, A. Paige-Bowman

Staff Present: *OAPC:* R. Cordero, D. Klotz, S. Bailous, R. Molina, C. Miller; *DOHMH:* J. Park; *MHRA:* J. Verdino, G. Weinberg, B. Carroll

Agenda Item #1: Welcome/Announcements/Minutes

Mr. Oldham opened the meeting, followed by member introductions and the moment of silence, introduced by *Mr. Santiago*.

Mr. Cordero reviewed the meeting package, noting changes in the Planning Council calendar.

The minutes of the December 11, 2003 Executive Committee (EC) meeting were approved with two changes: *Rev. Troia* added that she had questioned the planning principles used to justify cutting Psychosocial Support Services, and *Mr. Pressley* noted that he had expressed concern about communicating the scenario planning to the funder.

Agenda Item #2: Consultant Report on the December 4, 2003 Working Session

Mr. Oldham: Our technical assistance efforts demonstrate our commitment to improving the Planning Council and really doing effective planning. As background, we requested technical assistance (TA) from HRSA after last year's cut to help clarify roles and improve functioning. Consultant Emily McKay has held two sessions, in July 2003 (report previously distributed) and on December 4, 2003. This report from the December session focuses on clarity of roles and responsibilities, Planning Council structure, and relationships between the Planning Council, grantee and staff. The report proposes additional ideas to move forward, such as a retreat, improved orientation, and the need to document Planning Council history. A by-laws task force is looking at the structure to improve functioning.

Mr. Abadia: The report's description of the PWA Advisory Group (AG) as "learning how to disagree" is more accurate for the Planning Council as a whole. The AG has always known how to disagree.

Mr. Oldham (in response to a question from Ms. Melore): Ms. McKay prepared the report, as noted therein.

Ms. Nagy: Restructuring was a big focus. We should use this document to make us better so as to help prevent another funding cut in the future.

Mr. Oldham: The next steps recommended in the document are: 1) The EC needs to develop a timeline that provides for recommended committee structure and other bylaws changes to be completed in time for Law Department review, Planning Council approval, and implementation in September 2004. This means working backward from September to identify key tasks and deadlines; 2) The Bylaws Task Force needs to meet with workgroup chairs as soon as possible, work with the EC to agree on a timeframe for completing its recommendations for a revised committee structure and for other bylaws changes, and begin meeting approximately every two weeks to ensure that the Task Force is able to finish its work on schedule.

Mr. Brown: By-laws Task Force will meet again shortly to continue its work.

Agenda Item #3: Public Comment, Part I

A. Melina: (En Espanol): El Faro (the adult day care program of Harlem United) is a critical service in my life.

C. Torres: The Air Bridge program has been a great help to me, as services in Puerto Rico are limited. They have helped me access and learn about treatments and learn English.

M. Ducret: Some programs do not do what they are contracted to do.

S. Richardson: El Faro has helped me as a Department of Corrections releasee. Releasees do not have support, especially those who are HIV-positive.

I. Kiser: El Faro has helped me and other people who had no hope. The staff went out of its way to help me get my life back together. Cuts will hurt PLWH.

V. Williams: As a Project Samaritan client, I can attest that cuts will mean people going back to using drugs and to homelessness. They helped me with treatment adherence and mental health.

C. Monroe: Project Samaritan educated me. Jamaica, Queens does not get its fair share of services.

C. Rosario: As program director of El Faro, I know that adult day care programs are still needed. We serve undocumented immigrants, the homeless, chronically mentally ill and other under-served populations. We provide low threshold services that any HIV-positive person can access. Any service not provided on site is provided through referrals. Client data shows the demand.

P. McGovern: The "medicalization" mandate from HRSA should apply to all categories. The planning process is flawed, as voting on ranking was done without a full understanding of the services. Adult day care can stand alone as a service and it meets all criteria for support – it does not receive Medicaid reimbursement, meets the HRSA mandate that services provide access to and maintenance in primary care, and they serve the most vulnerable populations.

Agenda Item #4: FY 2004 Spending Scenario B

Mr. Oldham: When the Eligible Metropolitan Area (EMA) received its funding cut last year, former Finance Officer Bobby Watts suggested that we not be blind sided this year by preparing scenarios for all funding possibilities. Hopefully we will not see another cut, but we need to prepare for all contingencies as well as be united in our advocacy efforts to ensure that New York gets its fair share of resources.

Last year had to do across-the board cuts, which is not planning. We hope there will not be a cut, and that the reality will be implementation of the increase scenario, but we have to plan for worst. The Mayor, Governor, Planning Council and AG are all advocating in Washington that NYC cannot receive another cut.

To plan for this year, the EC developed a series of principles for planning for spending scenarios. These principles flow from the guiding principles from the FY 2004 Title I grant application: Revise care delivery systems to meet emerging needs; Ensure access to quality HIV/AIDS care; Coordinate CARE Act services with other health-care funding streams, such as Medicaid, ADAP, other City and State programs, other Ryan White titles, Medicare, CDC and HOPWA; Evaluate the impact of CARE Act funds to make needed improvements.

The principles for planning for a reduction in the award are: 1) Maintain Title I base funded services that provide access to and maintenance in quality HIV/AIDS primary care; 2) Coordinate Title I services with other existing resources (i.e., other Title I programs, Medicaid, ADAP, other City and State programs, , other Ryan White titles, Medicare, CDC and HOPWA); 3) Ensure that Ryan White Title I funds are the payer of last resort.

We also begin with the understanding that under-spending contracts will have already been reduced. The grantee does take-downs for poor performers as a matter of course, and so we will have already saved some money before having to make any additional cuts, should that be necessary.

The suggestions presented here were developed during extensive meetings involving the Planning Council officers, and staff from the Office of AIDS Policy Coordination, DOHMH/Ryan White Bureau and MHRA/HIV CARE Services. They were discussed at the December EC meetings where additional ideas were developed. This list is a template for developing a final spending plan once the award is announced (likely late February or March). The EC will develop an FY 2004 Minority AIDS Initiative (MAI) spending plan at the February EC meeting, and the complete spending plan will be presented to the full Council for final approval after the award is announced.

Mr. Pressley: HRSA knows that we are doing scenario planning, and I do not know if that is wise.

Mr. Oldham: Other EMAs plan for various spending scenarios prior to the award, including large EMAs like Chicago.

Mr. Pressley: It makes sense to do scenario planning, but it is better to talk with the funder about unmet need, rather than what we will do if cut.

Mr. Oldham: Mayor Bloomberg has sent a letter to US Department of Health and Human Services Secretary Tommy Thompson that NYC can not afford another cut, and that we want our entire request funded, based on need.

Mr. Cruz: I agree with Mr. Pressley, but doing this is good planning, and it is impossible to do it quietly in New York City. Also, the NYSDOH Commissioner sent a letter to Secretary Thompson advocating for the FY 2004 Title I application. This is a moment for all types of advocacy on behalf of our award.

Ms. Nagy: This is a painful process, as each service category is important, and I have used many of them. NYC is epicenter and gets a proportionately unfair share. We have the option, should there be a cut, of filing a class action suit on behalf of our PLWH.

Mr. Oldham: Senators Clinton and Schumer and the City Council are also sending letters.

Mr. Abadia: The AG co-chairs are sending letter, and we are sponsoring an open letter from PLWAs, who are encouraged to sign it if they are willing to openly proclaim their status on a public letter.

Mr. Hemraj: This is a painful process and I pray that we do not get even one dollar cut. At the December 11, 2003 EC meeting, seven possible items for reduction were discussed should there be up to a $10 million cut. They were ranked by fax vote, with 13 EC members voting. The ranking is not binding, but will be discussed today, with other suggestions. The items were tied to the planning principles. While we will have discussed all scenarios – small, medium and large cuts and increases, we will not know the reality until the award comes in. The ranked categories are (in the order that they would be cut): Day/Respite, Buddy/Respite, Permanency Planning, Oral Health Care, Support Services in HASA Housing, TA, Psychosocial Support.

Mr. Abadia: I want to stress that the ranking is not binding, but for discussion.

Rev. Troia: The Social Services Workgroup (SSWG) consulted by conference call and in person on this scenario. They decided not to participate in the ranking but tried to be "solomonic", and through our own process make recommendations for exploring funding cuts according to the principles. These suggestions are limited by factors such as a lack of current epidemic trend analysis data, information on geographic distribution of services marked for potential cuts (and related impact of cuts to specific communities), and a listing of alternate service availability.

The SSWG concluded that the EC list was created in a flawed and rushed process. The link between the proposals and the principles are not clear, and they do not give equal weight to the programming and services necessary to maintain multiply diagnosed and disadvantaged populations in care, and instead give weight only to accessing care. For example, Promoting Access to Early Intervention (outreach), which is a Social Services category, was untouched in consideration because it gave access to care, while other equally important categories for maintenance in care appear not to have been given equal consideration in this first ballot. The proposed list did not take into consideration social service categories (such as psychosocial support services) provided in Article 28 facilities and funded as non-medical services under the category of Outpatient Medical Care.

Furthermore, the proposed categories for possible elimination are almost entirely borne by community-based services. We know that these cuts will decimate some services geographically, where Ryan White services support borough-wide services for HIV-infected populations. We know too that community-based services cannot sustain massive funding cuts, and we know anecdotally – and probably statistically if we analyze the data – that CBOs introduce to, help access and sustain multi-need HIV infected populations in care much more successfully than hospital-based care, due to the flexibility of low threshold, drop-in, and client centered services in a variety of harm reduction modalities.

Without data that would indicate to us what populations are most utilizing the categories recommended for elimination, or without in-depth scrutiny of how the services are crucial to PLWH, it is hard for any of us to make recommendations for cuts without jeopardizing the quality of life or indeed the life itself of persons living with HIV/AIDS and in need of Ryan White Title I services.

The SSWG hopes that the EC will give serious consideration to finer, surgically precise budget cutting recommendations that are sub-categorical. In so doing, there is preservation of services in some of the categories while still proposing a reduction within the category. We are not making geographically analyzed recommendations, even though such an analysis would be prudent. Category-wide recommendations may not serve the interests of multiply diagnosed and persons of color living with HIV/AIDS. We need to reexamine the guiding principles and look at populations, impact, etc.

Ms. Nagy reviewed the current EC list with program descriptions and linked principles.

Mr. Halperin: This is a sad meeting, not just because we are planning for cuts. It's a sad meeting because it took the presence of PLWHs at this meeting for the EC to do the right thing. This process is politicized and full of conflicts of interest. It is a tainted process because DOHMH has taken over the community planning process and OAPC is doing bidding of the Health Commissioner. EC members need to speak out when PLWHs are not present as well.

Mr. Chavez: The EC talked about the potential external impact of the cuts, but not the internal impact. Eight new TA programs are just starting, but when agencies realized that the entire portfolio might be cut, they delayed hiring staff, thus delaying any TA services. Perhaps this could have waited until the award was announced.

Mr. Pressley: There is a need to engage the workgroups fully. I have gotten calls from many CBOs. We cannot put forth this plan until we have put in place a process employed across the board. Perhaps a motion is needed to halt the process. Last year's budget cutting was painful, but it came from the bottom up and the process worked. This process has been more top-down.

Mr. Cruz: Whenever there are cuts, they will hurt someone. I agree with Mr. Pressley about last year's process, but it was different because we did not have alternatives. Drug assistance and primary care are core services that touch PLWH lives like no others. Last year, ADAP offered up a lot in cuts. There is a continued demand for adult day care, but there has been a State moratorium on new programs for a long time. Permanency planning has been under-funded for years, and women are rising as a percentage of cases. Finally, the Leadership Training Institute is crucial, especially in light of the need for advocacy.

Mr. Pressley: It makes sense to do scenario planning before the award, but I am concerned that the workgroups have to be fully engaged.

Mr. Halperin: Not all of the workgroups were engaged in April's process, and only the Social Services and Infrastructure Workgroups came to the table with a menu of possible cuts.

Mr. Oldham: We have applied for a large increase in award, and that is what the Mayor, Health Commissioner and everyone else wants and hopes will happen. Having people who use services here is helpful. Maybe we should plan for cuts in smaller increments.

Mr. Abadia: All categories can be linked to primary care. I am also, concerned, like Mr. Chavez, about the impact on new TA programs that went through the RFP process. They were ranked highest, but if the category was cut, then lower ranked proposals will still be funded with the additional HOWPA funds.

Rev. Troia: The SSWG process pointed out the flaws in the EC's process. Supportive Services in HASA Housing is an enhancement. Cutting that still preserves the basic program. Based on the description the SSWG had, they felt the same about Outpatient Medical Care (OMC)/Service Enhancement. We also looked at Psychosocial Support Services, and think that it is a unique service. Also, social services in the OMC category are not being cut, thus cuts to social services are only in CBOs, even though they promote access to and maintenance in primary care. In Staten Island, there are no HHC primary care facilities, and so CBOs are the principle avenue for access to primary care. The April across-the-board cut did not gut entire programs. We need to look at more surgical cuts. For example, Promoting Access to Early Intervention is well represented in the MAI portfolio. There is $25 in HOPWA funds for HASA case management. Is there any way that some can be shifted to fund case management in OMC contracts? We should look at alternative planning principles.

Mr. Johnson: I am an alternate for Mr. Ng, but I have been briefed and respect the amount of time that went into this process. I acknowledge that cuts will hurt, but two critical issues need to be addressed: the legitimacy of the process (e.g. involvement of workgroups), and how we can assess the impact of cuts (who will be hurt and any potential ripple effects). We need more time and an improved process, while respecting the real and honest work done up to this point.

Dr. Abramowitz: If the process is to be reconsidered, it should dovetail with the reassessment of the portfolio.

Dr. Wainberg: The Mental Health Workgroup had no meeting in December, and thus had no opportunity to review the proposals. The April process was better, if not perfect. We need to stop this process, even though it was done with good intentions, and reevaluate what we have. We need improved principles and more information.

Mr. Santiago: We are being asked to make decisions to disrupt the continuum of care without enough information.

Ms. Nagy: From the beginning, I have never agreed with any cut. Any cut will negatively impact PLWH, but we do have guidelines from HRSA. When I suggested considering an across-the-board cut, I was told that that is not real planning. I hope that the community's involvement continues. Even with the principles, I do not feel secure with the decisions. For example, Title IV for women and families is the lowest funded title of CARE Act, and so I do not know if permanency planning services can be absorbed by other funding streams.

Mr. Stabile: Workgroups are reassessing their portfolios and looking for data, but it is a long process. What is the time frame for this spending plan? The first priority is access to medications and care. New York is fortunate that there is no waiting list for ADAP, and we must preserve this.

Mr. Oldham: Congress reconvenes Jan. 20. We do not know when they will make decision about appropriations.

Mr. Cordero: After appropriations are signed off by the President, it goes to the federal agencies. Then HRSA goes through their process to make awards. The notice of grant award will probably come in late February or March. This scenario planning started early, and we have two more Planning Council meetings to complete it.

Mr. Petro: This process is emblematic of our history as an EMA. We do not have an adequate planning process. The leadership of the Planning Council has identified categories they consider to be least vital if there have to be cuts. This gives a sense of the EC. Last year, we got our award in March and had to finish the spending plan by the April meeting. We need to establish a time line and create more principles and criteria and get as much information as reasonable.

Ms. Melore: I have no sense of how these recommendations were developed. They are unbalanced (e.g. only CBOs are affected, not government agencies). The impact on women of cutting Permanency Planning is great. Is the HRSA mandate being used by DOHMH to its advantage? We need a better understanding of what is driving these recommendations.

Dr. Wainberg: We need more PLWH on the workgroups.

Mr. Oldham: This discussion is part of our open process. It is the first attempt at developing scenarios. There is no other agenda.

Mr. Hemraj: As stated earlier, this is a suggestion. We are in a process, and while it can be improved, not going through it would be a failure on our part.

Mr. Pressley: Motion to set aside the current scenario B and form an ad-hoc committee to form a new set of planning principles to investigate more surgically precise cuts and the impact of cuts on communities of color, the multiply diagnosed, and communities that do not - or can not - access traditional models of care, and that principles must be employed in all service categories. (Seconded)

Ms. Nagy: If guiding principles came from HRSA, can they be changed?

Mr. Pressley: We interpreted HRSA's guidance, but we can also tailor them to our own needs.

Mr. Cordero (in response to a question from Mr. Cruz): The principles developed last April were incorporated into these principles.

Mr. Abadia: Friendly amendment to Mr. Pressley's motion to add immigrants and the undocumented (amendment accepted). The term "illegal aliens" is offensive.

Ms. Nagy: Friendly amendment to add development of a timeline.

Mr. Pressley: We can add something about the timeline after the motion passes.

Mr. Cordero: The EC can form an ad-hoc committee, but the by-laws charge the EC as a whole with creating a spending plan. An ad-hoc committee will lengthen the timeline.

Mr. Brown: I agree. It should come back to the EC. Also, would workgroup feedback be part of the process?

Mr. Pressley: I agree. We will need a second motion on the timeframe and workgroup involvement.

Rev. Troia: Friendly amendment remove "service" before "categories" (accepted).

Mr. Cruz: If the EC charges an ad-hoc with developing principles, then it has to go back to the EC, which will develop a plan, we may not have a scenario in time for the award.

Dr. Abramowitz: Data Day3 on February 6th will start the work of reassessing the portfolio, with data from HIV QUAL, service utilization, etc.

Ms. Hilger: The motion needs to be clarified. Do the ad-hoc's principles go to the EC for approval, and then what?

Mr. Pressley: I suggest that the ad-hoc meet quickly to set principles, and we can have emergency, extra EC meetings as needed.

Mr. Oldham: We have to have buy-in for the process.

Mr. Cordero: We should look at the process for how to institutionalize it for future years. There are currently two ad-hoc committees that report to the EC.

Mr. Pressley: It can be a small group of EC members.

Mr. Klotz restated the motion.

Mr. Pressley: I amend my motion to change ad-hoc to a subset of EC members.

Mr. Chavez: The EC must decide how the process will play out in respect to workgroup involvement, which should be uniform.

Mr. Pressley: This can be part the of development of principles and how its implemented.

The motion passed 17-0-1 (Y-N-A).

[Five minute break]

Mr. Brown: Motion that, in addition to a timeline, the sub-committee develop a uniform structure for scenario planning. (Seconded)

Mr. Pressley: Friendly amendment, to expand the sub-committee to include more than EC members.

Ms. Melore: Some workgroups have bigger portfolios and different planning needs.

Mr. Cruz: The Health Workgroup also had the biggest cut last year.

The motion passed 16-0-1 (Y-N-A).

Mr. Pressley volunteered to chair the sub-committee. Mr. Johnson volunteered Mr. Ng to serve. Other members will be: Mr. Hemraj, Mr. Stabile, Mr. Oldham, Ms. Hilger, Mr. Abadia or an alternate, Ms. Curry, Ms. Verdino, Rev. Troia.

Mr. Pressley: We can invite additional members.

Mr. Oldham: Thanks to everyone from the community who came to make their voices heard. We want to keep the process open.

Mr. Brown reviewed the by-laws language on ad-hoc committees ("The City Co-Chair, in consultation with the Community Co-Chair, may designate and determine the size, composition and chairs of all the Planning Council's standing and ad hoc committees").

Action Items/Follow-up (Responsible Parties/Timeline)

- Convene sub-committee to develop principles, timeline and process for spending scenario B (Sub-committee/ASAP)

Agenda Item #5: Public Comment, Part II

E. Reyes (en Espanol): The Air Bridge has been vital to me since I arrived in NYC from Puerto Rico. The program has helped me to adhere to my treatments.

Q. Chasner: El Faro has helped me with treatment education and adherence and building hope and self-esteem.

N. Javier: As an El Faro counselor, I am glad that the EC has heard clients' voices and taken a pause. We are getting an influx of new clients from all over NYC.

T. Smith-Caronia: I commend the SSWG for abstaining from ranking. It felt like the EC was being pushed to move on the scenario, despite a flawed process, but they have taken back their own power, as the public was watching. OAPC is trying to guide the process, not just support it. I am also concerned that the NYC Commission AIDS is closed to the public. The Program Monitoring Report will not be published this year due to lack of funds, even though the data is critical.

S. Howze: I supervise the El Faro program. We know that sometimes there have to be cuts, but you should know their impact. We are connecting people to primary care. Putting adult day care on the top of the list to be cut shows a lack of knowledge of the service.

M. Pinott: The Legal Aid Society has reconstituted the Families in Transition coalition, which includes permanency planning programs. The primary care setting is not optimal for social services. Permanency planning is more than

just coordinating legal guardianship. We link families to respite care, mental health services, etc., and serve immigrants.

L. Holley: You need to go to the people that you serve and ask them what they need. PLWH know what is needed to make programs better. You need to educate PLWH on available services and not form so many committees.

There being no further business, the meeting was adjourned.

Minutes approved by the Executive Committee on February 5, 2004

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Frank J. Oldham, Jr.
Governmental Co-chair