Meeting of the

EXECUTIVE COMMITTEE

Thursday, October 7, 2004
2:40-4:30PM
Friends House, 130 East 25th Street

MINUTES

Members Attending: B. Stackhouse, Ph.D. (Acting Governmental Co-chair), S. Hemraj (Finance Officer), R. Abadia, S. Abramowitz, Ph.D., E. Camhi, F. Carroll, C. Cobb, H. Cruz, I. Gamble-Cobb, J. Grimaldi, M.D., M. Hill, Ph.D., J. Lehane, Ph.D. (for T. Petro), P. McGovern, D. Ng, W. Okoroanyawu, M.D., J. Pressley, E. Santiago, T. Troia

Members Absent: M. Barnes, L. Dolloway, N. Nagy, T. Osubu, H. Mateo, A. Paige-Bowman

Staff Attending: *OAPC:* G. Moon, D. Klotz, S. Bailous, S. Dwyer, R. Molina, C. Miller, M. Lesieur, R. Shiau; *DOHMH:* J. Hilger, J. Park, S. Forlenza, M.D., M.P.H.; *MHRA:* J. Verdino, P. Jensen

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Agenda Item #1: Welcome/Introductions/Minutes

Dr. Stackhouse opened the meeting, followed by introductions.

Mr. Abadia introduced the moment of silence.

The minutes of July 8, 2004 Executive Committee (EC) meeting approved with no changes, with 2 abstentions.

Agenda Item #2: Public Comment

O. Roman: I question the way people were picked for the Consumer Committee. There should have been an application process.

M. Gold: The PWA Advisory Group sponsored an HIV and Over 50 and Long Term Survivor conference last weekend, which was a big success, featuring a keynote speaker from HRSA. Thanks to everyone who worked so hard on the event, which validated the seriousness of the issue. We need to look seriously at this population. Also, the EC needs to address the new Medicare prescription drug policy. Up to 60,000 PLWH may lose their prescription drug coverage or be forced into plans with limited coverage.

Agenda Item #3: Committee Orientation Follow-up

Dr. Stackhouse: Thanks to consultant Emily McKay for a quick turnaround on the committee orientation report. We also have prepared a timeline and flow chart for Council and committee activities. After the orientation, Mr. Hemraj suggested having a follow up meeting of the committee chairs. We will try to cover as much as possible of the orientation follow-up here, but a chairs meeting is still a possibility. Let's review and comment on the McKay report. Chairs will need to feel comfortable articulating the roles of their committees.

Ms. Hilger: The by-laws can address the concern raised in the public comment, as well as further clarifying planning tasks.

Mr. Cobb: We also need to clarify how communication between committees happens.

Mr. Ng: There are some overlaps in committee membership. Also, it will be a demanding process and it is important for people to be present at meetings.

Mr. Pressley: We can do a better job of using EC meeting as an opportunity to foster more collaboration and communication.

Mr. Hemraj: We need to document formally, in writing, any communication between committees.

Dr. Stackhouse: People in the Council leadership should also be able to articulate the roles of the other committees and to help people understand the planning process.

Mr. Santiago: It is still not clear what the committees' charge is. We should look at making sure the work is divided fairly. We should also not have one person on multiple committees to avoid conflicts of interest.

Ms. Verdino: The Council should consider adding policies in addition to the legislative requirements. For example, the grantee has occasionally received Council guidance for service priorities that are not allowable under Title I.

Mr. Camhi: The report should include something about our responsibility to coordinate with other CARE Act Titles and planning with those funding streams in mind.

Ms. Moon: The mapping project is meant to identify all HIV services, both Ryan White and non-Ryan White.

Mr. Cruz: Developing standards of care (an IOC responsibility in the report) is usually a treatment issue decided by a clinical body. Rather than creating standards of care, we make recommendations that are considered by other bodies.

Mr. Hemraj: We need to start looking at unit cost for services. This will be crucial for allocating resources.

Ms. Hilger: There are references to standards of care in the HRSA Title I manual. I think what they mean is not just a clinical perspective but applying them to the other service categories (e.g., developing standards for the QM programs). There are different definitions of "standards of care". Also, unit cost is not a HRSA requirement. They ask us to consider cost effectiveness when planning for services. We should consider using broader language.

Mr. Ng: Perhaps substituting "models of care" (which will be IOC's emphasis) for "standard of care" would be more accurate.

Ms. Verdino: The quality management (QM) program is developing standards of care, and the Council has been involved in that effort (e.g., chairs of old workgroups were on the QM advisory committee). There should be some Council members designated to be liaisons to the QM program.

Ms. Moon: Former workgroup chairs are continuing chairs of new committees and will continue to participate in the QM committee.

Ms. Verdino: We should formally designate people.

Dr. Stackhouse: We need to make sure that there is a policy in place to ensure on-going representation on QM committee. There seemed to be some consensus at the orientation concerning moving to a three-year

planning cycle, and we are bringing this here to the EC for a decision. If the EC decides to move to a three-year cycle, what year are we in? Let's first discuss the general concept.

Mr. Cruz: It is difficult to maintain continuity of communication, information, etc., as some people will be Council members at the beginning of the cycle but will not be involved at the end. This is a complex process, and we need a document that tells us every year where we stand in the process, documents the history, and describes how the process will continue.

Ms. Hilger: Even if there is a three-year cycle, there is a requirement to update the epidemiological data every year and to do resource allocations and funding levels change.

Dr. Hill: This could be part of the larger discussion on policies and procedures. It might take time to communicate changes, e.g. from our HRSA Project Officer to the Council to the committee level, then back to the EC and full Council. We need to look at ways of continuing the discussions on process to ensure that we are all on the same page. The two-day orientation is a start, and data days can also give us a review of how we make decisions.

Ms. Moon (in response to a question from Dr. Grimaldi): We post all the information we send to the Council on our website, including all data day materials.

Mr. Abadia: Please make sure to do regular mailings, in addition to e-mail, as some consumers do not have e-mail.

Mr. Camhi: It takes time to identify the significance of changes in data, and a longer planning cycle will allow for this.

Mr. McGovern: A three-year cycle can lead to a higher level of analysis and less busy work, but is there a downside?

Dr. Stackhouse: It is a big change, on top of the major changes in the Council's structure. We should be cautious and be able to say that we discussed this fully and feel comfortable with the decision before voting here to recommend the change to the full Council.

Mr. Hemraj: I support a three-year planning cycle. Annual priority setting can be done within an overall three-year plan. I move to accept the proposal. [Seconded]

Mr. Pressley: I would like to add a friendly amendment that in the transition to a three-year cycle, that we develop better mechanisms for communication across years and Council members.

Mr. Cruz: I propose re-wording that amendment to have yearly written updates on the progress of the plan. [Accepted]

Motion carried.

Dr. Stackhouse (in response to a question from Mr. Cobb): The details would have to be worked out, but Staff would prepare a draft with the co-chairs' input and present that to the EC for comment and approval.

Ms. Moon: In past years, workgroup chairs met periodically on progress of the planning cycle. We can do something similar.

Mr. Cruz: HRSA requires a comprehensive strategic plan every three years, plus coordination with the Statewide Coordinated Statement of Need (SCSN). We need to think about what the three-year requirement refers to. We can use it as a framework, looking every year at what gaps need to be filled in.

Dr. Stackhouse: Is Mr. Cruz willing to lead a small ad-hoc group to pull together an outline for the next EC meeting?

Mr. Cruz: I will ask my AIDS Institute colleague Gloria Maki to convene a group, as she facilitates the development of the SCSN, although it might not be by the next EC.

Mr. Hemraj: Maybe at the end of each year, the leadership of each committee can present a report with their accomplishments, strengths, weaknesses, upcoming challenges, etc.

Ms. Hilger: Whatever is done should be tied in to the Strategic Plan.

Dr. Stackhouse: We need a concrete outline on how this will work. [The following members volunteered to serve on the ad-hoc committee: Mr. Hemraj, Mr. Camhi, Mr. Cobb, Mr. Pressley, Ms. Verdino.]

Dr. Hill: The issue of a review of a three-year cycle is a good discussion, but as Mr. Pressley stated, we need to ensure that whatever we come up with, there is clear communication around it. This is a staff function, and so the EC does not necessarily have to discuss placing it.

Dr. Stackhouse: Last year, the Council reassessed all its service priorities, and so that can be considered the first year of the cycle.

Mr. Cruz: I caution that, with reauthorization coming up, everything could change. We should develop a plan that can incorporate any changes from reauthorization.

Ms. Verdino: It should be considered as a foundation that the task of comprehensively examining each priority was done last year and it is not necessary to do that again this year.

Ms. Hilger: We are also doing a three-year Strategic Plan for 2005-7, and so to some degree we have already fast-tracked into a three-year plan.

Dr. Abramowitz: The Council's goals changed with restructuring to promoting access ti and maintenance in care. The challenge is to examine how programs accomplish that. It may take three years, but that is our charge.

Rev. Troia: We did ask the questions last year about how programs promote access and maintenance and changed templates accordingly, and so now need to look forward and plan from there.

Dr. Abramowitz: That is, I believe, a different way of saying same thing. Now, with mapping data, we can look at the structure of services across funding streams and how they interact, which is a different set of questions that may result in different models.

Ms. Verdino: Committees will look at the work that was done. The Priority Setting and Resource Allocation Committee (PS&RA) will decide how much funding to commit to each service (e.g., less if covered by another Title). Because something exists as z priority does not necessarily mean it will be funded as it is now. Within the new structure, the Council can take the work that was done last year and move forward.

Dr. Stackhouse: It sounds like it is important to have certain annual milestones, even within a three-year plan.

Mr. Cruz: I am committed to having Ms. Maki help develop an outline of a three-year plan, not to answer all of the questions raised here.

Mr. Pressley: Ms. Verdino's statement needs to be repeated as a mantra. PS&RA will be making some real changes at the end of this process, based on the mapping and other data.

Dr. Stackhouse: This was a good discussion and a tough decision, and we will have to work creatively as we move forward.

Ms. Moon: In your packets is a draft timeline organized by task. Please send comments on it to OAPC staff. The first task is update to Needs Assessment Update, with a final product in November. Then, a conceptual model should be developed in November by the Integration of Care Committee (IOC), in consultation with the Needs Assessment Committee (NAC), for submission to the EC. We hope to present that at the first Data Day on December 10th, along with new data (e.g., epi). The Access to Care and Maintenance in Care Committees (ATC, MIC) will use the IOC charge to revise the model, based on the adoption of a three-year plan. This may include reviewing services, identifying target populations, etc. Then we will develop the goals and objectives for the next Strategic Plan, which will not be workgroup-based as the previous one.

Mr. Ng (in response to a question from Mr. Santiago): It is best not to think in terms of templates, but in a new way of examining services. We still need to develop this further, but IOC will provide the overall framework, ATC and MTC will work on the details.

Ms. Gamble-Cobb: ATC and MIC are meeting soon and need guidance from IOC to help allay anxiety around the new structure.

Ms. Hilger: When discussing this yesterday in the NAC, the assumption was a twelve-month process, and so there is a possibility that dates could change. We also need to define what terms like "conceptual framework" means.

Dr. Grimaldi: The discussion of a conceptual model can be done at another time. It is my understanding that IOC does plan to lay some groundwork for its sub-committees.

Ms. Moon: To continue with the time line, in the winter will have Data Day 2, followed by priority setting and resource allocation. Recommendations will go from ATC and MIC to IOC, and then on to PS&RA, which recommends rankings and allocation of resources to the EC and full Council by July.

Dr. Stackhouse: The staff has done a lot of thinking on the process and will help the chairs implement the plan.

Mr. Camhi: Each committee will develop its own tools (e.g., NA is working in a data inventory) and bring that to the table.

Ms. Moon (in response to a question from Mr. Ng): IOC does not need to develop a final model before AIC and MIC meet. Their first meeting can still be about orientation and the Needs Assessment update.

Dr. Stackhouse: I think it is important that committee members feel that their time is well spent. If the chairs feel that they can not lead a productive meeting, then we need to negotiate about rescheduling. If a meeting will be rescheduled, it should be done at least one week in advance.

Mr. Abadia: The Consumer Committee members are PLWH Council members, but it is open to all to attend, unlike the AG, where attendees have to be PWLH. We want to make presentations to the other committees.

Agenda Item #4: Indicators for Success: Access/Maintenance

Dr. Stackhouse: There has been a general concern on the Council around developing indicators for measuring success in promoting access to and maintenance in care. We want to make sure that there is a brief discussion on this.

Mr. Cobb: Are we talking about outcome measures? It needs to be concrete rather than theoretical.

Dr. Stackhouse: There is success in planning activities, and success in programs that are funded.

Ms. Moon: We did try to set up a meeting on this topic over the summer but were unable to schedule it. We still plan to have it, however.

Ms. Verdino (in response to a question from Dr. Grimaldi): The QM program is looking at several programs, doing chart reviews to determine outcomes. There is another program funded this year to develop general outcomes for whole EMA and specific kinds of services, and will do measurements with the same chart reviews. There was a concern that this effort not get lost. We will present on the progress of this effort to the Council so that people feel comfortable with it.

Mr. McGovern: It is difficult to measure the outcomes of specific programs, much less across a service category. It is a complex task that may not produce reliable data.

Dr. Okoroanyawu: IPRO uses 17 indicators for quality assurance, and for us to use their guidelines means that we would have to include co-indicators to include areas not measurable by IPRO indicators, e.g., housing.

Mr. Cruz: QM is producing indicators for not only health programs, but housing, case management, etc. The indicators are based on available data sets. We may not be able to find data for every single indicator, but we will find out which services have the best chance of providing the data we want.

Ms. Hilger: With the amount allocated for this initiative, we can not do outcomes for every program, just a few overarching outcomes. It is in its infancy stage and for only a few services. In addition, we have client level outcomes data for MAI programs.

Ms. Verdino (in response to a question from Mr. Hemraj): MHRA does the Program Monitoring Report (PMR) with data on service utilization and demographics from contract monitoring data. This is not what the Council often wanted, but we will work with you to let you know what we can provide. In future years, will be able to provide more client level data, based on the current project.

Dr. Stackhouse: As someone new to this myself, I know that this is a challenging topic, and I appreciate the participation of the new Council members.

Agenda Item #5: New Business

Ms. Moon: The draft orientation agenda is in your packet. It is geared towards new members, but continuing members are encouraged to attend. It is a packed agenda with a lot of information. Also, please send your alternate.

Mr. Abadia: I will forward information on a Latino awareness event.

Dr. Stackhouse: Thank you to everyone for your warm reception to me as Acting Governmental Co-chair.

Minutes approved by the Executive Committee on November 4, 2004

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Bill Stackhouse, PhD
Acting Governmental Co-chair