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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, July 22, 2010
3:00-5:00 pm
Cicatelli Associates, 505 Eighth Avenue, Lavender Room, 20th Fl., New York, NY

M I N U T E S

Members Present: Jan Carl Park (Governmental Co-Chair), Charles Shorter (Community Co-Chair), Steve Hemraj (Finance Officer), Victor Benadava, Felicia Carroll, Gregory Cruz, Marya Gilborn, Alexander Hardman, JoAnn Hilger (for F. Laraque, MD), Julie Lehane (for T. Petro), Gonzalo Mercado, Dorella Walters
Members Not Present: Damian Bird, John-Anthony Eddie, Joan Edwards, Graham Harriman, Lee Hildebrand, Maria Irizarry, Matthew Lesieur, Darryl Ng
Staff Present: NYCDOHMH: Rafael Molina, David Klotz, Nina Rothschild, DrPH, Anthony Santella, DrPH Darryl Wong
Public Health Solutions: Bettina Carroll, Gucci Kaloo

Agenda Item #1: Welcome/Minutes:

Charles Shorter opened the meeting, Victor Benadava led the moment of silence and members introduced themselves. Jan Carl Park reviewed the Rules of Respectful Engagement and the meeting agenda and materials. Mr. Park opened the closed session during which Ms. Walters facilitated the discussion regarding 2010-11 Planning Council recommended new appointments and re-appointments. **[Please note that proceedings from the closed session are confidential and are therefore excluded from these minutes.]**

The minutes of the May 13, 2010 meeting were approved.

Agenda Item #2: Public Comment

There was no public comment.

Agenda Item #3: FY 2011 Base & MAI Spending Plans

Marya Gilborn reported that the 2011 Base spending plan was approved at the PSRA meeting on July 8, 2010, noting the changes that were made with the $10.5M increase in the Base award, using the priority setting tool as a basis for applying proportionate increases to the service portfolio, with adjustments in ranking in outpatient medical care (Bridge) to reflect an increase in the payer of last resort, shifting of funds from MAI to base in ADAP+ in order to offset the decrease in the MAI award ADAP, allocating ~$3M in additional funds to ADAP and moving funds from youth outreach services (HRSA Ranking #12) and the Field Services Unit into EIS (HRSA Ranking #8).

ACTION: *A motion was made, and seconded, to accept the Base & MAI spending plans*

as presented. A roll call vote was taken and the motion passed unanimously.

Julie Lehane presented the Tri-county FY 2011 application base and MAI spending plans. The request is based on the carrying cost of FY 2010 programs for Early Intervention Services, Medical Case Management, Mental Health, Food Bank and Transportation Services, plus $400,000 for ADAP.

***ACTION:** As the presented spending plan contained erroneous amounts, the vote on the corrected spending plan will be deferred to the full Planning Council on July 29, 2010.*

Agenda Item #4: Substance Use Services Directive

Mr. Park presented the NA and IOC's revised guidance for substance abuse programs, which is currently funded at over $12 million in 26 programs serving 20,409 clients. Given the HRSA change in the definition of allowable services, this guidance will be the basis for the new RFP prepared by the grantee. In preparation, DOHMH and IOC reviewed: epidemiologic data, data from existing substance abuse treatment contracts, evidence-based practices for provision of substance abuse services, and current HRSA guidance on substance abuse services. Of the over 4,000 newly diagnosed cases of HIV in 2006, 27.5% were substance users (frequency data was not available for alcohol or marijuana).

HRSA's definition of core substance use services is: 1) Provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs), and 2) Outpatient treatment by a physician or under the supervision of a physician, or by other qualified personnel. HRSA also allows residential/inpatient treatment as a non-core service. HRSA limits outpatient services to: pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; outpatient drug-free treatment and counseling; opiate assisted therapy; neuro-psychiatric pharmaceuticals; relapse prevention; and acupuncture.

The EMA's current definition is easily accessible harm reduction, recovery readiness, and relapse prevention services to individuals who are HIV-positive and actively using drugs, relapsing, or in recovery, and services include: rapid HIV testing; linkage to HIV primary care; outreach in SRO hotels; individual, family or group harm reduction counseling; assessment and referral for diagnosis and treatment of sexually transmitted infections; screening and referral for substance use treatment; training and provision for overdose prevention with Narcan; individual, family, or group low threshold AOD services; and Buprenorphine treatment.

Strengths of the current model are: provides counseling in a variety of settings and methods (individual, group, family); flexibility of the 'sobriety requirement' (clients do not have to be completely abstinent); few payer of last resort issues. Challenges are: counseling services are misunderstood and underutilized (almost no agencies serve eligible entities such as client families); retaining clients is challenging due to transient and often chaotic nature of the population; focus is on services for opiate users (does not include similar interventions for more prevalent crack, cocaine, crystal meth, and alcohol users); maintaining staff with prescribing privileges (MDs, NPs, PAs) is expensive; low threshold AOD services for clients with unknown HIV status (not allowed by HRSA).

Dr. Rothschild gave a summary of the literature reviewed by IOC concerning best practices in substance use programs. Key findings include:

- Harm reduction (HR) is based on the principle that individuals can become healthier even when they are still consuming drugs, does not penalize individuals for their choices about drug use but instead supports them in an open discussion, and employs Stages of Change and Motivational Interviewing and focuses on diminishing resistance and traversing stumbling blocks.
- HR techniques include: syringe exchange, preventing death from overdose with Narcan provision, and fostering access to physical and mental health care for drug users.
- HRP diminishes the damage of illegal drug use on families, neighborhoods, and society from overdose deaths; diminishes the number of new cases of infections such as HIV and hepatitis, lessens drug-connected injuries and trips to EDs; enhances the number of individuals who are able to obtain treatment; and lowers the number of disturbances to family life.
- Treatment for substance abuse, mental health, and primary care are best incorporated and managed together.
- Client retention and engagement in treatment is crucial.
- Fostering a therapeutic partnership is key for long-term mental health and recovery goals
- Incorporation of vocational rehabilitation and general enhancement of functioning support lasting sobriety.
- Continuing education is key for professional staff.
- Treatment should incorporate motivational interviewing, group and individual psychodynamic and cognitive-behavioral approaches.
- A single screening tool should be used for substance use assessment, and should include alcohol.
- Coordinated systems needed for HIV care and treatment. "One-stop shop" model works best because clients who are dependent on drugs and/or alcohol will not make multiple visits to multiple providers.

Outreach approaches to HIV-infected substance users include: use of peer advocates to engage and retain clients in care; actively involving recent releasees from jail/prison and linking them with services; offering services via mobile units; drop-in facilities, and transitional housing for people who are using drugs but also participating in harm reduction focused groups.

The Needs Assessment and IOC Committees service model recommendations were reviewed and include: drug and alcohol, mental health and medical services should be co-located; clients receiving AOD services should be screened for mental health needs, programs should be required to have a working relationship with clients;' case managers to ensure coordination; services should include Risk/Harm reduction and risk/removal approaches and psychosocial therapies to address AOD behavioral change; harm reduction programs should use low threshold models such as street outreach/peer workers; tools to screen and assess levels of alcohol and drug use should be systematically employed with all clients; programs providing outreach to individuals at risk should include a focus on youth; programs providing services to youth should demonstrate cultural and linguistic competence; programs treating homeless adolescents for substance use should include a drop-in center for daytime and for nights; peer to peer outreach is particularly useful with youth populations and IDU clients can be referred to non Ryan-White funded syringe exchange programs while NYC awaits information from HRSA re: SEPs.

IOC and Care Treatment and Housing Service Model recommendations include:

- Services only for HIV-positive individuals with active or recent drug/alcohol use
- HIV primary care on-site or via close affiliation
- All providers required to ensure that their clients are engaged in HIV primary care, and if not receiving primary care at enrollment, that they have made a visit to their primary care provider within 120 days
- Mental health on-site and/or dually trained staff
- Methadone treatment and syringe exchange (may need to be leveraged through other sources of funding)
- Linkage with Rikers Island transitional health care
- Linkage to other Mental Hygiene programs
- Target populations: women, youth, minorities
- Consider using funding for drug treatment and medical model type services
- Use of standard tool for screening and assessment and for patient self-assessment
- Health promotion and harm reduction to decrease risky and harmful behaviors
- Harm reduction brief intervention by medical provider
- Longer intervention by other health care provider (counselor or educator)
- Evaluation of clients for smoking cessation interventions
- Assessment and referral for mental health, STDs, and other co-morbid conditions
- Targeted case finding through outreach in locations frequented by AOD users
- Drug treatment: both medication-assisted (buprenorphine, methadone, naltrexone, etc.) and psychological (counseling)
- Case management and care coordination components
- Ensure that their clients are linked to other needed services and are enrolled in a medical case management program
- Accompaniment: clients receiving AOD services may receive accompaniment services to their first primary care appointment
- Mental health expertise and services
- Development of a comprehensive care plan with individually defined milestones and goals
- Programs should progress toward client graduation
- Counseling and behavioral interventions
- Individual, family, and group counseling sessions
- Acupuncture (optional)
- Programs are expected to apply for targeted HIV testing funds if they do not yet have or are not affiliated with a rapid HIV testing program. HIV rapid testing funds should be reallocated from this service category to Early Intervention Services in order for this service to be aligned with HRSA service category guidance

Discussion focused on Item #5, Linkage to HIV Primary Care (p.3 of Draft Program Guidance): clients who have not visited their primary care provider within 120 days would be denied services; as a harm reduction program, the guidance is too restrictive and the guidance is not reflective of the discussion by IOC, although there was service provider representation on the Committee.

It was suggested that the statement "All providers are required to assess that their clients are engaged in HIV primary care, and if not receiving primary care at enrollment, that they refer them to primary care, including care coordination or other linkage to care program, within 15 days, and re-assessed every 30 days" be included in the revised guidance.

Item #2 (Rapid HIV Testing) should be modified to "Programs are encouraged to have an HIV rapid testing program or be affiliated with or encouraged to have an HIV Rapid Testing Program" and be included as a note under the components of the service model.

These modifications will be presented to the full Planning Council for approval. A motion was

> ***ACTION:*** *The motion to accept the guidance, as modified, was made, seconded and approved unanimously.*

Agenda Item #5: HRSA Technical Assistance

Mr. Park reported that Emily Gantz-McKay conducted group interviews and will be issuing recommendations within a few months.

Agenda Item #6: New Business

The Staten Island HIV Care Network issued statement addressing their concerns with respect to the FNS RFP.

JoAnn Hilger reported that NYCDOHMH is expecting the release of the Part A grant application by late July, with a due date in late September.

There being no further business, the meeting was adjourned at 6PM.