Meeting of the

EXECUTIVE COMMITTEE

Thursday, July 24, 2014, 2:30-5:00PM
DOHMH, 2 Gotham Center, 42-09 28th Street, Conference Room 19-28
Long Island City, NY

MINUTES

Members Present: Jan Carl Park (Governmental Co-Chair), Victor Alvarez, Randall Bruce (Consumer At Large), Felicia Carroll, Daniel Castellanos, Nancy Cataldi, Sharen Duke, Joan Edwards, Adrian Guzman, Graham Harriman, Lee Hildebrand, DSW, David Martin, Tom Petro
Members Not Present: Robert Cordero (Community Co-Chair), Billy Field, Christopher Joseph, Daniel Pichinson, Sam Rivera
DOHMH Staff Present: David Klotz, Rafael Molina, Nina Rothschild, DrPH, Darryl Wong
PHS Staff Present: Bettina Carroll, Gucci Kaloo
Parliamentarian: Joan Corbisiero, PRP

Agenda Item #1: Recommended 2014-17 Planning Council Appts (Closed Session)

Jan Carl Park, Governmental Co-Chair, opened the closed session, with Felicia Carroll, Chair of the Rules & Membership Committee facilitating the discussion regarding 2014 Planning Council recommended new appointments. *[Please note that proceedings from the closed session are confidential and are therefore excluded from these minutes.]*

Agenda Item #2: Welcome/Introductions/Moment of Silence
Agenda Item #3: Review of Minutes/Public Comment

Victor Alvarez announced that he will be ending his term on the Planning Council at the conclusion of this planning cycle. Jan Park acknowledged the passing of more than 100 HIV/AIDS allies, colleagues and researchers travelling to the 20th International Conference of AIDS in Melbourne, Australia, who were lost on Malaysia Flight # 17 from Amsterdam to Kuala Lumpur. Darryl Wong reviewed the meeting agenda and materials. The May and June 2014 minutes were distributed to members electronically for review and comments and were accepted as presented, noting that there were two minor corrections pointed out by Tom Petro and Lee Hildebrand.

There was no public comment.

Agenda Item #4: Integration of Care Committee

Mental Health Services

Nancy Cataldi, Co-Chair of the IOC, presented on the revised Mental Health (MH) services directive which was approved by the Integration of Care (IOC) and the PSRA Committee after extensive data review, presentations and review of current services. The goals of Part A Mental Health services are to provide treatment and care to PLWHA with mental illness, with or without substance use disorders, to improve quality of life and mental health functioning, to overcome barriers to mental health care, to facilitate ongoing involvement in bio-psychosocial care and treatment, including adherence to ART and/or psychotropic meds and to reduce use of emergency care. These goals align with a number of objectives

in the New York EMA's Comprehensive Strategic Plan, including addressing and reducing health disparities.

The philosophy behind the new directive is client-centered, non-judgmental, guided by harm reduction principles, trauma-informed (understanding the impact of trauma and paths for healing), culturally appropriate and tailored to populations served. Specific targeted populations include, but are not limited to individuals with diagnosed mental illness or in need of mental health services, persons with co-occurring mental health, substance use, and other medical conditions, chronically homeless, homeless, and unstably housed PLWHA, home-bound clients; gay, bisexual, other MSM, lesbian, transgender men and transgender women and immigrants.

Required components of the service include referral to medical care, MCM, housing, substance use treatment, independent living skills, food and nutrition, and legal services, individual and/or group treatment adherence counseling (includes discussion about PCSM, appointment adherence, ART and psychotropics adherence) and coordination with client's providers, mental health intake assessment, diagnosis, and treatment, crisis intervention and individual and/or couple/family and/or group mental health counseling services.

Optional components include psychiatric evaluations and follow-up visits, psychiatric re-evaluation, psychotropic medication monitoring and management, and linkage with inpatient psychiatric care when indicated, individual, group, and family services for clients with a history of or currently using alcohol or other drugs, client engagement activities (scheduling appointments and coordinating services), outreach for client re-engagement to monitor scheduled appointments and follow-up on missed appointments, wellness individual or support groups to educate and monitor clients on key issues related to the client's current MH needs and potential barriers to MH treatment and interpersonal violence assessment and intervention. Special considerations include accompaniment services as appropriate to external agencies and within the mental health program's facility and home-based services for clinical purposes including services listed above as appropriate and necessary.

Client eligibility is individual and family units with one or more HIV+ persons and in which the HIV+ person has a DSM-5 diagnosis. Active substance use does not preclude eligibility for and maintenance in services. Also, client must have a household income less than 435% of FPL and live within the NY EMA.

Agency eligibility includes Licensed Article 31 or Article 28 mental health providers currently certified to deliver outpatient mental health services or CBOs with an MOU with an Article 31 provider who has added the CBO site to its licensure. Organizations should have multi-disciplinary MH programs including counseling, psychiatric care and/or pharmacological management, and alcohol and substance use services, should use multiple, evidence-based therapeutic modalities and/or best practices including harm reduction approach, should have experience with HIV+ persons and active substance users, and should have experience with persons who are out of care or sporadically in care, transitioning from institutional care, or needing self-management support. Agencies must be co-located or have linkages with programs providing medical and psychosocial support services, Medicaid, Medicare, and NYS Health Insurance Exchange Systems, and health homes, must ensure that staff have HIV knowledge, training, cultural sensitivity and must be able to provide services in languages of populations served, and must be accessible to clients from throughout the NY EMA.

Next steps for the adoption of this service directive include today's review and approval by the Executive Committee, to be followed by review and consideration for approval by the Planning Council. It will then be referred to the Grantee for development into an RFP; when the RFP is released, the Planning Council will be notified by the Grantee and will be informed when providers are identified.

David Martin recommended that clients with physical, behavioral, psychosocial, or sensory impairments be included in client and agency eligibility. After discussion, a two-part motion was made to amend the Mental Health Service directive, as follows:

1) Individuals with physical, behavioral, psychosocial, or sensory impairments that may or may not limit them from presenting to an office location.

   ACTION: A motion was made, seconded and approved to adopt this language as presented.

2) The approved language will be added as the third bullet under the Program Directive and Service Model section.

   ACTION: A motion was made, seconded and approved to place this language as presented.

ACTION: With the acceptance of the two prior motions, a motion was made, seconded and

Home and Community-Based Health Services

Ms. Cataldi presented the new service directive for Home and Community-based Health Services, which was approved by the Integration of Care Committee after much discussion. The goals of the service are to provide comprehensive, coordinated home and community based healthcare, support and service coordination that addresses the full range of needs of PLWH and facilitates continued engagement in medical and psychosocial care and treatment and aims to enhance the quality of life and to reduce the number and length of hospitalizations and nursing home placements of PLWH.

Objectives are to increase proportion of newly diagnosed individuals who enter primary care within 3 months of diagnosis, increase retention in HIV care and treatment, increase proportion of clients with optimal level of ART adherence, increase viral suppression, improve immunological health, decrease reliance on acute care, reduce socio-demographic differences in delayed diagnosis of HIV, reduce socio-demographic differences in prompt linkage to HIV care after diagnosis, reduce socio-demographic differences in retention in primary medical care and reduce socio-demographic differences in viral suppression.

Required components of the service include HIV treatment education, assistance with medication adherence, client engagement activities to schedule program appointments, coordinate services, and maintain connection to primary care, advocacy services to assist with navigation of home care resources and address any grievances that may arise regarding home care, regardless of payer, outreach for re-engagement to monitor scheduled appointments and follow-up on a client's missed appointments, psychiatric evaluation and visits, individual and family supportive counseling, substance use counseling, homemaking/chore services (including child care), home health and personal care services/assistance with activities of daily living, skilled nursing services, home intravenous and aerosolized drug therapy, provision of durable medical equipment, physical therapy, occupational therapy, speech therapy, independent living skills, nutritional counseling and emergency food provision and respite for caregivers, childcare during appointments and hospitalizations. An optional component is use of a multidisciplinary team, including peer-delivered services, as some clients may initially consider home-based services an intrusion and a peer can facilitate willingness to accept services.

Client eligibility is as follows: individual and family units with one or more HIV+ persons; active substance use does not preclude eligibility for and maintenance in services; household income less than 435% of FPL; client lives within NY EMA; and clients with physical, behavioral, psychosocial, or sensory impairments limiting them from presenting to an office location. Some clients may be able to leave home, but require the assistance, for example, from a home health aide.

Agency eligibility is as follows: organizations must have experience serving HIV+ individuals and experience reaching out to and engaging individuals who are out of care or sporadically in care, transitioning from institutional care, or in need of self-management support; agencies must be co-located or have linkages with programs providing medical and psychosocial support services, Medicaid, Medicare, NYS Health Insurance Exchange Systems, and Health Homes; must have the capacity to bill

Medicaid for Medicaid-billable home based services or be in a contractual relationship with an agency that can bill Medicaid; must ensure that staff have HIV knowledge, training and cultural sensitivity and must be able to provide services in languages of populations served; and must have the capacity to provide services to clients with physical, behavioral, psychosocial, or sensory impairments limiting them from presenting to an office location. Although any individual agency does not have to serve clients from all five boroughs, funded agencies should be accessible to clients from throughout the New York EMA.

Differences with the existing model are that the new directive allows funded agencies to offer advocacy services to assist with navigating the home care system and address objections/ complaints regarding home care, irrespective of payer; allows funded agencies to include peers as part of a multidisciplinary team for providing services; addresses the issues of clients with sensory impairments; and requires co-location or linkages with programs providing NYS Health Insurance Exchange Systems and Health Homes. It was noted that the IOC Committee has recommended level funding for this service category. The PSRA Committee has reviewed and allocated approved funding levels.

If approved at today's Executive Committee, this service directive will be followed by review and consideration for approval by the Planning Council. It will then be referred to the Grantee for development into an RFP; when the RFP is released, the Planning Council will be notified by the Grantee and will be informed when providers are identified.

ACTION: A motion was made, seconded and approved to adopt the revised Home and Community-based Health Services service directive as presented.

Agenda Item #5: Priority Setting/Resource Allocation (PSRA)

FY 2013 Carry-over Request

Sharen Duke, *Co-Chair of the Priority Setting/Resource Allocation Committee*, announced that the PSRA Committee approved FY 2013 carry-over plan, based on the preliminary carry-over request approved by PSRA and the Council in December 2013. $615,731 in base carry-over and $5,669 in MAI will mostly go to ADAP. The Tri-county (TC) portion of the Base carry-over, includes $10,903 that goes to Housing and $35,312 that goes to Medical Transportation in the TC region. Also, the grantee is reporting that they expect an approximately additional $70,000 because of funds that will be freed up due to a recently-awarded NIMH grant. This would go to ADAP but is not reflected in the plan as presented.

ACTION: A motion was made, seconded and approved to accept the FY13 carry-over plan as presented, with the flexibility to add approximately $70K when it becomes available, carried unanimously.

Reclassification of Counseling Services at Syringe Exchange Programs from Mental Health to Supportive Counseling

The IOC Committee's recommendation to reclassify a portion of the currently funded mental health services (not included in the new MH directive) to the Supportive Counseling category was supported by the PSRA Committee. Currently funded at $812,733, this will provide wrap-around counseling services in State-funded syringe exchange programs. The proposed reclassification better aligns with the HRSA service definitions, and will allow small agencies that cannot get Medicaid certification to provide these services. The change is reflected in the FY 2015 spending plan.

ACTION: A motion was made, seconded and carried unanimously to adopt the reclassification of $812,733 for wrap-around counseling in syringe exchanges from the Mental Health category to the Supportive Counseling category.

FY 2015 Service Category Ranking Scores

In planning for the FY 2015 application, PSRA received updates from the AIDS Institute on ADAP, from John Rojas, newly-appointed Assistant Commissioner for Disease Control Administration, on the recent $5M cut to HOPWA, Care Coordination, including client outcomes, the Payer of Last Resort (POLR) tool and score cards. In FY 2014, PSRA made major changes to the ranking scores. In FY 2015, the PSRA Committee focused on categories with new service directives, i.e., Mental Health Services and Home & Community Based Health Services and areas where there were major changes. The Committee voted unanimously to re-affirm the previous year's ranking scores for the following categories: ADAP, ADAP+, Non-medical Case Management (both parts), Medical Case Management, Food and Nutrition, Harm Reduction, Mental Health, Legal Services, Health Education and Risk Reduction and Early Intervention
Regarding the Housing services category, PSRA voted to increase the Access to Care/Maintenance in Care score from 5 to 8 (based on an analysis of the effect of housing on viral suppression), in addition to other housing scores being re-affirmed, resulting in Housing being the third highest ranked category.
PSRA also increased the POLR score from 5 to 8 in the Supportive Counseling and Family Stabilization category, based on the lack of Medicaid reimbursement for this service. All other criteria rankings were reaffirmed. Because there are no other payers for Part A Home & Community Based health services, the Payer of Last Resort score was increased from 1 to 5, raising this category from 14th to 11th. The ranking scores are used in scenario planning when funding decreases are anticipated.

ACTION: A motion was made, seconded and approved unanimously to adopt the service category ranking scores as presented.

NYC FY 2015 Application Spending Plan

Ms. Duke acknowledged that in response to the HOPWA cuts, the PSRA Committee agreed to ask for $3,000,000 in additional funding for Housing services. PSRA also proposed an across-the-board weighted increase of 8%, including the $3M for housing, to meet unmet needs in all other Base categories and to offset some of the funds lost in FY 2013. Our MAI award, composed entirely of formula funding, remains at its current level, as the FY 2013 MAI cut was restored in the FY 2014 award. Public Health Solutions provided information regarding the ability of some categories to absorb increases based on three years' of historical spending data and utilization. Consequently, the Executive Committee voted **not** to apply the proportionate increase to Mental Health and Harm Reduction. The additional funds bring the Base award up to $101,625,113 from $94,097,327. When combined with MAI, the total request for FY 2015 is $111,447,355.

ACTION: A motion was made, seconded and moved unanimously to adopt the FY 2015 NYC application spending plan as presented.

FY15 Tri County Application Spending Plan

Tom Petro of the Westchester County Department of Health presented the FY15$5,107,871 spending plan, which includes additional funds for medical transportation, as well as $315,000 in housing services, to adjust the Tri County allocation to 4.71% of the New York EMA's award.

ACTION: A motion was made, seconded and moved unanimously to adopt the FY 2015 Tri-County application spending plan as presented.

Agenda Item #6: Planning Council/Committee Updates

Finance Committee Report

On behalf of the Finance Committee, David Klotz presented the following:

FY 2013 PC Budget Close-Out Report

Overall, the Planning Council support budget was 99% spent. There were a number of minor budget modifications in both personnel and OTPS lines.

FY 2013 Base and MAI Close-out Reports

Overall, spending was at record levels, with 100% of the Base and MAI awards committed, with only 0.65% of the Base, or $615,733, and 0.06% of the MAI award, or $5,600, unspent. Of Base funds, $503,692 of the under-spending was in the Quality Management program, and $60,381 from NYC administration, due to staff vacancies resulting from the late arrival of the award, as NYCDOHMH was unable to post positions until the award was received. Most of the remainder of the under-spending was in the Tri-county portion of the grant.

Due to the late award, the first round of contract one-time take-downs, affecting 30 contracts for a total of $1.4million, was performed in January. After close-out, 68 contracts, representing $1.7 million in contract reductions, were taken down; per the Council's re-programming plan, these funds were reprogrammed to 80 over-performing contracts ($3.1M), for a total of $3.8M in contract enhancements. While 35% of Base and 27% of MAI contracts were enhanced, enhancements had to be capped because sufficient funds were not available to enhance every over-performing contract. In FY13, the Tri-County region also demonstrated a record year for spending, with only 2%, or $51,880, compared to 11% the previous year, in under spending.

Assessment of the Administrative Mechanism

A checklist summarizing the work of the Finance Committee to fulfill the legislative requirement to assess the administrative mechanism on the timely allocation of Part A funds was provided.

Subcontracts were executed and renewed on a timely basis using the partial award, which only allowed for 4 months of contract amounts for Base contracts and 5 months for MAI contracts. Notification of the full Ryan White Award was received on June 18th. The NYC EMA received a large reduction to its award in 2013 (14.75%). DOHMH and Public Health Solutions created a plan to implement the cuts which impacted all subcontracts. Contracts were adjusted and renegotiated and executed on a timely basis. Uncommitted funds resulting from contract negotiations and/or contract terminations were reprogrammed on a one-time basis as per the Planning Council's reprogramming plan.

A Request For Proposal (RFP) for Ryan White Housing Services was released on 7/24/13. Contract awards for the Ryan White Housing Services RFP were announced on December 9, 2013. A total of 14 awards were made as follows: Short Term Rental Assistance: 1; Short-term Housing Services: 8; and Housing Placement Assistance: 5. The contract awards were posted on Public Health Solutions' website. Negotiation meetings, led by DOHMH Housing staff with Public Health Solutions staff in attendance occurred from January 9-16, 2014. Contracts were executed on a timely basis. The list of housing providers resulting from this RFP were announced to the Planning Council in the December 2013 Grantee report.

As with the previous year, sub-contractors were paid in a timely manner (within 30-60 days) of receipt of a complete and accurate expenditure report / invoice. FY 2013 expenditures by service category were reported quarterly to the Finance Committee, the Executive Committee and the full Planning Council. Spending rates continued at record high rates. Modifications to the spending plan were reported by service category to the aforementioned committees and to the full Planning Council and matched the PC's reprogramming plan.

> ***ACTION: A motion was made, seconded and approved to adopt the assessment of the administrative mechanism as presented.***

Policy Committee Update:

Adrian Guzman, Co-Chair of the Policy Committee, provided an update:

- The Florida AIDS Institute recently filed a complaint with the Department of Justice regarding four qualified health plans which have categorized HIV antivirals as Tier 5 drugs, with deductibles as high as $2,700, with 50% co-insurance, alleging that the pricing dissuades PLWH from joining these plans, which may constitute unlawful discrimination.

- In June, Governor Cuomo announced the Plan to End AIDS, which comprises an increased focus on HIV testing, linkage to and retention in care to enhance viral suppression and the availability of PREP to high risk individuals in New York.

Agenda Item #7: Grantee Report

Graham Harriman, Director of the Care & Treatment Program, reported that HRSA released the application guidance for FY2015 Part A funding earlier this month. The Planning Council and the Grantee both contribute to the final document, with Planning Council members being given the opportunity to review the application on August 19th & 20th, before submission to HRSA in mid-September.

The NYCDOHMH Commissioner of Health announced this week that *Demetre Daskalakis, MD, MPH has been appointed as the Assistant Commissioner for the Bureau of HIV Prevention and Control.* After completing his training and moving to New York City in 2005, Dr. Daskalakis established himself as a leader, innovator, and spokesperson for people living with HIV and gay and bisexual men. He pioneered programs that brought HIV testing, meningococcal meningitis vaccination, and other vital medical care into bars, clubs, bathhouses and other non-traditional settings to reach men at risk of HIV and other infectious diseases. In 2013, he played a vital role in helping stop an outbreak of meningococcal meningitis among men who have sex with men, running community events that vaccinated over 2400 men, an estimated 10% of all men vaccinated in NYC as part of the outbreak response. Since July 2013, he has served as an associate professor and medical director of the HIV program at Mt Sinai School of Medicine. In his new role, Dr. Daskalakis will be responsible for accelerating declines in HIV infections and eliminating disparities in HIV mortality through adoption of new tools, intensified community outreach, and strengthening of existing programs. As previously mentioned, John Rojas has been appointed interim Assistant Commissioner of Disease Control Administration & Management.

Planning Council members are invited to join the Care and Treatment Program in our interagency meeting with the New York State AIDS Institute to discuss service category and quality management indicators.

It was noted that today is Council Member Victor Alvarez' birthday. Thanks were extended to outgoing Executive Committee members Victor Alvarez, Lee Hildebrand, Nancy Cataldi and Felicia Carroll for their service to the Planning Council.

Agenda Item #8: Public Comment

There was no public comment.

Agenda Item #9: Adjournment

There being no further business, the meeting was adjourned at 5:30PM.