Meeting of the

EXECUTIVE COMMITTEE

Thursday, July 14, 2005
2:30-4:25pm
Friends House, 130 E. 25th Street

M I N U T E S

Members Present: B. Stackhouse (Acting Governmental Co-chair), P. McGovern (Community Co-chair), S. Hemraj (Finance Officer), S. Abramowitz, PhD, M. Barnes, E. Camhi, F. Carroll, C. Cobb, H. Cruz, I. Gamble-Cobb, J. Grimaldi, MD, J. Hilger, J. Lehane, PhD (for T. Petro), H. Mateo, D. Ng, W. Okoroanyanwu, MD, J. Pressley

Staff Present: OAPC: G. Moon, D. Klotz, R. Shiau, S. Bailous, C. Silva, I. Gonzalez, R. Molina, M. Lesieur; DOHMH: S. Kellerman, MD, MPH, J. Park; MHRA: R. Miller, G. Kaloo, B. Carroll

Agenda Item #1: Welcome/Minutes

Mr. Stackhouse and Mr. McGovern opened the meeting.

Mr. Pressley introduced the moment of silence in honor of Amy Herman, who passed away recently after a long struggle with cancer. Amy was the previous Executive Director of the New York AIDS Coalition, a mentor to Mr. Pressley and many others, and a fighter for PLWHA.

The minutes of the June 9, 2005 meeting were approved with no changes, with three abstentions.

There were no public comments.

Agenda Item #2: Preliminary FY 2006 Spending Plan

Mr. Pressley: The discussions of the Priority Setting & Resource Allocation Committee (PSRA) and its Task Force were very difficult. Earlier this year, we implemented an across-the-board cut, and this year we wanted to do our planning in a more considered manner, based on the best data we have. I want to thank the Task Force members, particularly its leaders, Mr. Camhi and Mr. Petro, for their hard work on this task.

Mr. Camhi: Through 2001, the New York EMA could rely on increases in Title I appropriations to sustain a growing service portfolio. With additional funds, the Planning Council expanded programs and developed new programs. In FY 2003 (Year 13), the New York EMA received an unexpected $14M cut in its Title I award. There have been challenges in developing a spending plan that cuts programs, which resulted in an agreement that in the future, the Council needed to develop a more systematic and rigorous scenario planning process. Key issues during the PSRA's 2005 scenario planning process were: across-the-board cuts (planning vs. "paralysis"); best available data vs. "impressionistic" info; lack of a transparent, repeatable process for setting priorities and allocating resources from year to year. It was decided to convene a task force to address priority-setting and resource allocation issues. The Task Force, composed of 17 members from the Council and grantee, met seven times for a total of over 28 hours. The Task Force was charged with developing a priority-setting "tool" that would provide a rational way to

evaluate the portfolio given the data that we have, applying the tool in a transparent process to the service categories, and developing recommendations for changes/recommendations to the service portfolio.

The tool that the Task Force developed does the following: defines the set of features to take into account or evaluation criteria; Decide on the relative importance of the features or evaluation criteria ("weighting factors"); Rank from 0 (None/Poor) to 3 (Excellent) how well each item meets each evaluation criteria. The weighing factors are: Payer of Last Resort, Access/Maintenance, Service Gaps/Needs, HRSA Core Service Category, and Consumer Priority. During the Task Force's deliberations, all members disclosed their conflicts of interest, all members voted, votes of members with conflicts were noted and tracked, and PSRA voted to include all votes. Data sources used were: 2005 Needs Assessment Update; CHAIN (various reports from 2004 and 2005); Service Gaps/Needs data; Consumer Advisory Board Survey; 2004 & 2005 Community Forum Reports; 2004 NAPWA Focus Group Reports; 2005 Data Days; expertise of the group.

Ms. Mateo: Thank you to the Task Force and Mr. Camhi and Mr. Petro for their hard work. The recommendations of the PSRA are: 1) Air Bridge, Adult Day Care, Buddy Services, Housing Enhancements for Special Populations, and Tuberculosis Services will not be in the Year 16 Spending Plan submitted to HRSA. 2) Limit Technical Assistance to 2.5% of total program funding (LTI is not part of the reduction). 3) Use the funds allocated to the above to enhance service categories that improve access to and maintenance in care: 3a) Ambulatory Outpatient Care/Outstationed Medical Care Teams in Commercial SRO Hotels and Homeless Shelters (+$576,394); 3b) Ambulatory Outpatient Care/Maintenance in Care: fund additional programs; all new programs to be base-funded; provider eligibility expanded to any organization with on-site HIV primary health care services (not just limited to Article 28 facilities (+$700,000); Mental Health Services: additional programs out-stationed/co-located within HIV/AIDS supportive housing programs (+$500,000); Substance Abuse Services/Integrated HR/RR/RP & Family HR/RR/RP: additional programs out-stationed/co-located within HIV/AIDS supportive housing programs (+$1,000,000); Housing/Emergency Rental Assistance (+$1,732,787); Housing/Emergency and Transitional Housing: provide additional units of emergency/transitional housing for various populations (+$1,000,000); Outreach Services/Access to Care: fund additional programs; all new programs to be base-funded (+$700,000); Early Intervention Services: fund additional programs with broader service settings to include all appropriate settings with high HIV prevalence (+$700,000).

Mr. Pressley: PSRA used the Task Force's tool and followed the available data to recommend funding additional initiatives through a request for funds above the current level of funding. Early Intervention Services ($571,600)**;** ADAP Pools (est. $4M – full cost of the program); Emergency Rental Assistance ($500,000); Outstationed Medical Teams in SROs ($500,000); Housing Referral Coordination ($500,000 in MAI); P&E Initiative - Primary Care Status Measures & CHAIN ($360,000). The last six initiatives, formerly funded through reprogramming, would be put into the base award. Thank you also to Ms. Moon and Mr. Shiau for their invaluable support.

Mr. Pressley (in response to a question from Dr. Grimaldi): There was no specific formula for deciding on dollar amounts for increases.

Mr. McGovern: Dollar amounts were tied to the amounts from categories that were decreased. For example, funds from Adult Day Care went to Harm Reduction, since that category provides a similar service.

Mr. Pressley: As another example, funds from Housing Enhancements for Special Populations were reallocated to mental health and harm reduction categories for use in SROs.

Mr. McGovern: We need to be more explicit in the intent for each of our proposed reductions, when presenting this to the full Council.

Dr. Abramowitz: There are areas of disagreement with the rationale presented in the PSRA grid. For example, CHAIN supports the continued need for case management for women and children, and many dental services are still not reimbursable by Medicaid and have a huge demand, and so are under-weighted vis-à-vis payor of last resort. The nature of the Council membership means that when there is turnover, a key member with knowledge of a certain issue might not be present, such as dentist Dr. Peter Catapano.

Mr. McGovern: I suggest that the Council fund an analysis of payor of last resort, as we weighted this criterion instinctively.

Mr. Barnes: The process used should be praised. There will be objections to specific recommendations, as it is always hard to do zero-sum planning and to prioritize services. It is not that the services being eliminated are bad, but that that some have higher priority given the funding that we have. We should not pick apart the plan. While there might be objections to specific items, it was derived through as scientific, transparent and fair a process as possible. I move to accept the plan as presented. [Seconded]

Mr. Cruz: After reauthorization, we may have to change some of these recommendations, as HRSA may change what can and can not be funded. We should clarify which funds are redirected and what is a new request.

Ms. F. Carroll: The PLWHA Advisory Group has reviewed and endorses this plan. We are happy with the high level of consumer participation in the process.

Mr. Hemraj: The CAB Survey was critical is assessing needs, yet it is still a challenge to get agencies to complete it. I propose a friendly amendment that the Council recommends that completion of the annual survey be incorporated into all Title I contracts. [Accepted]

Mr. Camhi: Since we developed these recommendations, there is new information that not all TB services are reimbursable, specifically directly observed preventive therapy (DOPT). We should maintain funding for this portion of the service.

Mr. Ng: Utilization of TB services declined greatly, and there is definitely evidence that it needs to be cut. Two programs are currently funded, and we can modify the proposal to fund only one, thus scaling back the category.

Mr. Camhi: TB has resurfaced in the past and could again.

Ms. Hilger: We did some more homework after the Task Force met and found that the service is being used for people in SROs, who are exactly the population that we should be serving. If we pull out, there may be a negative result.

Dr. Grimaldi: The SRO population often has concurrent mental health needs that would make DOPT particularly urgent.

Mr. Barnes: I accept as a friendly amendment that half the TB category be restored.

Mr. Pressley: This could be done by increasing the amount of the additional funding request.

Ms. Hilger: I recommend taking the funding out of Emergency Rental Assistance. [Accepted]

Mr. Ng: I would add to the justification for the 2.5% cap on TA funds that given scarce resources, Title I funded TA services should be provided only to Title I contractors, with the exception of Housing TA. [Accepted]

Ms. B. Carroll: Regarding the CAB Survey, this year, OAPC and HIV CARE Services co-signed the letter, which helped bring the response rate up to over 60%. There were some problems however. Some responses came to the HIVCS office, rather than OAPC, including with client names, which raises HIPAA regulation issues. Also, mandating the survey in the contracts is problematic, as it is difficult to monitor.

Mr. Barnes: There is no reason to get into that level of detail. The master contractor can implement this recommendation as it sees fit, as long as the providers make a good faith effort to complete the survey.

Ms. Hilger: I want to reinforce that such a big change to the portfolio will require two years to fully implement.

Mr. Barnes: I encourage everyone here who votes in support of this plan to support it at the Council meeting next week and not back down under pressure from advocates for particular programs.

Ms. Gamble-Cobb: Make sure the recommendations and background goes out to the Council well in advance of the meeting. It is a lot to absorb.

A vote was taken and the spending plan, as amended, was approved unanimously.

Dr. Okoroanyanwu: It looks like we did use data to evaluate program performance.

Mr. Camhi: While we could always do more, the challenge was to use what was available to us. Also, program performance is really a grantee monitoring task. Our task was different – to determine the services and allocations that best meet the greatest need of PLWHA.

Mr. McGovern: MHRA staff participated meaningfully in the process, providing us with non-contract specific data. Also, PSRA's work is a small part of the entire process of determining priorities. We rely on the work of the Needs Assessment Committee, the Integration of Care Committee, etc. to tell us what data to use and what service models are appropriate.

Mr. Cruz: Ten years ago, Mr. Barnes and I created the Air Bridge programs, and it is painful to vote it out of existence. However, the process was fair and we had to make a hard decision, but I just want to say that it saddens me to see it end.

Ms. Mateo: I am proud to have been part of this process. We had a lot of expertise, a high level of consumer participation, and came up with the best tool that we could. It will improve as we continue to use it.

Mr. Ng: These changes will look great in our Title I grant application, showing the reviewers that we did the work needed to respond effectively to CARE Act mandates.

Mr. McGovern: Thank you to Mr. Pressley and Ms. Mateo, Mr. Camhi and Mr. Petro and everyone involved for a fair and transparent process.

Dr. Lehane: The Tri-county spending plan (already approved as part of the overall spending plan), contains no changes from FY 2005.

Agenda Item #3: Proposed Bylaws Changes

Mr. Cobb: Since the discussion at the last Council meeting, the Rules and Membership Committee (R&M) met to address the concerns raised at the meeting. We eliminated the clause giving the co-chairs authority to act on behalf of the Council. After looking at other EMAs' conflicts of interest (COI) rules, we also revised the COI language in our bylaws to clarify and strengthen it. Also, Mr. Barnes has a few small additional changes to recommend.

Mr. Barnes: I do COI language for clients regularly, and it is standard to add spouses and other family members. In other words, if your wife works for an agency, you should not vote on a matter that would benefit that agency.

Mr. Cruz: Under the current language, the AIDS Institute (AI) could not vote at all, as we get funding in almost all categories. Would we be able to participate? I am concerned that we would not.

Mr. Banes: We can add language that governmental interests are not prohibited from voting on behalf of the public interest.

Mr. Cobb: We want to satisfy HRSA, but respect our EMA's unique relationships. I agree with Mr. Barnes' suggestion.

Ms. Hilger: The idea is not to preclude members from votes on the general spending plan or reprogramming plan, but rather, it is meant for one specific category or enhancement. Broad language would preclude a majority of members from voting.

Mr. Barnes: Without knowing the history of the discussions on this issue, when I read it, I understood that it would not preclude voting on broad plans, but on specific categories, when it would involve one's own agency.

Mr. Cruz: I still think it is too general. There are specific elements in large groups of categories that would benefit agencies.

Mr. Barnes: There is already a specific statement that clearly says one could vote in such a case.

Mr. McGovern: We need to reconcile that sentence with an earlier sentence that members may not vote on matters regarding allocations to service categories.

Mr. Ng: How about changing service "category" to program"?

Dr. Okoroanyanwu: There is also an oversight in the section on the composition of the Integration of Care Committee. There should be a member of both the Access to Care and Maintenance in Care Sub-committees.

Mr. Cobb: We will add that.

Mr. Barnes: I suggest that we adopt Mr. Ng's suggestion and add a sentence that governmental entities can vote.

Mr. Cobb: I accept and move to accept bylaws changes as revised by Mr. Barnes and Dr. Okoroanyanwu. [Seconded]

The motion was approved unanimously.

Agenda Item #4: New Business

Ms. Moon: The revised draft Comprehensive Strategic Plan is available for your review. We had planned to finalize it last week, but we received additional guidance from HRSA. We will talk to out HRSA project officer on how to proceed.

Mr. Cruz: NYS objected to some HRSA requirements on our strategic plan that will be hard to comply with. We are putting our displeasure in writing. In addition, I was on a conference call recently with states that receive SPNS grants where I heard about two proposed changes in reauthorization that will negatively impact high incidence states. One could result in New York losing 58% of its base Title II funding (contracted activities, not ADAP). Also, there is a proposal to eliminate the "hold harmless" provision, which will result in drastic shifts in funding. There have been private meetings with the White House, legislators and our state Congressional delegation. 18 states (CA, TX, PA, IL, NJ, PR, others) will lose money. We are coming up with joint strategy to fight this and will need help from the community and the CAEAR Coalition.

Mr. Cruz (in response to a question from Mr. Cobb): We are in contact with all potentially influential Congress members. Several AIDS Action Council proposals would negatively impact NYS and we oppose them.

Mr. Cobb: I suggest that you talk to Debra Frazier-Howze.

Mr. Cruz (in response to a question from Mr. Pressley): NASTAD is in a difficult position. They have to be neutral, unlike CAEAR, which is supported by high incidence EMAs.

Mr. Pressley: NYAC is doing a tour upstate, and we can get the message out.

Mr. Cruz (in response to a question from Mr. Hemraj): Consumers will be negatively impacted; a lot of service dollars will be eliminated. Any group advocacy would help. We will coordinate it with you.

Mr. Cruz (to Abramowitz): I can share a two-pager we have created for dissemination. The NY/NJ AETC lost 20% of its funding due to "geographic redistribution of resources". This is a portent of an attempt to redirect funds to other parts of country.

Ms. Carroll: I encourage Council members to become involved in the Campaign to End AIDS, which has demands to fully fund quality treatment to all, ramp up prevention efforts based on science, increase research for treatments, fight stigma and protect civil rights of PLWHA.

Mr. Hemraj: It's been a rewarding two years on the EC, thanks.

Dr. Abramowitz: This is my last EC meeting, as I complete four years on the Council. It took two years to learn how things work, and then when you have the most to contribute, it's time to leave. Nevertheless, I have enjoyed it a lot. Congratulations and good luck to all.

There being no further business, the meeting was adjourned.