Meeting of the

HIV Health and Human Services Planning Council of New York

December 20, 2007
3:10-5:10 PM
LGBT Center, 208 W. 13th Street

DRAFT MINUTES

Members Present: J. C. Park, MA, MPA (Governmental Co-chair), S. Elcock (Community Co-chair), E. Telzak, M.D. (Finance Officer), B. Backofen, R. Bramble Weed, E. Camhi, C. Checa (for L. Freddy Molano, M.D.), J. Edwards, A. Etienne, T. Faulkner, Y. Gebhardt (for E. Viera, Jr.), A. Gutkovich (for D. Marder, M.D.), J. Irwin, G. Joseph (for T. Mack, M.D., M.P.H.), P. Laqueur (for I. Feldman), F. Laraque, M.D., J. Leandry-Torres, J. Lehane, Ph.D. (for T. Petro), M. Lesieur, F. Machlica (for L. Fraser), D. Ng, G. Philip, A. Richardson

Members Absent: A. Aviles, M.D., M. Bacon, L. Bishop, M. Brune, R. Canosa, F. Carroll, I. Gamble-Cobb, A. Hardman, R. Jackson, V. Jarvis, M.D., G. Mercado, W. Okoroanyanwu, MD, A. Perry, A. Quinones, L. Scaccabarrozzi, S. Self, Ph.D., R. Spellman

Staff Present: *DOHMH:* J. Hilger, D. Klotz, D. Wong, R. Molina, N. Rothschild, B. Cutler, M.D., Ph.D.; *MHRA:* R. Miller; *CHAIN*: G. Lee, Ph.D.

Agenda Item #1: Meeting Opening/Minutes

Ms. Elcock opened the meeting.

Ms. Faulkner introduced the moment of silence.

Rev. Backofen reviewed the rules of respectful engagement.

Mr. Park reviewed the agenda, meeting packet and January meeting calendar.

Mr. Park: We had a lengthy discussion on the format for public comment at last week's Executive Committee meeting. The public comment periods are an opportunity to bring issues of importance relevant to PLWHA to the Council. We would like people to choose only one of the periods so that everyone gets a chance to speak. Your comments will duly noted and we will respond if the issues is in the purview of the Council, but we will not get into a back-and-forth on every issue.

The minutes of the November 15, 2007 meeting were approved with no changes.

Agenda Item #2: Public Comment, Part I

M. Ducret: At a recent community forum in Washington Heights, I told representatives from the AIDS Institute that they need to target prevention messages to youth of color.

V. Benadava: We need to publicize the availability of post-exposure prophylaxis (PEP) so that people who are potentially exposed to HIV can get treatment to prevent infection. PEP also needs to be available at night, which people are most likely to need it.

Agenda Item #3: PLWHA Advisory Group (AG) Report

Ms. Etienne: At the December 8th AG meeting Mr. Camhi gave a marvelous presentation on SNPs and the priority setting process. Mr. Lesieur also gave a wonderful presentation on policy issues, particularly Medicare part D and federal appropriations. Dr. Laraque also attended and explained her role at DOHMH and said that we were welcome to come to her with our concerns. The AG approved a letter to ask the NYC City Council to come to the Planning Council or AG so that they know what is going on in their communities. The AG's sub-committees have been doing public education on the Council and AG. Our next meeting is January 12th, featuring a presentation on smoking cessation. We hope to see more Council members there. We also want to thank Mr. Wong and Ms. Rothschild for helping out in Mr. Molina's absence.

Agenda Item #4: Finance Committee Update

Dr. Telzak: I chaired my first meeting as Finance Officer on December 3rd. The Finance Committee was established in 2003 in a year of unusually high under-spending. This year, the consequences of under-spending are more dire. Our task is to make sure that the grantee rapidly allocates funds as per the Council's priorities. The new HRSA policy on under-spending, as best we understand, is that EMAs must track formula, supplemental and MAI spending separately. Unspent formula funds will be returned to HRSA, and if it is over 2% of the formula award, it will be applied to the next year's award and we can not apply for a supplemental grant. Thus, careful monitoring is of the utmost importance. As of the 2nd quarter. over 99% of funds were committed, leaving only $850,000 from contracts that were declined or relinquished. MHRA finds a use for those funds, or they become available for on-going reprogramming. The second quarter report showed strong spending compared to the same point last year. This is especially good since there are new contracts in 5 categories. Those start-ups are being reimbursed on a cost basis for the first six months, then on a performance basis. MHRA is doing aggressive take-downs, but close monitoring that the second (performance-based) half of the year will still be required, thus the Committee agreed to meet in January to assess spending in month 8, instead of at the end of the 3rd quarter. Also, the commitment and expenditure report will be enhanced to show reprogramming/enhancements.

Mr. Ng: In light of the 2% rule, we need to do our best to spend down the funds. Is there plan to spend money quickly?

Ms. Miller: HRSA is silent on how we account for formula and supplemental funds, and so we are being strategic on how we report those, and we will make sure that formula under-spending is under 2%.

Ms. Miller (in response to a question from Ms. Bramble Weed): There were 32 take-downs in the first round for new contractors during their cost-based reimbursement period. We prorated their spending and took them down accordingly. The second round is going on now, including permanent cost-based reductions.

Ms. Miller (in response to a question from Mr. Lesieur): The first 32 take-downs were all new contracts in their start-up period. We always expect under-spending in start-ups, but it was lower than expected.

Agenda Item #5: Carry-over Waiver

Mr. Park: Generally, when we need make decisions about funding, it is vetted thru the EC. However, we only just found out that we have to submit this to HRSA, and so we are bringing it directly from the Priority Setting & Resource Allocation Committee (PSRA) to the full Council.

Ms. Hilger: HRSA has issued a new requirement that we have to submit carry-over waiver by January 2nd. In the past, we developed a carry-over plan after we had an idea of what the amount will be after the Financial Status Report is completed in June. Because we have flexibility in how we spend the formula award, it is in our interest to

spend the formula award first. We are proposing to use 2% of carried-over formula funds into FY 2008 ($1.49M). Last year, we carried over $2.6M of the total award. HRSA can not consider the proposal until the FSR is reconciled (August), and so there is no expectation that we will receive the carry-over any earlier than in the past. This is one-time funding that we have to track separately. The plan, approved yesterday by the PSRA, is to spend 100% of the carry-over to pay for prescriptions through ADAP (4,365 at $339/each) for 1459 participants thru February 2009.

Mr. Camhi: It should be noted that PSRA voted unanimously to support this.

A motion was made, seconded, and approved unanimously to accept the carry-over waiver plan as recommended by PSRA.

Agenda Item #6: HIV Prevention Update

Dr. Cutler: The DOHMH HIV prevention program focuses on: HIV testing and linkage to care, condom distribution, harm reduction, and social marketing and media. In October 2005, the NYC Commission on HIV/AIDS recommended that we increase voluntary HIV testing and linkage to care of those who test HIV-positive, monitor HIV testing closely, and evaluate testing programs and expand those that are effective. In addition, the CDC issued new testing guidelines calling for voluntary HIV testing for patients in all health-care settings. DOHMH provides funding for testing directly through testing sites (e.g., STD clinics, homeless shelters, jails), and in hospitals and CBOs through grant-funded programs. From 2005 – 2006, the number of HIV tests increased from 100,000 to 135,000 (35%), and the number of positives identified went from 1369 to 1518. For 2008, DOHMH has awarded a $5.4 million grant to expand testing among populations disproportionately affected by HIV, is collaborating with STD, TB, Hepatitis C, and the Field Services Unit to scale up/integrate testing efforts, and has devised a social networked-based strategy for HIV testing recruitment. DOHMH has started a pilot 3-year testing initiative in the Bronx with the goals of: test every Bronx resident (18-64) who has never had an HIV test (approximately 250,000), identify undiagnosed HIV-positive persons, and increase routine offer of HIV test in medical and community settings.

DOHMH's condom distribution program includes: the NYC-branded male condom, water-based lubricant, female condoms, HIV & sexual health brochure coordination, community presentation coordination, and the new NYC Condom Dispenser (2/14/08). Since the new condom initiative started, condoms distributed have gone from 250,000/month to 1.5 million/month. Our harm reduction program includes 12 syringe exchange programs, 4 expanded syringe access sites, and overdose prevention. We are currently conducting three media campaigns: HIV prevention among young MSM, the NYC condom/dispenser launch, and the Bronx-wide HIV testing initiative, as well as the "HIV stops with me" campaign.

Dr. Cutler (in response to a question from Ms. Faulkner): The Bronx initiative is now in the technical assistance phase. We are meeting with leaders of Bronx hospitals and CBOs on how to increase testing capacity and providing TA on getting a waiver to implement rapid testing.

Mr. Camhi: If the rate of newly identified HIV-positives increases as expected, you will need to prepare adequately for bringing them all into care.

Dr. Cutler: We are creating a resource directory for referrals.

Dr. Cutler (in response to a question from Mr. Lesieur): For the new condom dispensers, we have prioritized ZIP codes with high prevalence rates where condoms are not readily available, and are targeting high traffic sites, such as bars and clubs.

Dr. Cutler (in response to a question from Ms. Edwards): We hope to replicate the Bronx initiative in the other boroughs. The Bronx was selected because it is disproportionately affected with higher HIV mortality and the number of people who have never been tested. Also, the hospitals there have a strong history of collaboration.

Dr. Cutler (in response to a question from Ms. Irwin): We started the media campaign for young MSM because of the disproportionate increase in the number of new cases. We hope to expand to women of color and other populations.

Dr. Cutler (in response to a question from Dr. Telzak): There is some seed money for the Bronx, but not for distribution to programs. We provide test kits, TA and media to encourage testing.

Dr. Cutler (in response to a question from Mr. Philip): We will evaluate the program quarterly looking especially at an increase in testing.

Mr. Laqueur: Project WAVE in the Bronx is active in getting community groups and churches to encourage testing. You should consider working with them.

Dr. Cutler (in response to a question from Ms. Bramble Weed): Currently female condom distribution is mainly through the district public health offices, but we hope to scale up the number. We also hope to include undocumented people in a media campaign to encourage testing.

Agenda Item #7: PLWHA Over 50 Data

Dr. Lee: In New York City, older PLWHA represent a much higher proportion of all PLWHA than in the rest of the country. The proportion of older PLWHA will continue to increase because the proportion of older PLWHA among the newly diagnosed is high, and the average age of PLWHA continues to increase. CHAIN has examined whether the differences and similarities among age groups remain the same in the current cohort. We found that older cohort members were more likely to be male and to reside in Manhattan than younger members. Older cohort members were better off financially than younger members and reported higher income and fewer difficulties paying for utilities, clothing and recreational activities. Older cohort members are more socially isolated than younger members, more likely to have been infected through injection drug use (IDU), and are less likely to be MSM or IDU/MSM. More older cohort members indicate "sickness" as a reason for HIV test. HIV-related clinical health outcomes (CD4 count and viral load) are similar. Physical health functioning is worse among older cohort members. Older cohort members have higher rates of chronic conditions (e.g., hypertension). Older cohort members have higher scores on a standard measure of mental health functioning and report lower perceived stress. Older cohort members have lower rates of all risk behaviors and report lower rates of need for a range of ancillary services: alcohol or drug treatment, professional mental health services, supportive counseling, housing, and transportation. Older cohort members have a higher level of unmet need for housing services

Dr. Lee (in response to questions from the public): CHAIN subjects are a representative sample of PLWHA from the entire City and are followed for around 8-10 years. We also interview the unconnected to care.

Mr. Park: CHAIN studies delved into in more detail at NAC. To follow up, often questions arise about services that we provide. Have asked MHRA to provide brief overview of what Part A services they are accessing.

Ms. Miller: Recent data from unpublished program level unique client data shows the same approximate prevalence of PLWHA over 50 in Part A programs as the CHAIN cohort. In general, over 50 clients received a similar proportion of services than those under 50. They received a slightly larger proportion of care coordination, primary care and substance abuse services, and had a slightly higher utilization level of treatment adherence services.

Agenda Item #8: Grantee Report

Dr. Lehane: Tri-county is in the last stages of reviewing 13 medical case management proposals. We hope to announce the awards in January.

Agenda Item #9: Policy Issues

Mr. Lesieur: There are two letters in your packets generated by the Policy Committee and approved by the EC. One is to Congressional appropriators asking for an increase of $84M for Ryan White, which was the amount that the

president had previously vetoed. Congress passed an omnibus bill yesterday for all non-defense appropriations, and Ryan White got a $29M increase, $23M of which goes to Part A. We have also commented on the proposed HRSA policy on waivers from the 75% core medical services requirement, even though our EMA meets the requirement. Our biggest concern is that grantees only have one opportunity to request a waiver, and so if an EMA gets a cut in their award and has to reallocate funds, they may not be able to do so appropriately.

Agenda Item #10: Public Comment, Part II

J. Livigni: We need more information on how to support PLWHA.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on January 17, 2008.

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Jan Carl Park, MA, MPA
Governmental Co-chair