

# HIV Health and Human Services Planning Council of New York

Joint Meeting of the

## EXECUTIVE COMMITTEE and PLANNING AND EVALUATION COMMITTEE

SEIU/Local 1199, 310 W. 43<sup>rd</sup> Street

May 13, 2004

2:10-5:50pm

### MINUTES

**Members Present:** F. Oldham, Jr. (Governmental Co-chair), S. Hemraj (Finance Officer), J. Pressley (Chair, Planning and Evaluation Committee), S. Abramowitz, PhD, B. Agins, MD, M. Barnes, E. Baez (for M. Wainberg, MD), G. Brown, MD, R. Chavez, B. Chu, MD, H. Cruz, M. Hill, PhD, J. M. Garcia-Orduna (ex-officio), H. Melore, D. Ng, R. Ortiz (ex-officio), A. Paige-Bowman, T. Petro, E. Santiago, P. Stabile

**Members Absent:** R. Abadia, C. Cobb, B. Curry, L. Fraser, S. Halperin, T. Hamilton, F. Machlica, N. Nagy, T. Troia

**Guest Present:** D. Barr

**Staff Present:** *OAPC:* R. Cordero, D. Klotz, G. Moon, S. Dwyer, S. Bailous, I. Gonzalez, C. Miller, R. Shiau, C. Silva, R. Molina, M. Lesieur; *DOHMH:* J. Hilger, *MHRA:* J. Verdino, B. Carroll, R. Miller, P. Jensen

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#### Agenda Item #1: Welcome/Introductions/Announcements/Public Comment

*Mr. Pressley* opened the meeting followed by the moment of silence.

*M. Gold:* I attend many planning bodies and I am seeing an increased need for services. People are still dying, with many recent deaths. People are not getting the education they need on the availability of services.

#### Agenda Item #2: FY 2004 Reprogramming Plan

*Mr. Pressley:* For background, the full Planning Council has already approved the allocation of the first \$5.4M of under-spending for the ADAP pools, followed by four Planning and Evaluation (P&E) initiatives. Today we will consider what the workgroups have proposed. After we finalize this list, we will rank them and forward them to the full Planning Council for final review and approval at the May 20, 2004 meeting.

*Mr. Ng:* The Policy Committee's letter to the Mayor on the City budget should be on the agenda so that we can approve it and send it out.

*Mr. Pressley:* We will add it. I have also asked DOHMH and MHRA to provide us with guidance on the feasibility of the proposed reprogramming initiatives, which is in a memo in your packet.

*Mr. Chavez:* The Infrastructure Workgroup only looked at one-time initiatives. We were not aware that we could propose on-going initiatives.

*Mr. Cordero:* It was made clear in the April 1, 2004 memo from the P&E Chair to the workgroups that, while most of the available funding would be for one-time, that there would be some uncommitted funds for on-going initiatives.

*Ms. Hilger:* I met with MHRA staff to review the proposals. Along with our feasibility analysis, we had some questions for clarification.

*Mr. Petro:* It makes more sense to go through the initiatives first, followed by the DOHMH/MHRA memo.

*Mr. Pressley:* Agreed.

*Mr. Baez:* The Mental Health Workgroup also only looked at one-time initiatives.

*Mr. Cordero:* The charge to the workgroups was to develop primarily one-time initiatives, but allowed them to look at on-going ones as well, as there will be a small amount of uncommitted.

*Mr. Chavez:* Is it too late to submit additional proposals?

*Mr. Cordero:* I am not sure why there was a discrepancy in the way the charge to the workgroups was conveyed, as it was in the P&E memo that set the parameters for planning and reiterated at the April P&E and Planning Council meetings. Also, be mindful that we have over \$5M committed to ADAP and over \$6M in new proposals, but only limited funds will be available.

*Mr. Chavez:* If a WG has an additional proposal it should be considered.

*Mr. Pressley:* We should proceed with what we have, but workgroups can hold an emergency conference call before end of the process to consider other initiatives.

*Mr. Oldham:* If we get through everything today, we can consider additional proposals at the end of the meeting.

*Mr. Pressley:* The first 3 P&E initiatives (needs assessment, client level data project, mapping) are to fulfill HRSA mandates. The other proposals are: emerging populations, staffing (no dollar amount), and an integrated resource directory.

*Mr. Cordero:* The resource directory will be similar to one developed in the Tri-county region and will include providers from all CARE Act Titles. The proposal for discretionary enhancements for contracts with excellent performance and capacity to increase performance (on-going) was suggested by the grantee, as was technical assistance (TA) for contracting, fiscal management, client grievance procedures, etc. (no dollar amount yet).

*Mr. Cordero (in response to a question from Ms. Melore):* There will be no solicitations for any of these proposals, but will be an enhancement to an existing Title I contractor that MHRA will choose.

*Mr. Pressley (in response to a question from Mr. Baez):* The P&E will have to figure out the exact amount for the staffing study, but it will probably be up to \$50,000.

*Mr. Cordero (in response to a question from Mr. Baez):* The P&E asked the Office of AIDS Policy Coordination (OAPC) and the DOHMH Ryan White staff to cost out the P&E initiatives. The amount for the needs assessment is much lower than in past years as we already have a contract with a consultant.

*Mr. Pressley (in response to a question from Ms. Melore):* MHRA will not necessarily actually do the P&E initiatives, but that is not for discussion here. Also, approving any on-going programs means that the funding will continue in future years.

*Mr. Petro:* As we have already approved the first four P&E initiatives, which are needed to strengthen the application, they can be taken off the list.

*Mr. Pressley:* With permission, we will remove P&E proposals #1 to 4.

*Mr. Ng:* What is the range of the dollar amount for discretionary enhancements, as this looks like a potentially big ticket item.

*Ms. Verdino:* We are not suggesting a specific amount, but would enhance contracts based on need. We can do this now within the large categories (“bubbles”) without going back to the Planning Council. This would allow us to shift funds across bubbles.

*Mr. Barnes:* If you look at overall needs, alcoholism and drug treatment is a burning need and Medicaid does not adequately cover it. Why then, are the amounts for the AOD initiatives not larger?

*Mr. Santiago:* After looking at the numbers of the other proposals, it is clear that AOD did not propose realistic amounts. I want to go back to the workgroup and revisit the numbers.

*Mr. Cordero:* Food can be absorbed quickly (e.g. buying perishable food), and so we cannot compare with AOD (e.g. it is difficult to quickly spend \$600,000 on AOD services).

*Mr. Santiago:* AOD planned under the constraint of being realistic about the amount that would be available.

*Ms. Verdino:* I agree with what Mr. Cordero said about the ability of programs to absorb additional funds. With food and legal, we agree, as there are many programs over capacity. Other programs are not. There may be an increased need in neighborhoods or populations that we are not currently serving, which would mean re-RFP-ing the service. Also, AOD proposal #2 (harm reduction training for case managers) is already a requirement for all case management contracts, and so no extra money is needed.

*Ms. Hilger:* Also, no AOD providers have expressed a need for more supplies. This would require a limited solicitation among existing providers, who would have to demonstrate need.

*Mr. Santiago:* We continue to hear from clients that providers do not know how to deal with AOD issues. I do not know who is doing the training, but it is not effective enough.

*Mr. Ng:* Maybe AOD did the right thing by costing things downward. We need to pay attention to getting a good bang for the buck.

*Mr. Santiago:* I do not see why we cannot look at best practices around case managers for AOD users. We can incorporate it into AOD proposal #1 (conference).

*Mr. Cordero:* I propose you incorporate #2 into #1 and adjust the amount to \$60,000 for a 2-day conference.

*Mr. Santiago:* Accepted.

*Dr. Abramowitz:* The client level data project is based on the CARE Act Data Reporting system, which has limited utility for tracking medical outcomes. Can we consider more clinical data points?

*Mr. Cordero:* Those fine points can be worked on by the Outcomes Evaluation group that you and Mr. Pressley are on.

*Mr. Santiago (in response to a question from Ms. Hilger):* Providers do not know that money is available for supplies, and so do not ask, but supplies like hygiene kits help engage people and get them into services.

*Mr. Oldham:* That makes it more meaningful, and so we will add that comment to the justification.

*Dr. Brown:* Health Workgroup proposal #1 is inexpensive, as a card already exists and just need to be printed. It will help clinicians keep track of people who have multiple providers.

*Mr. Stabile:* Proposal #2 is for purchase of rapid testing kits. For proposal #3 (hepatitis C), there are other funding streams, and so it is OK to remove it from the list. We will also remove #4 (TB) from consideration.

*Dr. Brown:* The additional funds for ADAP is above and beyond the \$5.4M already allocated and would come from any additional funds left over after reprogramming.

*Mr. Cordero:* I suggest that language that CBOs already have rapid testing as part of their contract.

*Mr. Ng:* If the ADAP proposal is for the balance of leftover funds, then should it be ranked last?

*Ms. Verdino:* If it is ranked #1, then after the \$5.4M and P&E, the ADAP pools would sop up the remaining funds.

*Mr. Cordero (in response to a question from Mr. Chavez):* HRSA allows Title I to be used for to provide rapid testing if it is linked to getting people into care, e.g., as part of an early intervention program.

*Mr. Lesieur:* Housing proposal #1 (emergency rental assistance) has always been an identified need. With proposal #2 we recognize DOHMH's concerns on the non-allowability of funds to purchase certain items. Proposal #3 (harm reduction outreach in SROs) is needed to bring people into care. Proposal #4 (housing TA) is needed because providing housing is difficult. Proposal #5 is for CHAIN data.

*Ms. Hilger:* Proposal #5 is a data request and should go through the P&E.

*Mr. Ng:* We want to implement it now.

*Ms. Hilger:* Harm reduction in SROs should be an expanded priority.

*Mr. Lesieur:* We assumed there would be contractors already doing that.

*Ms. Verdino:* Outreach in SROs is not really a one-time expense. It requires additional staff. If they do not have funds next year, then they cannot keep the staff they add to provide the service.

*Mr. Santiago:* With the loss of HOPWA funds for this, there will be a gap in services.

*Mr. Ng:* For proposal #2, consumers have expressed a need for cribs for PLWH with children.

*Ms. Hilger:* Household appliances and furniture are not allowable. The water filter could be, but it would have to be done so that it is under agency auspices.

*Mr. Ng:* Given the concerns, we will take this off the table.

*Mr. Ng (in response to a question from Ms. Melore):* We are asking CHAIN to use their existing data set.

*Ms. Hilger (in response to a question from Mr. Cruz):* HRSA does not allow Title I funds to be used to purchase refrigerators, even if they are for preserving medications.

*Mr. Lesieur (in response to a question from Mr. Petro):* The funds for proposal #1 would be split between one-time and on-going depending on need.

*Mr. Ng (in response to a question from Dr. Brown):* CHAIN said they needed additional resources to fulfill our data request.

*Mr. Chavez:* Two new housing TA programs were just awarded. Infrastructure did not identify a need for more housing TA.

*Mr. Lesieur:* The Housing Workgroup may not have realized that 2 new providers were coming on line.

*Ms. Verdino:* I do not know if the two existing programs are at capacity, but two new programs will be on line soon. Also, this proposal sounds like it would include buying equipment (e.g. MIS). We recently bought a lot of MIS equipment for many providers with reprogramming funds. While this can be allowable, it is hard to monitor and implement, and it is incredibly expensive. The Planning Council should think about this for future years' planning.

*Mr. Chavez:* Infrastructure proposal #1 would enhance the New York LINK program to improve services in immigrant communities. Proposal #2 is to prepare consumers for a changing CARE Act.

*Mr. Chavez (in response to a question from Ms. Melore):* The workgroup did have information on what NY LINK has accomplished and what the next steps of the project will be.

*Dr. Brown (in response to a question from Mr. Hemraj):* NY LINK brings clinicians, PLWH and others to New York City for training, team building, etc. on taking care of PLWH. PLWH get information on community building and partnering with providers. The program has resulted in PLWH from NYC who return to their country of origin and share information and coordinate HIV care for immigrants.

*Ms. Melore:* This seems duplicative of the AETC and Air Bridge programs.

*Dr. Brown:* AETC has different goals (clinical issues within the US), setting up clinical consultations with experts and people who see small numbers of patients.

*Mr. Stabile:* The Air Bridge links only Puerto Rico and NYC, not the other Caribbean or Central American countries that NY LINK serves.

*Mr. Oldham:* We have so many PLWH from other countries who are disconnected from services. This is a successful program. In Chicago there are many PLWH from Mexico who are disconnected and don't have this kind of service coordination.

*Mr. Barnes:* This seems to replicate Air Bridge, a successful program, to other areas. I am concerned that one-time funding will not be adequate.

*Dr. Brown:* We are training in a step-wise fashion, where clinicians we train disseminate the information to their home countries.

*Mr. Baez:* There is an international component to the AETC. This is about training, but Air Bridge is about linking to services, and so it is not a similar service.

*Mr. Chavez:* Mr. Barnes brought up the issue of a long-term strategy, and the Infrastructure workgroup will consider it for an on-going template next year.

*Mr. Santiago:* I am concerned that the provider of this program is here presenting information on it.

*Mr. Chavez:* The program was scrutinized by the workgroup, and it is just a coincidence that Dr. Brown is here to answer questions about it.

*Ms. Hilger:* Technically, this is not one of the existing priorities. Also, last year HRSA said that we could not use funds for training for other countries.

*Ms. Gonzalez:* Social Services Workgroup proposal #1 is for one-time and on-going enhancements to the Food and Nutrition category.

*Ms. Hilger:* Our concerns regarding the on-going Social Services proposals are that the enhancements should have guidance concerning targeted neighborhoods or populations. Also, it is not clear how the ongoing enhancement to the service category relates to the Year 15 template for food and nutrition, which asks for an increase of \$350,000.

*Mr. Klotz:* The amount in the template was a placeholder. The amount in the reprogramming proposal was suggested by MHRA, based on their assessment of need and what the providers could absorb.

*Ms. Gonzalez:* Proposal #2 is one-time and on-going enhancements to legal services.

*Ms. Hilger:* We have the same issues with this as with Food and Nutrition. Also, implementing large amounts for enhancement without targeting is problematic. Finally, there are some issues with the legal services category that might be revised in the Year 15 template. For all 3 on-going proposals, if they are approved, the Council must do some targeting of the services.

*Ms. Gonzalez:* Proposal #3 is for one-time and on-going enhancements to the transportation program to make up for cutbacks in the program due to the loss of in-kind contributions in the transfer of the program, and the pending loss of AIDS Institute funding.

*Ms. Hilger:* It may be premature to increase funding for this category beyond this year since the Social Services workgroup is re-evaluating the transportation model that will be implemented in future years.

*Ms. Verdino:* The change in transportation providers is only a one-year contract, as we are waiting for a potentially new template. The one-time funds will address cutbacks in hours of operation that were implemented with the transfer.

*Ms. Gonzalez:* Proposal #4 (transportation resources directory) may be able to be folded into the larger P&E integrated service directory.

*Mr. Klotz:* The idea behind this proposal was to reduce reliance on the Title I transportation program by giving referring agencies information about the myriad other transportation assistance programs available.

*Ms. Hilger:* It makes sense to integrate this into the larger directory, which will be a big project. We will have to identify someone to implement it, and they will have to do a lot of research.

*Ms. Melore:* Who will maintain website after the first year?

*Mr. Chavez:* As an example, the TA Clearinghouse, was originally a one-time initiative, but the Planning Council realized that it required on-going funding.

*Mr. Petro:* Tri-county is a small area, and it took us a long time to create our directory. Given NYC's size and complexity, this may not be feasible to do in the given time frame.

*Mr. Cordero:* I recommend that we increase the amount for the integrated directory.

*Mr. Cordero (in response to a question from Dr. Brown):* Tri-county printed 3000 copies for \$25,000. We can consider this seed money and re-consider it for on-going funding in the future.

*Mr. Barnes:* The proposed allocations are heavily weighted towards social services. We need to consider how this will look in the application, given HRSA's emphasis on medical services.

*Mr. Cordero:* The first \$5.4M of reprogramming is for drug reimbursement (ADAP pools), which addresses the HRSA focus on access/maintenance. Plus, there will likely not be much more available, thus the bulk of reprogramming will be on HRSA priorities.

*Ms. Hilger:* Given the nine months it took for Tri-county's directory, is it realistic for NYC? The money won't be available until the fall at earliest.

*Mr. Cordero:* We have a Title I directory already. We are trying to leverage all other resources. We already have a collaboration with the AIDS Institute, Title III and IV providers, and there is only 1 AETC, thus it is not *tabula rasa*. Plus, we will put OAPC resources behind it.

*Dr. Brown:* The service directory needs more money. I recommend \$150,000 (accepted).

*Ms. Gonzalez:* Proposal #5 is for unusual one-time expenses for all Title I providers.

*Ms. Verdino:* We did this a couple of years ago and it was administratively difficult, although that is not the reason why I do not think it is a good idea. It was hard to see the direct impact of many of the items proposed on clients' health. HRSA requires that this be quantified for carryover proposals.

*Dr. Agins:* The Health Workgroup discussed this and realized it would not work, because it is too difficult to develop and implement eligibility criteria. Travel assistance for clients should be a separate initiative, as it is related to client service.

*Mr. Barnes:* I move that this be removed from the list. [Seconded and approved unanimously.]

*Mr. Cordero:* We will send a revised ballot. Please examine the criteria and memo on feasibility.

*Mr. Cordero (in response to a question from Dr. Brown):* If we only have a partial amount available for the next initiative on the ranked list, we will bring it back to the Planning Council.

*Mr. Ng:* We need more than just one business day to consider this. Also, we should separate one-time and on-going initiatives into two separate ranking ballots.

*Mr. Cordero:* Agreed. The revised ranking ballots will be sent to EC/P&E members tomorrow and are due to OPAC by close of business May 18<sup>th</sup>.

*Mr. Cordero (in response to a question from Mr. Santiago):* As chair, you can go back to your workgroup in a way that you see fit (e.g. conf call) to discuss this.

*Ms. Verdino (in response to a question from Mr. Chavez):* One-time and on-going initiatives come from two different pots of money, and thus are funded on parallel tracks with their own rankings.

*Ms. Verdino:* I recommend taking the three on-going social services proposals off the table, but will defer to workgroup chair.

### **Agenda Item #3: New York City Commission on AIDS**

*Mr. Barr:* I am working with OAPC to coordinate the New York City Commission on AIDS (NYC COA), a mayoral appointed advisory body, chaired by Commission of Health and Mental Hygiene Thomas Frieden and Deputy Mayor Dennis Wolcott. Members (list distributed) serve as volunteers. NYC COA was asked to look at emerging issues in HIV prevention and care, to examine current programs and policies, and to identify issues for review. They will make recommendations to Mayor Bloomberg to help direct HIV policy and programs in NYC. NYC COA is different than other planning bodies, as it is not tied to discussions around a particular funding stream, not legislatively mandated, and can look across all funding streams (City, State and federal). There are three sub-committees: Prevention (chaired by Moises Agosto-Rosario), Testing (chaired by Kim Nichols), and Treatment and Care Coordination (Chaired by Dr.

Benjamin Chu). I will distribute summaries of each sub-committee for your information. As an example, in the Prevention Sub-committee, while looking at epidemiological and other data, current prevention efforts, etc., issues have emerged as high priorities in discussion, which will go into the recommendations. The plan is to have short reports to the full commission soon, which will be reviewed and presented to Mayor Bloomberg in September. Commission members have met with the Executive Committee of the PPG, and will hold community forums to get input from infected communities.

*Ms. Melore:* There appears to be only two self-identified PLWH on NYC COA.

*Mr. Barr:* There are more than that that are open about their status, but it may not be noted in the short bios you have.

*Dr. Hill:* The Commission came about from discussions on cross-agency collaboration and was expanded with PLWH and other representatives. We wanted it to be representative, but also a manageable size.

*Mr. Barr:* Two of the three sub-committee chairs are openly HIV-positive.

*Mr. Santiago:* Are there any members from the Bronx? And were areas of expertise considered?

*Dr. Hill:* That depends whether you are asking about where they live, work, have experience, etc. The overriding factor was to have consumers, and people who represented research, providers, the Planning Council, and the PPG, and to keep the number under 20.

*Dr. Chu:* The overall goal of NYC COA is to prevent the further spread of HIV and to identify PLWH and better manage their care and give them a healthy and productive life. The Treatment and Care Coordination Sub-committee is looking at access to high quality medical care that gives people an optimal healthy state, including a maximally achievable level of low viral load. We are also looking at related social factors (housing, mental health issues, AOD issues, financial support, etc.), what can we measure and monitor, and what are the baselines for measuring success. We want to ensure that every PLWH that comes within our care system has the level of baseline support that they need to have a happy and productive life. The health care system is traditionally passive – we take care of people when they come to us when they are sick. We generally do not know how well people are doing (e.g. how many of a doctor's patients have diabetes and how many of those are controlled). With HIV, we are trying to define a minimum of what they need for a healthy life, but cannot do so unless we know where they are and how they are doing. We are looking at what tools are available to make these things happen. We often see patients and have no idea what medications they're on, etc. To be a good clinical provider or case manager, we need a range of health information on a patient, which brings up tricky confidentiality issues (e.g. a confidential data base). Yet we need to do what it takes to make sure they get best care possible.

*Ms. Melore:* How will the Mayor implement the recommendations? Will he take them to the State and federal level to challenge policies that hinder care and prevention (e.g. federal syringe exchange rules)? Also, there is no unique identifier to track people in the City system.

*Dr. Chu:* The Commission was asked to be free with its thinking. We need a confidential unique identifier to track both medical and service support. As for needle exchange, the City would be willing to take this on. Some NYC COA members are pushing even more radical ideas, which we will look at. NYC has long tradition of not letting the federal climate dictate local policies.

*Mr. Barr:* Most discussion on syringe exchange is taking place in the Prevention Sub-committee. We want to strengthen prevention methods that we know work, and the first on the list is syringe exchange. As for standards of care, the idea is not create new standards, but how to apply existing one so that we can measure that each person is getting best care.

*Dr. Abramowitz:* This approach does not address systemic issues that cause problems for PLWH, e.g. housing. We need to address what programs need to deliver care (e.g. staff).

*Dr. Hill:* The initial charge was to develop a short list of doable recommendations. Also, if something is under the purview of an existing planning body, it will not be a NYC COA priority. This is a chance for the EC to hear about initial recommendations and to talk about what we are doing that may relate to them (e.g. client level data project).

*Dr. Chu:* It is not that we are not paying attention to things like housing, but we are trying to be focused. Our approach is very client centered.

*Mr. Petro:* We have done planning every year in the same pattern, building on models that are segmented. Do you have any suggestions on how CARE Act programs might be retooled?

*Dr. Chu:* We do have a charge to look at the outcomes of existing services.

*Mr. Barr:* There is an opportunity to look at fresh approaches because NYC COA is not tied to a funding stream, but we are just getting started. Care and Testing are developing innovative ideas. Prevention is harder because it is easy to identify problems, but not solutions.

*Mr. Hemraj:* We need to look at people who are healthy enough to go back to work. Some are scared that they will lose their benefits.

*Mr. Santiago:* Why are meetings not open to public, and what is NYC COA doing for community input? Also, HHC should be ESAP provider.

*Dr. Hill:* The Commission members discussed this, as part of the AIDS community's culture is to have open meetings. The members felt that closed meetings would help discussions. They are having open community forums, and there will be additional opportunities for public comment.

*Mr. Oldham:* The community forums are a priority for Commissioner Frieden.

*Ms. Melore:* I don't agree that dialogue and productive work depends on closed meetings. The Planning Council and PPG have productive open meetings with public comment. Closed meetings are a way to keep the recommendations secret.

*Dr. Hill:* I did not mean to convey that open meetings were not productive.

*Mr. Cruz:* Funding streams can dictate how we provide services. The Institute of Medicine (IOM) report on the CARE Act indicates that there will be changes to the act that may change the way we deliver services. We need to discuss how do we adapt to changes.

*Mr. Barnes:* Whatever happens because of the IOM report, there was great dissatisfaction over several things, particularly that there is still no unduplicated count of how many people are served by CARE Act programs, and that people in Mississippi do not have drugs, but New York is talking about things like transportation. Social services, housing, etc. must be tied to health outcomes and be accountable. There is a long dialogue ahead of us, but this critique will have legs in Congress.

*Mr. Barr:* The Testing sub-committee is looking the following: the fact that 1/3 of HIV-infected people do not know their status; that 30% find out they have HIV through an AIDS diagnosis; advances in the technology of testing and the availability of treatment; how to get people to use testing and get into treatment; how to destigmatize testing and incorporate it into routine health care. We are concerned that this is not casual information on a personal, social and legal level, and so the committee is looking at testing's parameters (e.g. appropriate venues for testing). Every case of PCP is a failure of those of us who are addressing HIV.

*Ms. Melore:* We need to look at how HIV testing is taught in medical schools. Are you looking at what the benefits have been of post-partum testing?

*Mr. Barr:* The level of acceptance of voluntary testing in family planning and pre-natal care is very high (over 90%). We know that there has been a big impact on pre-natal transmission rates, but not on getting mothers into care.

*Dr. Brown:* Anyone who delivers in New York State has to be offered testing. If they refuse, blood is taken from the newborn.

*Ms. Melore:* I'm talking about how to improve testing.

*Mr. Oldham:* We will have community forums and on-going reports on NYC COA to the Planning Council, PPG and HOPWA Advisory Group.

#### Agenda Item #5: New Business

*Mr. Ng:* I recommend that we send a copy of the Policy Committee letter to the Mayor for approval at the full Planning Council.

*Mr. Cordero:* We are downloading the IOM report and a Kaiser Institute analysis and will distribute it to the Planning Council and put it on the agenda for a future meeting.

*Mr. Oldham:* I start as Executive Director of Harlem Directors group on June 14. This is a new challenge for me, but I will still work closely with the Planning Council. One of my goals is to see "Take Care New York" fully implemented in Harlem. It has been a year and a half since I became Citywide Coordinator for AIDS Policy, and we have accomplished a lot in that time, including the largest Title I award in history, and the best staff of any EMA. Mr. Cordero will become acting Citywide Coordinator of AIDS Policy and Governmental Co-chair of the Planning Council. Hiring Mr. Cordero is one of my proudest decisions. Also, I want to thank Ms. Nagy and Ms. Smith-Caronia who defended us when we were under attack for our award. Finally, I want to thank Dr. Hill for her tremendous leadership and support.

*Dr. Hill:* When Mr. Oldham joined us, we were in a difficult position, with the cut in the award. His ability to bring people together and see the bigger picture contributed to our success this year. We will continue to benefit from his leadership in his new position and he will continue to be a part of our family. There will be a national search for a successor, and we hope to have someone on board for the new Council in September 2004.

*Ms. Melore:* I want to echo Dr. Hill and thank Mr. Oldham for sticking it out as long as you have.

There being no further business, the meeting was adjourned.

Minutes approved by the Executive Committee on June 3, 2004

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Frank J. Oldham, Jr.  
Governmental Co-chair