



Meeting of the

## HIV Health and Human Services Planning Council of New York

January 25, 2007

3:10-5:10 PM

LGBT Center, 208 W. 13<sup>th</sup> Street

### MINUTES

**Members Present:** J. C. Park, MA, MPA (Governmental Co-chair), S. Hemraj (Community Co-chair), P. McGovern (Finance Officer), R. Bramble Weed, E. Camhi, R. Canosa, F. Carroll, O. Clanton, I. Gamble-Cobb, J. Grimaldi, MD, A. Gutkovich (for D. Marder, MD), J. Hilger, L. Holley (for C. Craig), J. Irwin, V. Jarvis, MD, J. Lehane, PhD (for T. Petro), F. Machlica (for L. Fraser), H. Mateo, D. Ng, D. O’Gormley (for A. Perry), A. Palermo, G. Philip, L. Rañon (for W. Rodriguez), J. Cossey (for A. Richardson), S. Self, PhD, S. Smith-Sweeney (for E. del Campo), R. Spellman, E. Telzak, MD, D. Tietz (for L. Scaccabarozzi), T. Troia

**Members Absent:** A. Aviles, MD, M. Bacon, M. Barnes, L. Bishop, H. Cruz, A. Etienne, I. Feldman, R. Jackson, W. Okoroanyanwu, MD, A. Paige-Bowman, S. Reid

**Staff Present:** *OHAPCP:* D. Klotz, C. Silva, N. Rothschild, D. Wong; *DOHMH:* R. Shiau, L. Buckley, C. Murrill; *MHRA:* R. Miller, A. Chi

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#### Agenda Item #1: Meeting Opening/Minutes

*Mr. Park* opened the meeting.

*Ms. Mateo* introduced the moment of silence.

*Mr. Hemraj* reviewed the rules of respectful engagement.

Members introduced themselves.

The minutes of the December 21, 2006 meeting were approved with no changes.

#### Agenda Item #2: Public Comment, Part I

M. Ducret: There is a new prevention effort in Washington Heights targeting the drug using population with needed resources .

Mr. Cossey: More input from consumers is needed. Providers do not always speak for consumers, and consumers can speak for themselves best.

T. Smith-Caronia: I want to commend the Priority Setting & Resource Allocation Committee (PSRA) in completing their difficult task of developing a plan to cope with possible funding cuts. I urge the Council to denounce HRSA’s housing policy, which will be addressed later in the meeting. The Mayor’s preliminary budget has no new dollars

for HIV/AIDS. We should advocate for increased funding in city tax levy dollars. I have concerns about what the City wants to include in the Medical Monitoring Project survey, and I want to know what they will do with data and when they will have it. Finally, I urge HRSA to give our EMA a waiver from the 75% core services requirement.

Mr. Park: The PSRA has developed scenarios for possible funding cuts, to be presented to the Executive Committee on February 8<sup>th</sup>, and then to the full Council on February 15<sup>th</sup>. We hope to hear from the community about the plan. It was a difficult process to consider having to cut programs, but we had an open and frank discussion and came to a consensus on a plan that we think is fair.

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

*Ms. Mateo:* The AG met on January 20th. I want to thank the guests who gave presentations. Rachel Miller presented on HIV CARE Services and their Community Advisory Group, and she answered questions from AG members on issues such as grievance procedures. Grace Moon presented on reauthorization of the Ryan White Treatment Modernization Act, David Klotz gave an update on the FY 2007 scenario planning, and Mr. Park reported on CDC-funded prevention grants. We look forward to more informative presentations. We had a number of new consumers at the meeting, and we want to encourage more to attend. The issue of Spanish translation came up at the meeting, which we would like to address. The next meeting is February 10<sup>th</sup>.

### **Agenda Item #4: HRSA Housing Policy**

Mr. Shiau: After an audit from the Office of the Inspector General (OIG), HRSA developed a draft policy on the use of Title I funds for Housing in March 2006 and requested comments from grantees. Written comments can be submitted to HRSA until February 5, 2007, and the policy takes effect March 1<sup>st</sup>. The new policy requires that the necessity of housing service for purposes of medical care must be certified or documented by a case manager, social worker, or other licensed healthcare professional. There is also a 24-month cumulative lifetime limit on short-term or emergency housing assistance. Finally, there is a requirement to identify non-RW funded housing assistance.

The impact of these changes may include: 1) housing clients that reach the 24-month cap will be displaced from housing, potentially becoming homeless and disengaging from care; 2) clients with recurring needs will not be served; 3) an additional administrative burden placed on NYC/MHRA and housing providers (NYC would have to develop mechanism to track client RW housing assistance in perpetuity); and 4) Ryan White housing providers will be required to develop long-term housing plans for clients that identify funding source for long-term housing assistance.

According to HRSA, the proposed 24-month cumulative cap is needed to bring Ryan White housing policy in line with US Dept. of Housing and Urban Development (HUD) programs such as HOPWA, but no HUD programs have a lifetime cumulative cap recipients of short-term or emergency housing assistance. DOHMH has contacted its community partners, including the Planning Council and providers, and submitted comments that, in place of the cumulative lifetime limit, the HRSA policy should follow similar utilization guidelines to HUD programs, and that if limitations on utilization are imposed, a waiver should be available when there is documented evidence of an individual's medical necessity for housing stabilization support services that exceed the lifetime cap. Community groups, such as NYAC and Housing Works have submitted comments and provided templates for others to submit comments. Two members of Congress have written letters supporting the policy.

Mr. Shiau (in response to a question from Ms. Mateo): We think that this resulted from a special OIG audit of housing programs.

Mr. Shiau (in response to a question from Mr. Cossey): We do not know if the lifetime cap is retroactive.

Mr. Tietz: The cap is per household, but we do not know if there are two individuals with 12-months of emergency housing use who move in together if they will be considered to have reached the cap.

Ms. Holley: The HIV/AIDS Services Administration (HASA) should get clients out of emergency housing and into permanent housing. Also, asymptomatic HIV-positive people should be eligible for HASA housing.

Mr. Park: This policy only pertains to Ryan White-funded housing. HASA eligibility issues are the purview of the City Council.

Ms. Holley: The Planning Council should advocate with the City Council to change their policies.

Ms. Hilger (in response to a question from Dr. Grimaldi): We do not know exactly how many clients this policy would affect. Most client who use emergency housing use short-term housing services, but many have recurring needs (e.g., mental illness, substance use) and so the lifetime cap is a problem.

Mr. Shiau: People who reach the lifetime cap will hopefully be able to get supportive housing from HASA, HOPWA or another program, or be placed in an SRO, which is not an ideal situation. HOPWA is enhancing its supportive housing contracts, but resources are still limited.

Mr. Shiau (in response to a question from Ms. Palermo): There is limited guidance from HRSA on implementing the policy, and none on tracking clients. We should have the opportunity to review any protocols. The National AIDS Housing Coalition has made known to HRSA that most localities oppose this.

Mr. Camhi: It is in our best interest to address the continuity issues that this brings up, regardless of the policy. HRSA may extend a similar cap to other services, such as food provision, and we need to plan for that.

Ms. Mateo: Tracking clients would mean having to get documentation that clients do not often have access to.

Ms. Hilger: Any tracking of clients would have to be a shared responsibility with providers.

Mr. Shiau: A template is available for both consumers and providers to send comments to HRSA.

#### **Agenda Item #5: Medical Monitoring Project**

Ms. Buckley: The CDC is funding a study that would provide a nationally representative sample of people infected with HIV, the type and quality of care received, and the behaviors they are currently engaging in. Called the Medical Monitoring Project (MMP), it is a multi-year (2005-2008) project with an annual multi-stage probability sample of US adults in care for HIV. It will provide locally and nationally representative samples of HIV infected adults in care and will match interview and medical record abstraction on behaviors, clinical outcomes, type and quality of care received, and met and unmet needs for HIV care and prevention services.

The overall goal is to understand health-related needs of people living with HIV/AIDS. The MMP's specific goals are: 1) provide local and national estimates of behaviors and clinical outcomes; 2) describe health-related behaviors; 3) determine accessibility and use of prevention and support services; 4) increase knowledge of care and treatment provided; and 5) examine variations of factors by geographic area and patient characteristics. MMP will help estimate resource needs for treatment and services for HIV-infected persons.

Providers will be asked to provide a list of patients (by name or other identifier) to the health department, and assist the DOHMH in setting up patient interviews and chart reviews. Patients will be asked to voluntarily participate (they may change their mind about participating at any time), and give informed consent for an interview and chart review (they will receive a \$40 MetroCard as reimbursement). Data will be collected through interviews on demographics, access to health care, adherence to therapy, sexual and drug use behavior, access to prevention services, and health and well-being. Data will be collected through chart reviews on demographics, insurance status, opportunistic illnesses, anti-retroviral therapy (ART), laboratory data, substance use and mental health, and referrals to other services.

MMP will help us learn: What proportion use multiple sources of care, what are the met/unmet needs for medical services, what are the barriers to accessing care, what proportion are receiving treatment and care according to the PHS guidelines, of those eligible for ART, what proportion are prescribed ART, what proportion on ART are adherent to the current regimen, what factors are associated with non-adherence to ART, what risk behaviors for HIV are people engaging in, to what extent do they feel stigmatized due to HIV, and what prevention and support services are they receiving.

There are national and local provider and consumer advisory boards, and the local consumer board is the Council's Consumer Committee. They will provide input on recruitment of patients and providers, printed patient recruitment materials, and reimbursement of providers and patients. Maximum participation is essential for obtaining information that is truly representative of patients in care for HIV locally and nationally. MMP data adheres to the same rigorous confidentiality and security requirements as other HIV/AIDS surveillance data, facility; provider and patient names will not be disclosed to the CDC; data collected will be encrypted, stripped of identifiers, and sent to CDC via secure data network; and informed consent, with appropriate HIPAA language, will be obtained prior to patient enrollment.

MMP will provide population-based data for planning and resource allocation for planning bodies, and for advocating to reduce the gaps in existing resources and policy decisions, as well as evaluation of prevention and treatment initiatives. New York State and City are currently piloting interviews and chart abstractions, and we have a data base of 490 NYC HIV care providers with a patient load of 77,000. We expect to begin 2007 data collection by early fall.

Ms. Buckley (in response to a question from Ms. Holley): The number of providers and patients will change every year. The selection is done through random sampling. Providers can not apply to be selected.

Dr. Telzak: We are defining the study population as those in care a minimum of 4 months, but this excludes people in very intermittent care, who are the ones who need the most support.

Ms. Buckley: DOHMH is conducting a supplemental study of those never in care.

Mr. Park: CHAIN may have data on this population, which we can investigate.

Ms. Buckley (in response to a question from Ms. Palermo): CDC is not giving money for incentives to providers. There are some quality of care questions (e.g., are they following treatment guidelines), but MMP is mostly looking at patient experience.

Ms. Palermo: Part of the patient experience is the provider, and so we should look at provider quality more closely.

Mr. Camhi: There is variability of insurance coverage (Medicaid, ADAP, charity care, etc). It would be important to know the coverage at each event, as utilization may vary dramatically depending on coverage.

Ms. Buckley: We ask about coverage at every point, and so will be able to tell.

Mr. Clanton: Council members with more questions can give feedback to the Consumers Committee.

### **Agenda Item #6: Grantee Report**

Ms. Hilger: HOPWA funds will be used to enhance Title I legal services contracts to provide housing related legal services not allowed by Title I. Funding begins January 1. Complete contract packages are due back to MHRA at the end of January. MHRA is working with contractors around take-downs to keep under-spending under 2%. \$700,000 has been recouped from contractors and used for reprogramming.

We have compiled questions (in the meeting packet) for HRSA on implementing the Ryan White new legislation. HRSA scheduled a grantee conference call Feb. 6 to discuss reauthorization issues, and will develop a Q&A document, but up to now, in the absence of any formal written guidance the information shared with EMAs by their project officers appears to be inconsistent. The PSRA worked hard in the absence of any guidance, but by the time the PC votes on the scenario plans we should know a bit more about what will take effect on March 1st. We shared our questions to HRSA with the CAEAR Coalition. We have heard that the grant award will be in three stages, and we won't know the full amount until the third stage, which could be as late as June. The formula award will be in March (about 2/3 of the full amount). The supplemental award will not be announced until after 5 new EMAs submit their applications (due at the end of February, but they need to be reviewed). We expect cuts in the supplemental award, since the formula is held harmless, is a larger proportion of the award, and there are new cities competing for supplemental funding. Finally, the MAI award will be awarded after a competitive application, which is new. We do not know the MAI rules yet (e.g. eligibility). We are developing alternative plans for contracting with

agencies (both new contracts and renewals ) March 1st without a full award. We do not know the requirements for or process of a waiver for the 75% core services requirement or the definitions of the core services categories. There are a lot of administrative issues due to this (e.g., possibly having to track three different pools of funding). We also do not know about the new carry-over rules and the impact this may have on future supplemental funding. If you have additional questions, please send them to me.

Mr. Park: We wanted you to know the difficulty of planning in this environment. We are partnering with the CAEAR Coalition on these issues, and will report back on a HRSA conference call that will take place in early February.

Ms. Miller: HIV CARE Services is recruiting members for its Community Advisory Group. We are particularly looking for Title I providers and consumers.

### **Agenda Item #7: Tri-county Steering Committee Report**

Dr. Lehane: The Tri-county Title I Steering Committee is conducting a parallel process to the Council, developing a response to the housing policy, and developing scenarios for the FY 2007 award, where we are anticipating a reduction of as much as a 15% cut in our portion of the award. We are looking at cutting program support before direct services and realigning service categories to comply with the 75% core services requirement (e.g., retooling our outreach programs to be early intervention services).

### **Agenda Item #8: Public Comment, Part II**

C. Henderson: The HRSA housing policy would dismantle the housing opportunities that we have built for PLWHA.

D. Golden: I am active in the NYC AIDS Housing Network, and we want a formal meeting with the NYC Department of Corrections on services on Riker's Island for PLWHA incarcerated there.

A. Halpern: I want to urge the Council to aggressively push for a waiver to the 75% core services requirement. HIV is more than just a medical condition, and PLWHA are particularly vulnerable in areas of family law, public benefits and employment law (e.g., families that lose benefits have trouble staying connected to core medical services).

K. O'Neill: I want to echo the previous comments. Legal services are necessary to get people health care and to overcoming barriers to care. For example, we recently had a case where a doctor violated a patient's confidentiality, which led the client to fall out of care.

E. Hay: I also echo the above comments. Legal services are a critical part of the menu of support services that help people get medical care. Case managers are only part of the picture, and they need legal services providers as part of their team, as they can not represent people in court.

M. Ducret: Putting someone in a hotel will mean spending a lot more money than keeping them in emergency housing. Also, stigma questions in the MMP should ask about other stigmas besides HIV status.

Mr. Park: Thanks to everyone who provided public comments. Please stay involved in the process, as we have critical meetings coming up.

Ms. Holley: I encourage providers to seek alternative sources of funding. Also, we should provide sandwiches at Consumer Committee meetings.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on February 22, 2007.

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Jan Carl Park, MPA  
Governmental Co-chair