



Meeting of the

HIV HEALTH AND HUMAN SERVICES PLANNING COUNCIL

Thursday, October 21, 2004

3:10-5:05pm

LBGT Center, 208 West 13th Street

MINUTES

Members Present: B. Stackhouse, PhD (Acting Governmental Co-chair), S. Abramowitz, PhD, K. Ashley, MD, P. Avitabile (for E. del Campo), R. Bonilla, G. Brown, MD, E. Camhi, F. Carroll, E. Cates, O. Clanton (for R. Abadia), C. Craig, H. Cruz, L. Dolloway, C. Dzubilo, L. Fraser, I. Gamble-Cobb, R. Gonzalez, H. Hernandez, M. L. Hernandez, J. Hilger (for M. Hill, PhD), J. Lopez, J. Marciano (for E. Telzak, MD), D. Marder, MD (for C. Barometre), H. Mateo, G. Mercado (for T. Troia), D. Ng, W. Okoranyanwu, MD, J. Omi (for B. Chu, MD), A. Palermo, J. Pedraza, T. Petro, P. Quintero (for M. Bacon), A. Richardson, E. Rodriguez (for S. Hemraj), E. Santiago, P. Shelton (for B. L. Curry)

Members Absent: M. Barnes, K. Butler, R. Chavez, C. Cobb, I. Feldman, J. Grimaldi, MD, P. McGovern, N. Nagy, T. Osubu, A. Paige-Bowman, J. Pressley, A. Raiola, D. Woodard

Staff Present: *OAPC:* G. Moon, D. Klotz, C. Miller, I. Gonzalez, S. Dwyer, M. Lesieur, B. Barusek; *DOHMH:* J. Park, S. Forlenza, MD, B. Larson; *MHRA:* R. Miller, G. Weinberg; *American Express Business and Tax Services (Consultant):* C. Degenfelder

Agenda Item #1: Welcome/Announcement/Minutes

Dr. Stackhouse opened the meeting followed by introductions, noting that Ms. Nagy, Mr. Hemraj and others are attending the United States Conference on AIDS in Philadelphia.

Mr. Camhi read the rules of respectful engagement.

Mr. Santiago led the Council in the moment of silence.

Dr. Stackhouse: Thanks to new members and others who attended the two-day orientation. DOHMH has been active in promoting syringe exchange programs in Queens and I am happy to announce that last night, Queens Community Board 12 voted unanimously to support three new syringe exchanges in Jamaica.

Dr. Stackhouse reviewed the meeting packet, including a memo from Council leadership on community participation in committees.

Dr. Stackhouse (in response to a question from Ms. Hilger): We have asked the Rules and Membership Committee to develop a process and application form for additional community representation on the committees that will be sent to as broad an audience as possible. We hope to complete the process by December 1st.

The minutes of the September 23, 2004 meeting were approved with one change to note a question posed by Ms. Carroll.

Agenda Item #2: Public Comment, Part I

T. Smith-Caronia: Is DOHMH doing everything necessary to ensure that PLWHA have access to the flu vaccine?

Dr. Stackhouse: Mr. Park will address that under new business.

M. Gold: In addition to the flu vaccine, seniors still need HIV services, as was demonstrated at the Over 50 and Long Term Survivors Forum, where much valuable data was disseminated, in addition to inspiring speakers. Also, 60,000 PLWHA are in danger of losing comprehensive prescription drug coverage with the new Medicare rules.

D. Chandler: As a PWA with a very low CD4 count, I am personally worried about the flu vaccine situation. I am also concerned about the Medicare issue that Mr. Gold spoke of.

Agenda Item #3: PLWHA Advisory Group and Consumer Committee Reports

Ms. Carroll: On October 16th, the PLWHA Advisory Group (AG) had a well-attended meeting. Mr. Hemraj reviewed the new Council structure and we discussed consumer participation. We encouraged AG members to attend all meetings. Mr. Gold reported on the Over 50 forum, which was an outstanding success. Thank you to the planning committee on its success. In your packets is a report on the consumer focus groups held this summer. We will present on this at the November Council meeting. Also, the AG decided to make its name the PLWHA AG rather than PWA or PWA/HIV.

Ms. Dolloway: The Consumer Committee had its first meeting, which was a good start.

Mr. Clanton: Mr. Abadia asked me to convey that he was pleased with the meeting. We encourage everyone, especially – but not just – consumers to attend. We look forward to working with the full Council.

Agenda Item #4: Grantee Report

Ms. Hilger: As you know, we are working on the FY 2005 Title I grant application. Thank you to the Council members who came in to review and comment on it. We will get the application to the Mayor's office for signature and then into HRSA by November 10th. The shorter page limit has been a challenge to convey everything we want to. There is an emphasis on core services, rather than implementation of all programs, and so we have to stress to HRSA that we need funds for the whole range of services. In other news, MHRA is preparing the RFP that will include the priorities that the Council changed, plus new priorities if funding is available. MHRA is working on the FY 05 renewal packages, looking closely at all contracts. FY 05 contracts will have shorter terms if they are for priorities being re-RFPed. With contract take-downs for under-spending, we will be able to fund additional priorities in the Council's reprogramming plan, although most will go to ADAP, as the Council authorized \$5M for that priority. The carry-over request was approved by HRSA. We asked them if they are changing their policies for next year and were told that HRSA is not making any changes and that we will be allowed to have carry-over next year, although we will try to spend as much as possible to minimize it. Finally, the agencies participating in the client level data project will begin reporting client level data at the end of October.

Agenda Item #5: Adoption of a Three-Year Planning Cycle

Mr. Ng: The Council has been using a one-year planning cycle to review its service portfolio. As detailed in the report on the Committee Orientation by consultant Emily McKay, there are a number of benefits to switching to a three-year cycle: It recognizes the need for time to fully understand and implement the new structure. A three-year cycle reduces the burden on Planning Council and committee members. A three-year planning cycle fits with the requirement for a comprehensive strategic plan to be developed every three years. Service priorities do not usually change tremendously from year to year, because the service needs of PLWHA in New York are unlikely to change drastically from year to year. A three-year cycle allows for more time to think, plan, implement, and review various aspects of the planning process and can improve the quality of each aspect of the work. A three-year cycle will require an emphasis on continuous communication, as there will be changes in Council membership over a three-year cycle. The Executive Committee (EC) discussed this in depth and recommends that the full Council adopt this. I move that we adopt a three-year planning cycle. [Seconded]

Mr. Pedraza: What if there are changes to services that we want to implement?

Mr. Ng: It is built into the process that we are open to modifying services based on changes in the epidemic and environment (e.g., Medicaid). Most likely, any changes will be minor. Every three years we will do major modifications.

Ms. Hilger: The Council still has to update epidemiological information, re-rank priorities, and do allocations every year.

Dr. Stackhouse: The plan accounts for both three-year and annual activities.

Dr. Stackhouse (in response to a question from Mr. Rodriguez): Ms. McKay's report gives the narrative on the discussion and how this came to pass.

Mr. Ng (in response to a question from Dr. Brown): Ms. McKay said that most EMAs have a three-year cycle.

A vote was taken and the motion passed unanimously.

Dr. Stackhouse: The EC discussed having a working session with committee chairs to begin outlining the details of implementing the new process.

Agenda Item #6: Unit Cost Project

Mr. Degenfelder: DOHMH/MHRA has contracted with American Express Tax and Business Services to conduct a pilot to develop unit costs for six Title I services. This will include: defining and measuring units of service provided by the contracting organizations; developing global as well as individual organization costs by unit of service in all service areas; calculating the costs of providing Title I services among the contractors in aggregate and individually; developing global as well as individual organization fee schedules; and providing the tools/methodology for the contracting organizations to calculate and modify costs and fee schedules going forward. The project will develop "Relative Value Units" (RVU) to measure the intensity of services provided services as the basis for reimbursement. Cost of service per RVU will be calculated by using a formula to determining applicable costs based on a variety of factors, adjusting for things like use of volunteer services.

Mr. Degenfelder (in response to a question from Mr. Camhi): We are familiar with SNPs issues.

Mr. Cruz: The COBRA system uses a fee for service schedule. You should look at their methodology, specifically for case management. There is also the problem of common definitions, e.g., when using URS, it is difficult to define a service and how it differs in each program (e.g. case management intensity). This may create different cost levels and inaccurate perceptions across programs. Also, unit cost analysis is frozen in time, but costs escalate, which needs to be factored in. Finally, other parts of the State are doing work like this, and we will be happy to share it with you.

Mr. Pedraza: What is the timeline of the project, do you provide technical assistance to the participating agencies, what is the role for consumers, and how will the Council use the data?

Ms. Hilger: This is strictly an administrative project at this point and grantee funds alone are being used for it. We want to expand it to more contracts after the consultant gives us the methodology. It will help us with negotiating contracts. After that, an eventual goal is to work on cost effectiveness for the Council's planning use.

Mr. Degenfelder: TA will be provided intensively to programs participating in the study. This is a provider-focused project. We will distribute the taxonomy and would like to distribute it to consumers for input.

Mr. Camhi: It is good that you are accounting for volunteers and other intangibles. Many CBOs are actually in a deficit for the services they provide, and you will have to adjust for true cost.

Dr. Abramowitz: The experience in our institution is that if a program does not deliver enough RVUs, it will be cut. Children's services are undervalued and cost a lot.

Mr. Degenfelder: This project will be focused on activities, so if something takes longer or is more intensive, it will have a higher RVU.

Mr. Craig: PLWH pass on much information among each other and help each other access services. Will that be taken into effect?

Mr. Degenfelder: It will be difficult to capture all interaction, like peer-to-peer. We will try to measure the impact, but it will be hard to say that because of peer interaction someone needed a less intensive service. We will measure the overall level of usage of volunteers and the impact on cost.

Ms. M. L. Hernandez: With housing and nutrition we have to think about undocumented immigrants who often do not qualify for services.

Mr. Degenfelder: As part of the risk adjustment in the methodology, we will measure if a program is dealing with undocumented immigrants, among other factors which may make the cost of providing services higher.

Mr. Cruz: Geography also needs to be taken into consideration: it may cost more to provide a service in Manhattan than Far Rockaway.

Mr. Degenfelder: We will also look at that in the risk adjustment.

Ms. Hilger (in response to a question from Dr. Brown): The idea behind this project is to better understand how much it costs to provide services. This will help with resource allocation and generally provide more objective information for planning. It will also help us with contracting and will help agencies when doing other grants.

Dr. Stackhouse: Thanks for the informative presentation, and to the Council for its attention to this difficult topic.

Agenda Item #7: Monitoring and Evaluation Update to the Strategic Plan

Ms. Moon: McClain and Associates are developing the 2004 Monitoring and Evaluation Update of the Comprehensive Plan for HIV/AIDS Services for the New York EMA, and the Comprehensive Plan for HIV/AIDS Services for the New York EMA, 2005-2008. The first document examines the EMA's progress in achieving Strategic Plan goals and objectives between 2002 and the present using CHAIN, Quality Management and other data. In general, there were few changes noted in quantitative measures for NYC or Tri-County between 2002 and the present. The significant findings include: new CHAIN cohort was more likely than the old to have experienced an episode of unstable housing; here was an increase in the proportion of these individuals who received some form of housing services; there was improvement in the percentage of CHAIN participants who indicated they received continuous and comprehensive care; among individual with low mental health scores, those in the new CHAIN cohort were more likely to report good physical health scores. For the process objectives in the plan, most were not completed. The workgroups may have been too ambitious in their expectations of themselves given the limited time covered by the plan and the number of factors out of their control that contribute to outcomes.

As part of the Strategic Plan, McClain and Associates is producing an addendum to the Needs Assessment Update to capture new data from May-September 2004. The Strategic Plan will have three chapters: 1) Where are we now in the epidemic; 2) Goals and Objectives; 3) Monitoring and Evaluating Progress. It will address new challenges, such as changes in the environment, and will work closely with other collaborators. A final plan will be presented to the Council by February 2005.

Ms. Moon (in response to a question from Mr. Pedraza): We can address the needs of special populations through the goals and objectives that will be set. The Access to Care, Maintenance in Care and Integration of Care Committees will work on that.

Dr. Brown: Given the changing environment, we need quantifiable measures, e.g. improved health status, viral load, CD4.

Ms. Moon: We need to make sure that we can collect the data and that the goals and objectives are measurable and are available through existing sources.

Mr. Petro: When Tri-county develops our objectives, it will help to have a full discussion on the ways to measure objectives, since last year we created lofty objectives and had to scramble to see how we could measure them.

Mr. Clanton: One population is being overlooked – people with disabilities (e.g. visually impaired). Look at these populations when doing strategic planning.

Agenda Item #8: Public Comment, Part II

L. Holley: Why are most the of the committee co-chairs executive directors of agencies? Why are there not more front line workers or consumers? Tomorrow, there is a forum on child welfare and substance abuse, but no one from the HIV community will be there to address our concerns.

J. Livigni: How can unit costing take into account costs that arise from an aging population?

A. Perez: The harm reduction program I attend has problems with their policies and procedures.

Agenda Item #9: New Business

Mr. Park: My doctor told me I should forego the flu vaccine because my viral load was too low and my CD4 count too high. We are facing a failed national flu vaccine policy. NYC has received only 30% of what it needs. As stated in the DOHMH handout on the table, we are working with the State and others to urge practitioners to save vaccines for those most in need. We anticipate more vaccine coming into the City during flu season (December to April). As we progress, we will update you.

Mr. Cruz: New York State is working with the City continuously on this. For PLWHA, most providers do not have enough vaccine, but HIV+ people, regardless of viral load or CD4 count, are being given priority. The issue is supply. The CDC has taken control of availability and distribution nationally. We have communicated to them and urge that CBOs and practitioners make their need known and to call their original vendor. Providers should put themselves on the local health department list for a vaccine so that they can be notified when it becomes available. We are waiting for the CDC's guidelines before NYSDOH sends out info.

Mr. Park: If you have questions, call 311 or visit www.nyc.gov for the latest information.

Dr. Stackhouse: This will be a continuing issue and we will send out announcements as new information is available. Also, as many of you know, Chris Miller is leaving the Council after over two years at OAPC to become director of public affairs at the Department for the Aging. It is sad to see him go, and I want to thank him for his contributions.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on November 18, 2004

Bill Stackhouse, PhD
Acting Governmental Co-chair