

Meeting of the

HIV Health and Human Services Planning Council

November 20, 2003

3:10-5:05pm

Restoration Plaza

1368 Fulton Street, Brooklyn

MINUTES

Members Present: F. Oldham, Jr. (Governmental Co-chair), N. Nagy (Community Co-chair), S. Hemraj (Finance Officer), R. Abadia, S. Abramowitz, PhD, S. J. Avery (for S. Halperin, CSW), P. Avitabile (for E. del Campo), M. Barnes, L. Bishop, R. Bonilla, J. Bostic, G. Brown, MD, J. Brown, R. Busan (for M. Bacon), K. Butler, F. Carbone, R. Chavez, C. Craig, B. L. Curry, R. Gonzalez, E. Handelsman, MD, M. Hill, PhD, R. Joyner, D. Marder, MD, H. Mateo, P. McGovern, K. McGowan (for C. Dzubilo), J. Pedraza, J. Pressley, A. Raiola, N. Rodriguez (for D. DeLeon), P. Stabile, T. Troia, B. Watts

Members Absent: B. Chu, MD, C. Cobb, H. Cruz, I. Feldman, L. Fraser, H. Melore, D. Ng, A. Paige-Bowman, R. Recchia, E. Santiago, M. Wainberg, MD, D. Woodard

Staff Present: *OAPC:* R. Cordero, D. Klotz, C. Miller, S. Bailous, B. Allen, J. Mateo; *DOHMH:* J. Hilger, J. Park, S. Forlenza, MD, MPH; *MHRA:* J. Verdino, G. Weinberg, P. Jensen

Agenda Item #1: Welcome/Minutes

Mr. Oldham: Welcome to the first meeting of the HIV Planning Council in Brooklyn. We will have meetings in all five boroughs on a regular basis.

HIV Planning Council members introduced themselves.

Mr. Oldham: Later in the agenda, we will have a policy update, as we must be informed to prepare for potential cuts or increases in our award. Also, the "Faces of AIDS" exhibit will be unveiled by Mayor Bloomberg on World AIDS Day at Gracie Mansion. It will also be the centerpiece of a World AIDS Day observance at the Washington, DC headquarters of the US Department of Health and Human Services.

Mr. Joyner read the rules for respectful engagement.

Mr. Butler led the moment of silence.

Mr. Oldham: I am happy to announce that we are able to support some additional technical assistance programs using unspent HOPWA administrative funds. This helps alleviate the large cut to Title I TA programs last year.

Mr. Cordero: At the December Executive Committee (EC) meeting, our HRSA TA consultant Emily McKay will facilitate a discussion on Planning Council restructuring. Also, there will be a special EC session on December 11th to develop spending scenarios for Year 14. The scenarios will project cuts, flat funding and increases that we will apply to the grant when the award is announced. The meeting packet contains a letter from Mr. Oldham regarding a motion made at the September meeting regarding the creation of a new ex-officio seat on the Council.

Mr. Bostic: Mr. Halperin had asked that the Executive Order be made available to the Planning Council members. Also, Mr. Barnes comments may not be fully reflected in the October meeting minutes.

Mr. Klotz (in response to a question from Ms. Avery): The process for amending minutes is: they are mailed out within a week or two of the meeting. If members send any corrections back, I make the changes and re-send the corrected minutes (marked "revised") prior to the next meeting. Mr. Halperin's correction regarding Mr. Barnes' comments is reflected in the revised minutes that are in the meeting packet.

The minutes of the October meeting were approved with one minor change from Mr. Hemraj 20-0-6 (Y-N-A), with Mr. Abadia requesting that his abstention be noted.

Agenda Item #2: Public Comment, Part I

M. Gold: I am happy to be here 63 years after my birth here in Brooklyn. The Social Security Administration is reconsidering eligibility requirement that may adversely affect PLWH, including eliminating Medicaid spend-down for people on Medicare, which will be disastrous to people on fixed incomes. Also, we do not know what the effect of the pharmacy plan will be. This should be brought to the community.

A. Do: I am disappointed that the film showed prior to the meeting did not depict Asian women living with HIV.

L. Baker: I am distributing a survey for a study on HIV in the workplace and barriers to employment.

D. Bailey: There are no representatives from the Brooklyn CARE Networks and other locally-based providers on the Council. Will outer borough meetings be a regular, or a one-time occurrence?

Mr. Oldham (in response to a question from Mr. Joyner): For time's sake, we will respond to public comment after meeting.

Mr. Oldham and Mr. Cordero: We reached out to the CARE Networks for this meeting. Also, all CARE Network Coordinators are ex-officio members of the Planning and Evaluation Committee, and many members of the Planning Council are part of the networks. The Planning Council will conduct meetings in every borough, and this will be a permanent part of Planning Council operations.

Agenda Item #3: Committee Reports

PWA Advisory Group Report

Mr. Abadia: The PWA Advisory Group (AG) has its own EC, plus two committees – one to address Title I issues and one for external HIV issues. At the last AG meeting, we had reports from the committees. We discussed reauthorization and other policy issues. We intend to have AG members at all meetings concerning reauthorization. We are also well represented on the By-laws Task Force. The AG members are also very pleased that the new Community Co-chair and Finance Officer are AG members. Many AG members are part of the “Faces of AIDS” project, but everyone should remember that PLWH live with AIDS every day, not just World AIDS Day.

Finance Committee Report

Mr. Hemraj: I want to acknowledge Mr. Watts for his leadership of the Finance Committee (FC). The FC reviews and evaluates financial information concerning Title I grant, monitors the administrative mechanism for the timely distribution of Title I funds, and educates Planning Council members, workgroups members and the public about Title I finances and financial mechanisms.

The Finance Committee met on November 5th. Gucci Kaloo from MHRA/HIV CARE Services reviewed the second quarter fiscal report, which covers spending through the end of June (thus it is actually 1/3 of the calendar year), and which contains information collected through August 31st. The report shows that 99% of the year's funds have been committed, and spending is at about 33%, which is an improvement from the previous year and on target. While it is too early to predict final a carry-over amount, we are on track to have much less under-spending than last year, and MHRA should be commended for that. The Committee discussed the built-in lag in reporting, and we will be discussing further with MHRA how to obtain the data as soon as possible after the close of the reporting period.

The Committee is also seeking to replenish its membership. There are several open seats on the Committee. Workgroup members who are not Planning Council members are also eligible to apply. Applications for membership are available in the meeting packet. As per the by-laws, Ms. Nagy and I select the members.

Ms. Verdino (in response to a question from Mr. Bostic): The 1% uncommitted funds as of June 30th were due to the new MAI contracts that started July 1st and the new TA contracts that started November 1st. All funds are now totally committed and we know where every dollar is going. Anything left will go to the ADAP pools, up to the cap in the Planning Council-approved spending plan. Overall, contractors are doing well in spending. They recently

submitted budget modifications, and so under-spenders can readjust their budgets. Over the next week, MHRA will do take-downs on under-spenders.

Planning and Evaluation Committee (P&E) Report

Mr. Pressley: The P&E met 11/14. Congratulations are due to Dr. Abramowitz and Mr. Halperin on the overwhelming success of Data Day 2. The P&E approved guiding principles for the workgroups as they embark on the new planning cycle and re-assess the service portfolio. It is important that all workgroups are on the same page. The P&E also discussed the need for data on all services in the portfolio and the need to document the link to health outcomes for future applications. We will also develop questions with the Planning Council co-chairs for a discussion on the conceptual framework (“bubbles”), which we will examine to see if it needs to change to reflect the continuum of care.

Ms. Verdino (in response to a question from Mr. Barnes): The last big RFP re-bidding the entire portfolio was in 1998, but additional services were added after smaller RFPs in 1999, 2000 and 2001, due to increases in the award.

Mr. Barnes: The application writer had difficulty answering questions on how the Planning Council changed the portfolio in order to correspond with HRSA goals to focus on health care. This sounds like the P&E is doing exactly what needs to be done.

Mr. Pressley: It is also important to understand exactly what HRSA wants from us, and so it is good that the Planning Council is receiving TA from HRSA.

Mr. McGovern: While it is important to prove health outcomes, we know it is hard to capture them, as providers are not reporting health outcomes for many services.

Mr. Pressley: The P&E and Data Committee will have new staff resources to assist in planning and evaluation activities.

Mr. Watts: It is a sound principle that there be no provider presentations at the workgroups, but they can be appropriate when there is a single-source contract.

Mr. Pressley: I recommend that workgroup chairs check in with me and the Planning Council co-chairs on this. Also, data is available from MHRA.

Ms. Verdino: MHRA is happy to come to the workgroups to make presentations. I will speak to all chairs about what data we can provide to help plan for services.

By-laws Task Force Report

Mr. Brown: The By-laws Task Force developed a set of principles to guide their work. The Task Force met again last week and is developing a timeline for bringing its recommendations to the EC and Planning Council. The Task Force will present the full set of recommendations when they are ready. HRSA TA consultant Emily McKay has been participating by phone and will meet with the Task Force before the next EC meeting.

Agenda Item #4: Policy Issues Update

Mr. Cordero: The House of Representatives and Senate have passed their versions of the FY 2004 Labor/HHS appropriations bill, and the process has moved into conference where both sides will reconcile differences in their spending bills. Both chambers flat funded Title I, and that number is not expected to change in the final version of the bill. Title III, however, is poised to lose as much as \$4.4 million if the conference committee sides with the House. The Senate bill flat funds Title III.

Federally funded health programs, including the CARE Act, are currently being funded at FY 2004 levels through a continuing resolution that will expire on November 21, 2003. It remains unlikely that the 108th Congress will complete the roster of unfinished spending business in time for a Thanksgiving adjournment. Congress may have to resort to an omnibus spending bill (a measure that combines several spending bills into a single appropriations bill) that includes the CARE Act and HOPWA.

The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition continues its efforts to get a jump on the 2005 CARE Act reauthorization. The Coalition's reauthorization work group submitted several position papers to the membership for review during the September 2003 business meeting held in Washington, DC. Paper topics included formula funding, the Minority AIDS Initiative, coordination of funding streams, emergency designation, and possible harmful amendments. Those papers are currently being refined, and will be presented to the membership at the December 2003 business meeting in Atlanta.

New York CAEAR Coalition members Sharen Duke and Matthew Lesieur are leading the subcommittee on formula funding, which address several issues around Ryan White reauthorization and the Title I formula section, including: 1) Should the formula, based on AIDS cases remain the same, or should the formula be amended to include HIV case data? 2) Should the "hold harmless" provision remain the same, be amended or deleted? 3) Should other indicators (poverty, other STDs, cost of living, etc.) be included in the formula? 4) Should some mechanism be included in deciding award amounts to take into account the number of persons served in an EMA?

Mr. Cordero (in response to questions from Messrs. Barnes, Bostic and Pressley and Ms. Avery): Title III is usually popular in Congress because funding goes directly to community health centers and other health care providers in local Congressional districts. This year, the White House told Congressional leaders to hold the line on spending, and so there was a cut in Title III to balance an increase in Title II. New York is very strongly represented on the CAEAR formula committee, as well as others, to balance out efforts by southern states. The Planning Council voted to have updates on appropriations and reauthorization at every EC and Planning Council meeting. Changes in Medicare are legitimate issues for the Policy Committee and/or OAPC to address. As the Planning Council is a Title I body, Title I issues take precedence.

Mr. Cordero: The Institute of Medicine (IOM) released a report on November 7, 2003 (commissioned by the Secretary of US Health and Human Services, as required by the CARE Act) in preparation for reauthorization. The study evaluated three issues: 1) the feasibility of using HIV case data in the Ryan White allocation formulas, 2) data and tools that could be used to make an assessment an EMAs severity of need, and 3) to identify health outcomes and other data that can measure quality of and access to RWCA funded services.

The IOM study reached several conclusions: 1) HIV reporting was not yet developed and consistent enough across states to incorporate into the formulas for Titles I or II; 2) Southeastern states receive the smallest allocations per estimated living AIDS case; 3) Current formula overestimates the number of cases that qualify for RWCA services, as other forms of insurance are available for many PWLHs; 4) Current formula does not take into account variations in costs of care or fiscal capacity across EMAs and states.

The IOM study made several recommendations: 1) HRSA should continue to use estimated living AIDS cases in formula; 2) Concerted effort should be made to improve consistency of HIV case reporting; 3) CDC should accept HIV cases from all states, be they code-based or name-based (Currently, CDC seems only interested in using names based reporting, but many states only have code-based reporting systems); 4) CDC should obtain estimates of total HIV prevalence (including undiagnosed) and develop methods other than case reporting for using in RWCA formula allocations; 5) HHS should initiate several studies before future reauthorizations on RWCA formula allocation issues, relative burden of disease, and other related issues; 6) Congress should reevaluate RWCA formulas to determine whether funds are allocated based on PWLHs who are uninsured in EMAs & states; 7) HRSA should modify Title I supplemental application to amend severity of need section to be based more on quantitative data and much shorter narrative; 8) Other measures should be included in Title I award allocation that measures variations in costs of care and fiscal capacity across EMAs; 9) HRSA should evaluate feasibility of using social indicator models in allocating funds; 10) HHS should study specific needs and circumstances of PLWHs, which could be used to estimate resource needs and quality assessment activities; 11) HRSA should adopt quality of care measures for States and EMAs; 12) HHS should provide resources to HRSA & CDC to develop infrastructure for monitoring quality at patient, clinic and population levels, including: enhanced support for MIS, developing population based measures, and Congress should enhance flexibility in administrative caps at grantee level; 13) HHS should convene a working group to consider strategies for promoting greater collaboration between public health departments and private sector providers. We will forward this information to the Policy Committee for review.

Mr. Cordero (in response to questions from Messrs. Butler, Joyner, Watts and Bostic and Ms. Avery): HIV reporting can be done with names or through anonymous codes. New York uses names. The CDC does not accept

coded HIV reporting. The IOM report says that codes are just as good as names and be should accepted. The report recommended not using HIV data because the data is not consistent across states. Some states have been collecting HIV data for a decade; New York only implemented it in 2000. Given that New York does a good job of keeping people from progressing to AIDS from HIV, it would possibly penalize New York, but using HIV reporting will benefit states with rapidly increasing epidemics (i.e. the south). It is true that if a state and locality (like New York) have made a big investment in their care system, it is not fair to take away federal funds, while other states do not make that investment. Also, some states do not have EMAs, and so receive no Title I funds.

Mr. Craig: It should be pointed out that many southerners often came to places like New York because we have a better health care and social services system.

Mr. Barnes: If private insurance is taken into account, New York will benefit, as most PLWH in New York do not have it. For example, over 60% of PLWH in San Francisco private insurance, but they still get a large per capita share of Title I funds. Taking into account other third party payers can also hurt New York as we have a generous Medicaid program.

Mr. Cordero: These questions are why the Policy Committee is important and why we are holding a community forum in March on reauthorization issues.

Mr. Oldham: This is also why there needs to be a strong coalition between DOHMH, the Planning Council and all community partners so that we can all get behind the effort for more funding for New York.

Agenda Item #5: Grantee Report

Ms. Hilger: Last year, at end of the year, the EMA spent all but 4.7% of its award (including the previous year's carry-over). We expect to do even better this year. The EMA gets full points in the application on this condition of award if there is less than 5% under-spending. The Planning Council needs to think about the impact of such small carry-over on the spending plan. In the past, we counted on more carry-over to fund a larger program by shorting the ADAP pools at the beginning of the fiscal year and replenishing them with carry-over.

HRSA's external review of the application will take place the first week of December. After that, we will make copies available to the Planning Council. I gave a presentation at the P&E on using the application for planning. The application is a product of the Planning Council's work and shows the questions that HRSA is asking. Michael Isbell will present on the application to the Planning Council on December 18th, and the P&E will continue its discussions on how the application can help workgroups in planning.

DOHMH is engaged in collaborative planning with HOPWA to fund additional TA. MHRA will look at eligible proposals from the existing RFP. Proposals will need to provide TA to housing providers.

Ms. Verdino: After meetings with the AG co-chairs, it was suggested that MHRA/HIV CARE Services have a community advisory group (CAG), and so one was established. Its mission is to make recommendations to HIV CARE Services on their contract administration and monitoring services. The 26-member CAG includes Title I and prevention contractors and consumers, community members and staff. There are standing seats for the community co-chairs of the Planning Council and PPG and one of co-chairs of those bodies PWA advisory groups. The other AG co-chairs are on the CAG membership selection committee. The CAG had a successful first year, helping to streamline the contract renewal process (HIV CARE Services did much better this year, with almost all contracts renewed by March). The CAG provided feedback on the development of grievance procedures for contractors and for consumers who have not had their grievances resolved at the agency level and on the HIV CARE Services web site, suggesting the creation of contractor networks. We also conducted a satisfaction survey for providers on communication with MHRA, the contracting process, etc.

Ms. Verdino (in response to a question from Messrs. Abadia, Bonilla, Craig, Chavez, and Hemraj, and Ms. Curry): All contractors are required to have grievance procedures, and we ask to see any that have been filed related to the Title I-funded program. If a consumer does not want to file a grievance with an agency, they can contact us. We are monitoring implementation of grievance procedures now. Providers are also supposed to have grievance procedures posted, and we will monitor that. If we see on our site visits that they are not posted conspicuously, we will have them posted. We also ask for minutes of CAB meetings, which are confidential and subject to Health

Insurance Portability and Accountability Act (HIPAA) requirements, like medical documents. We monitor grievance procedures and CABs separately. CABs are not grievance bodies, but advise the agency on programs.

Agenda Item #6 Public Comment, Part II

D. Lesane: Brooklyn has always been under-represented on the Council and not funded proportionately. This is true again this year, with the removal of the previous community co-chair, who is from Brooklyn. The selection process was flawed and is not representative.

P. Warren: NDRI has a new TA grant to provide unique training and consultation, partnering with CBOs to develop training work plans unique to agencies. All services are free, including follow-up to see if the goals were met.

E. Ammons-Johnson: On behalf of the Bedford-Stuyvesant HIV CARE Network, we welcome the Planning Council to Brooklyn. It should be noted that CARE Network Coordinators are ex-officio members of P&E, which means that, while they participate, they do not vote. In Bedford-Stuyvesant and Crown Heights, one person a day is diagnosed with HIV. We are disproportionately affected. We need more meetings in Brooklyn and more advance notice of those meetings.

J. Scott: As a resident of Bedford-Stuyvesant, I ask that the Council assist this neighborhood and borough to combat HIV.

L. Holley: Officials need to educate people in the community who are infected and affected by HIV about available services. Also, CBOs should not compete with each other for funds.

R. Jones: As a long-term PLWH, I have fought for a long time to bring attention to HIV. All the PLWH who sit on the Planning Council should be commended for their efforts. Everyone should be accountable to the community.

Mr. Craig: I was born in Brooklyn, and my heart is still here, even though I live in the Bronx.

Dr. Hill: Through the support of the Planning Council, DOHMH, through its HIV Training Institute, is holding its Faith Forum II in February in Brooklyn. Everyone is encouraged to participate.

Mr. Abadia: All PLWH or parents of children with HIV are encouraged to participate in the AG and its committees. Meetings are held on the second Saturday of each month at GMHC (the AG is not affiliated with GMHC). Also, it is important to do outreach, including by regular mail to promote the Planning Council. The AG has discussed holding meetings in the outer boroughs, but is difficult, as there is no formal membership, and having it always in the same location means that people always know where it is. I will bring this back to the AG.

Ms. Curry: SMART University (Sisterhood Mobilized for AIDS/HIV Research and Treatment) had its first all-women's power walk, but it was disappointing that no DOHMH or OAPC representatives were there.

Mr. Oldham: We will continue to have meetings in all boroughs and improve and open up the process. We want a strong coalition to help New York.

There being no further business, the meeting was adjourned.

Parking Lot

- Examine impact of IOM report (Policy Committee)
- Coordinate Planning Council meetings in outer boroughs with HIV CARE Networks

Minutes approved at the HIV Planning Council Meeting, December 18, 2003

Frank J. Oldham, Jr.
Governmental Co-chair