



Meeting of the

HIV Health and Human Services Planning Council of New York

April 21, 2005

3:10 – 5:05 PM

Local 1199, 310 W. 43rd Street

MINUTES

Members Attending: B. Stackhouse, PhD (Acting Governmental Co-chair), S. Hemraj (Finance Officer), S. Abramowitz, PhD, K. Ashley, MD, P. Avitabile (for E. del Campo), M. Bacon, M. Barnes, P. Berrios (for J. Pedraza), R. Bonilla, K. Butler, E. Camhi, F. Carroll, O. Clanton (for R. Abadia), C. Cobb, C. Craig, H. Cruz, B. Curry, I. Feldman, J. Grimaldi, MD, R. Gonzalez, M. L. Hernandez, J. Hilger, F. Machlica, D. Marder, MD, H. Mateo, D. Ng, A. Paige-Bowman, T. Petro, A. Richardson, E. Telzak, MD

Members Absent: A. Aviles, MD, G. Brown, MD, E. Cates, R. Chavez, L. Dolloway, C. Dzubilo, I. Gamble-Cobb, H. Hernandez, J. Lopez, P. McGovern, W. Okoroanyanwu, MD, T. Osubu, A. Palermo, J. Pressley, A. Raiola, E. Santiago, T. Troia, D. Woodard

Staff Present: *OAPC:* G. Moon, D. Klotz, S. Bailous, I. Gonzalez, C. Silva; *DOHMH:* S. Kellerman, MD, MPH, S. Forlenza, MD, MPH; *MHRA:* R. Miller, R. Rasmussen

Guest: M. McClain, D. Wirth, S. Shah, MD, E. Williams, J. Bookhardt-Murray

Agenda Item #1: Welcome/Introductions/Minutes

Dr. Stackhouse opened the meeting.

Mr. Cobb introduced the moment of silence

Ms. Moon reviewed the meeting packet.

The minutes of the March 17, 2005 meeting were approved with one correction from Ms. Carroll.

Agenda Item #2: Public Comment, Part I

M. Gold: Thanks to the Council for having a presentation last month on Medicare/ Medicaid changes. The presenters still did not have all the answers, as there are many unknowns. One presentation is not enough. We need a continuing dialogue on this issue to get answers to help the thousands who will be affected.

G. Huang-Cruz: PLWHA self-empowerment is a quality of care issue. There are many barriers to self-advocacy around health care needs and community planning. We need to promote self-empowerment so that consumers can advocate with their health care providers and on planning bodies. Also, prevention needs to be integrated into clinical care settings. The Council and Prevention Planning Group should

initiate discussions on this issue. Finally, May 19 has been designated the first National Asian/Pacific Islander AIDS Awareness Day.

Agenda Item #3: PLWHA Advisory Group Report

Ms. Carroll: The PLWHA Advisory Group (AG) met on April 9th where Deloris Dockery of McClain & Associates presented on the 2005-2008 Strategic Plan. This was her second presentation to the AG on the plan and it was well received. There was a good discussion that we hope will help the development of the Strategic plan.

The AG Client Advisory Board (CAB) Survey results are available. We hope to have an opportunity to make a full presentation of them soon. In summary, the top ranked Title I service categories that promote access to and maintenance in HIV-related primary care are: ADAP, housing, case management, mental health, food and nutrition. The top current gaps in HIV-related services are: housing, mental health, supportive counseling, transportation, client advocacy. Finally, The AG was proud to welcome Annette of the "HIV Stops with Me" Campaign to the meeting. We are always encouraged when we see a woman of color standing up and speaking out about HIV/AIDS.

Agenda Item #4: FY 2005 Reprogramming Plan

Ms. Mateo: The Planning Council needs to develop a FY 2005 reprogramming plan now that the spending plan has been finalized. It is critical that we develop reprogramming ideas so that all Title I funds, including potential unspent funds, are spent in accordance with identified service priorities. The Council's first priority identified in the FY 2005 spending plan is the \$4 million commitment to the ADAP pools. Reprogramming funds come from three sources: uncommitted funds from FY 2005, under-spending from FY 2005, carryover from FY 2004. Most of the funds will be available on a one-time basis; however there may be a small amount available for ongoing priorities. If recurring funds are identified, the Council may use those to fund additional programs proposed in response to previously issued requests for proposals. The Council will develop a priorities plan for both one-time and on-going initiatives which the grantee will implement as reprogramming funds become available.

The timeline for the development of a FY 2005 reprogramming plan should allow for minimal disruption of the FY 2005 planning process. The co-chairs of the Integration of Care, Access to Care and Maintenance in Care committees must submit prioritized reprogramming ideas with proposed resource allocations to the Priority Setting & Resource Allocation Committee for review, approval and prioritization by May 25, 2005 in order to be considered. The timeline for development of the reprogramming plan is: April 14: EC discusses FY 2005 reprogramming plan criteria; April 26: IOC, ATC, MIC and Consumers Committee develop reprogramming ideas; May 11: IOC reviews and finalizes reprogramming plan; May 25: PS&RA reviews and finalizes reprogramming plan; June 9: EC reviews and finalizes reprogramming plan; June 16: Planning Council finalizes and approves reprogramming plan.

The criteria for the FY 2005 reprogramming plan are: 1) identify one-time, non-recurring initiatives; 2) develop ongoing initiatives that reflect the FY 2005 priorities; 3) implementation must not require a full solicitation; 4) funds may not be used for capital construction or other expenses prohibited by federal rules; 5) funds must be spent by February 28, 2006; 6) existing service categories should be enhanced if needs are identified; 7) carryover funds may not be used for Planning & Evaluation initiatives, but uncommitted and underspending can be used to fund one-time P&E initiatives.

Dr. Stackhouse: This is an ambitious time line. Good luck to all the committee members.

Agenda Item #5: SNPs Presentation

Mr. Feldman: Special Needs Plans (SNPs) represent new care and reimbursement opportunities as we enter into financially challenging times. Currently, the SNPs are covering over 1300 PLWHA, and there are a number of Council members that are active participants of SNPs.

Mr. Wirth: Special Needs Plans (SNPs) were set up to provide better access to and maintenance in care than traditional fee-for-service Medicaid. There are many opportunities for consumers with SNPs, and the four operational providers are here to describe their programs (one other SNP is in a pre-operational stage). SNPs are comprehensive health plans for PLWHA who have Medicaid and their children (to age 19, regardless of HIV status). They are voluntary to join and there is no lock-in period. They build upon the strengths of fee-for-service Medicaid, but address the problems with that service (e.g., ability to have more than one medical service per day, HIV-specialist as primary care provider, comprehensive network of providers, care coordination, 24-hour plan assistance, one-stop shopping options).

Mr. Camhi: NY Presbyterian Select Health has a network of specialists in a wide range of medical specialties and extensive care coordination (from benefit education to transportation).

Dr. Shah: Metro Plus Health Plan acts to increase patient retention by sending discharge summaries electronically to the patient's primary care provider and case manager within 24 hours of discharge and scheduling an appointment within seven days, among other steps. We collaborate on quality improvement efforts with HIV primary care sites and SNPs.

Mr. Williams: Health First has a comprehensive care model that goes beyond medical care, helping to secure housing and benefits.

Ms. Bookhardt-Murray: Vida Care offers individualized care through a team that facilitates coordination and ensures flexibility.

Mr. Camhi (in response to a question from Mr. Craig): We have a consumer advisory board, as well as several enrollees on our board of directors. We also do patient satisfaction surveys.

Mr. Camhi (in response to a question from Ms. Curry): About 1300 people are enrolled in SNPs so far, which is lower than expected. It is not easy to reach all consumers, and we encourage you to spread the word about them. We will do presentations. Also, our consumers are becoming advocates for the plans.

Dr. Shah: SNPs are a substantive improvement in care from fee-for-service Medicaid. We have an excellent retention rate (up to 94%), which speaks to the plan's success.

Mr. Williams: When SNPs were first developed, many of us who worked at CBOs discouraged enrolment due to concerns we had. This misperception may still persist, and CBOs need to let consumers know about the benefits of SNPs.

Ms. Burkhart: Each plan has a CAB. People have fears about enrolment and need reassurance. Also, from a quality perspective, it is better to have a steady provider.

Mr. Wirth (in response to a question from Ms. Paige-Bowman): The enrolment form has a release that allows providers in the plan to talk to one another to coordinate care. Fee-for-service Medicaid has breakdowns in communication that lead to loss of coordination. There is a special release form required to communicate with a provider outside of the plan.

Mr. Camhi (in response to a question from Ms. Mateo): Substance abuse treatment is a carve-out from SNPs and is still covered by regular Medicaid, as are medications and COBRA case management. All SNP providers must perform to the plan's quality standards and are credentialed and monitored. We are always improving quality and adding providers. If enrollees lose their Medicaid coverage, we can cover them for 6 months and hook them up with COBRA case management and get them reconnected to care. Also, plans follow children (regardless of HIV status) to age 19 and provide all care (they can go to non-HIV-specific doctors if they are negative).

Mr. Wirth: We have traditionally found that women with HIV/AIDS often forego care in order to take care of their children. In a SNP plan, we are able to intervene with the entire family and engage the mother in

care. We are also using Cicatelli Associates to do sensitivity training with even the people who move equipment and often come into contact with clients.

Agenda Item #6: Strategic Plan Presentation

Mr. McClain: The 2005-2008 Strategic Plan for HIV/AIDS Services for the New York EMA will have three basic chapters (a structure suggested by HRSA): 1) the current picture, 2) goals and objectives, 3) monitoring progress of chapter 2. There is a vision statement that that PLWHA in the EMA will have access to and maintain appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life. IOC developed initial overarching goals: to improve the health outcomes and quality of life for people living with HIV disease; to reduce the transmission of HIV; to increase the number of individuals who are aware of this HIV status. These goals break down into three large themes: access to care, maintenance in care, and the system as a whole. There are subsidiary goals for each of these, and measurable objectives for each of the subsidiary goals, developed by IOC and reviewed by ATC, MIC and the PLWHA AG. Goals and objectives were refined and action steps added by the committees, and IOC will be meeting again to finalize these with the input of the sub-committees. A draft plan will be submitted in mid-May for review, with a final plan published in July.

Mr. McClain (in response to a question from Mr. Barnes): It was a wish that the Council and PPG would have a joint goal, and I hope that we will do it in the context of the annual implementation plan.

Mr. Barnes: We should put what we can in the plan, and we can flesh it out during the comment period.

Agenda Item #7: Grantee Report

Ms. Hilger: FY 2004 ended February 28th, and we are closing out programs. The process should be finished by mid-May, after which we will know the carry-over amount. We will use the close-out information to do permanent take-downs for chronic under-spending, which may free up some money for on-going reprogramming proposals. We will submit our financial status report to HRSA in June, and then after the reprogramming plan is done, we can submit a carry-over plan to HRSA. We should have approval from HRSA anytime from September to December.

With the decrease in the award, we are only funding the pre-existing categories from the current RFP. We will notify proposers of the award in the next two weeks. We can hold the RFP open if funding becomes available later in the year or next year. Current contracts will run through the end of August, so there will be no break in service.

The US Senate Committee on Health sent letters to all Title I EMAs asking for planning council membership information for the past five years, as well as grant recipients and conflicts of interest guidelines and other information. We have responded, answering their questions and clarifying the role of the Council and grantee. The request is probably background information for reauthorization, but we do not know how it will be used.

The FY 2005 Title I grant application is in your packet. It was a very good application, succinct (because of page limits). It is a good resource throughout year for planning, containing much useful data. Please share it, and we have additional copies if needed. Also in your packet is HRSA's review of our application, detailing strengths and weaknesses of each section. The overall score for the application was 96 out of 100, which is excellent, but we do not know how the score was used in determining funding. The strengths far outnumber weaknesses. We address the weaknesses in our response, identifying the language in the application guidance and the relevant part of the application that responded to that guidance.

Mr. Petro: 96 is a great score, which shows the fantastic job of that application write Michael Isbell, DOHMH staff, and Council members did. Even though we lost some funding, it had to do with things out of our control, such as the national funding amount and formula issues.

Ms. Hilger: Many of the strengths cited by HRSA related to the planning process, which shows the great work done in the Council.

Agenda Item #8: Public Comment, Part II

D. Miller: SNPs should bring data to their presentations on how they are working. New York is a national model, and so it is important that SNPs demonstrate effectiveness.

R. Jones: I am impressed with the Council's process in developing the Strategic Plan, but I suggest that more PLWHA input be used in the monitoring of the plan.

L. Holley: I am generally happy with the SNP that I am enrolled in, but I am concerned that SNPs are taking health care out of the hands of consumers. The client should be at the center of all health care decisions. Also, few Planning Council members attended the recent community forums. They should have been there to hear the concerns of the community.

J. Livigni: There are not enough PLWHA at the table. Also, I want to see the results of the CAB survey.

E. Rodriguez: Body Positive is coming out with a special issue of our newsletter on SNPs. We are looking for enrollees to provide input about their experiences.

Agenda Item #9: New Business

Ms. Moon: The Policy Forum on CARE Act reauthorization is tomorrow.

Dr. Stackhouse: I was at three of the community forums and want to thank the Council members who were there and the community members who spoke. I especially want to thank Mr. Klotz for getting the report out quickly so that people who weren't there could read what people said.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on May 19, 2005

Bill Stackhouse, PhD