



## Meeting of the

# HIV HEALTH AND HUMAN SERVICES PLANNING COUNCIL OF NEW YORK

SEIU/Local 1199, 310 W. 43<sup>rd</sup> Street  
May 20, 2004  
2:25-5:30PM

## MINUTES

**Members Present:** F. Oldham, Jr., N. Nagy, S. Hemraj, R. Abadia, B. Agins, MD (for H. Cruz), A. Ali, P. Avitabile (for E. del Campo), L. Bishop, R. Bonilla, K. Butler, P. Catapano (for S. Abramowitz, PhD), R. Chavez, B. L. Curry, D. DeLeon, C. Dzubilo, I. Feldman, R. Gonzalez, A. Gutkovich (for D. Marder, MD), H. Halperin, M. Hill, PhD, R. Joyner, F. Machlica (for L. Fraser), H. Mateo, P. McGovern, H. Melore, D. Ng, A. Paige-Bowman, J. Pedraza, T. Petro, J. Pressley, P. Quintero (for M. Bacon), M. Reynolds, P. Stabile, T. Troia, L. Wactor (for C. Cobb), B. Watts

**Members Absent:** M. Barnes, F. Carbone, B. Chu, MD, C. Craig, E. Handelsman, MD, A. Raiola, E. Santiago, M. Wainberg, MD, D. Woodard

**Staff Present:** *OAPC:* R. Cordero, D. Klotz, G. Moon, S. Dwyer, S. Bailous, I. Gonzalez, C. Silva, M. Lesieur, R. Shiau; *DOHMH:* J. Hilger, J. C. Park, B. Larson, A. Kolodny, MD, L. Lasenburg; *MHRA:* R. Miller, B. Carroll, P. Jensen

**Additional Guests Present:** P. Staley, D. Bimbi

---

### Agenda Item #1: Welcome/Announcements/Minutes

*Mr. Oldham* opened the meeting, followed by introductions.

*Mr. Joyner:* Before I read the rules of respectful engagement, I want to say that it has been an honor working with Mr. Oldham. Thank you for the unity and continuity you have brought to the Planning Council.

*Mr. Halperin:* Thank you, Mr. Oldham, for the integrity and respect you have brought to the Planning Council. For the moment of silence, let us remember those for whom HIV/AIDS is still an emergency in this City.

*Mr. Cordero* reviewed the meeting packet.

*Mr. Oldham:* As you are all aware by now, I have resigned as Citywide Coordinator for AIDS Policy effective June 11<sup>th</sup>, and on June 14<sup>th</sup> I become Executive Director of Harlem Directors Group. The past eighteen months have been challenging, and rewarding. The staff that we have assembled in the Office of AIDS Policy Coordination (OAPC) is the best in the country, and I think the community recognizes their talent. Nationally, New York is once again viewed as a key policy player in the field of HIV/AIDS. This has only happened through hard work, long hours and a tireless commitment to improving the lives of people living with HIV/AIDS.

I am also proud that PLWA Initiatives has become a vision realized under the direction of Mr. Bailous, whose support of the PWA/HIV Advisory Group has been outstanding, along with Mr. Molina and Mr. Mosley. We look forward to all of the future initiatives that the AG is planning, in order to improve consumer input into the Ryan White planning process. Dr. Hill has been a tireless supporter of our office and the community planning process, and she is committed to ensuring that there is a smooth transition in leadership of the Office. Mr. Cordero has been appointed Acting Citywide Coordinator for AIDS Policy and Governmental Co-chair effective upon my departure. There will be a national search for this position, and the goal is to have a strong candidate in place in time for the new planning cycle.

The record \$122 million Title I award that we received this year demonstrated what we can achieve when we all pull together and work toward a common goal. As we all know, the President has proposed no new money for Title I in 2005, which means next year's application process will be just as competitive as this year's. That means continuing to have the very best planning process we can and building upon the coalition that has formed between the community and government through our Ryan White, housing and prevention planning processes.

*Ms. Nagy:* The next major steps in the priority setting process for fiscal year 2005 planning is presentation by the workgroups of their reassessed templates to the Planning and Evaluation (P&E) Committee on May 21<sup>st</sup>, June 11<sup>th</sup> and June 25<sup>th</sup>. The P&E will vote on all workgroup templates on June 25<sup>th</sup>, and the Executive Committee (EC) will review and vote on priorities and resource allocations at its July 1<sup>st</sup> meeting. The full Planning Council will vote on final priorities and resource allocations at its July 15<sup>th</sup> meeting. If necessary, we have tentatively scheduled an additional Planning Council meeting on July 29<sup>th</sup>. It is critical that we stick to this timeline as we have all year long.

Today, P&E Chair Mr. Pressley will present the ranked FY 2004 reprogramming plans, as approved on May 13<sup>th</sup> by the EC and P&E. This is important because we need to demonstrate to HRSA that we have a plan in place for any carryover or unspent funds. In our FY 2005 application, we will be scored on our ability to spend at least 95% of our award by February 28, 2005.

The minutes of the April 15, 2004 meeting were approved with one change to note the attendance of Rev. Troia's alternate.

### **Agenda Item #2: Public Comment**

*M. Gold:* I just met with Congressman Nadler's staff, where they emphasized that the way to be able to increase allocations for HIV programs is to beat Bush in the election. We are busy planning the first conference targeting PLWH over 50 and long-term survivors. There should be some exciting workshops. I am also happy about the AIDS Institute's new brochure on oral health for PLWH. Finally, having been involved with the Planning Council through three City administrations, I want to thank Mr. Oldham for his support of the PLWH community.

*G. Huang-Cruz:* As previous community co-chair of the PPG, I want to thank Mr. Oldham for his contributions. Also, the Planning Council needs to respond to the Institute of Medicine (IOM) report on the CARE act, as it could jeopardize all planning councils. I invite the Planning Council co-chairs to join the PPG co-chairs in this effort.

### **Agenda Item #3: PWA/HIV Advisory Group Report**

*Mr. Abadia:* I want to thank Ms. Carroll for her work as my alternate. Also, on behalf of the PWA/HIV Advisory Group (AG), thank you to Mr. Oldham for his support. As he is a member of the AG, we will continue to see him.

*Ms. Carroll:* The recent AG survey of Title I community advisory boards (CABs) got 72 responses, double the return rate of previous years. Thanks go to CAB members who completed the survey. Copies of the report are available in print and on the Planning Council website. I urge everyone to read it and use the results for planning. The survey identified the top 5 Ryan White Title I services that promote access to and maintenance in HIV-related primary care: 1) Case Management; 2) Access to Care and Early Intervention; 3) ADAP; 4) Food & Nutrition; and 5) Transportation. The survey identified the top five service gaps as: 1) Housing; 2) Legal services; 3) Food and Nutrition; 4) Home care; and 5) Mental Health services. Finally, 90% reported that they are satisfied with the quality of the Title I services they receive. At last AG meeting, members shared updates on participation in the workgroups and other concerns, such as outreach. The AG tabled at AIDS Walk, reaching a large number of people.

Thank you to AG members and staff who helped out at this event. The June AG meeting will be at Project Hospitality on Staten Island.

*Mr. Abadia:* Thanks to Rev. Troia for hosting the AG. Please read the CAB survey results.

*Mr. Oldham:* The survey will be a big help for our next application. Thanks to Mr. Abadia and Mr. Bailous for such a successful effort.

#### **Agenda Item #4: FY 2004 Reprogramming**

*Mr. Pressley:* Thank you, Mr. Oldham, for helping bring the Planning Council together. Before discussing the FY 2004 reprogramming plan, I want to commend DOHMH for working so hard to ensure a high spending rate. In March 2004, the Planning Council began discussing principles for allocations. At the April 1<sup>st</sup> EC meeting, we discussed reprogramming criteria, which was communicated to the workgroups, who met through April and May to develop proposals. At a joint EC/P&E meeting on May 13<sup>th</sup>, the proposals were reviewed, followed by a ranking. Reprogramming funds come from carry-over, accruals and uncommitted funds. The Planning Council already approved as its first two priorities for reprogramming \$5.4M for ADAP, and \$470,000 (one-time) and \$70,000 (ongoing) for P&E initiatives to fulfill HRSA requirements. In your packet is the ranked list of one-time and ongoing initiatives.

*Mr. Pressley (in response to a question from Mr. DeLeon):* The NYC Commission on Human Rights did not submit any reprogramming proposals.

*Ms. Miller (in response to a question from Mr. Halperin):* We will know the exact amount of carry-over shortly, but we are predicting somewhere around \$3.5M. Additional money will be identified later in the year.

*Mr. Halperin:* So it is unlikely that we will be able to fund anything beyond ADAP.

*Ms. Hilger:* That scenario is likely, but it is still worth doing a thorough plan.

*Ms. Miller:* We expect around \$2M to \$2.5M in FY 2004 under-spending from late starting contracts. The amount of uncommitted funds will be small (around \$0.5M).

*Ms. Melore:* Has the memo from Ms. Hilger been revised, specifically comments around NY LINK?

*Ms. Hilger:* There is a clarification on questions that HRSA gave us last year, i.e., that funds can only be used for training local people from the New York EMA.

*Ms. Reynolds:* There are no proposals addressing services for adolescents

*Mr. Pressley:* Every workgroup had an opportunity to develop proposals.

*Mr. Cordero:* Title IV funds youth programs (as well as women and children), and there are multiple Title IV providers in the EMA, and so if we develop Title I services for these populations, the planning should be coordinated.

*Ms. Nagy:* The Planning Council has been working to coordinate services with Title IV providers, and we are making progress.

*Mr. Chavez:* Given the financial projections and the unlikelihood of anything beyond ADAP and P&E being funded, I move to accept the rankings and move on to the rest of agenda. [Seconded by Mr. Petro]

*Mr. Halperin:* I need a response to some things in the minutes of the May 13<sup>th</sup> EC/P&E meeting. Two workgroups said that they only looked at one-time initiatives.

*Mr. Chavez:* There was misunderstanding in the Infrastructure Workgroup about ongoing initiatives, but we did have an opportunity since then to consider other proposals, but declined to do so.

*Mr. Pressley:* All workgroups were given an opportunity to consider more proposals.

*Mr. Halerpin:* In the conversation on NY LINK, it was inappropriate that Dr. Brown, who works for the same organization, advocated for the program.

*Ms. Melore:* Dr. Brown did disclose her conflict of interest.

*Mr. Chavez:* There is a difference between advocating for one's self-interest and answering questions to provide clarity on details.

*Mr. Halperin:* I am still concerned that some programs can advocate for themselves.

*Mr. Stabile:* Dr. Brown only answered questions for clarification. The proposal did not come from her workgroup, and she was not in the Infrastructure Workgroup discussions where it was proposed. Since she was present at the EC/P&E meeting when a question came up about it, she answered it to clarify some details.

*Mr. Pressley:* If there is no further discussion, we should move onto a vote.

*Mr. Chavez* restated the motion. Approved 30-2-1 (Y-N-A)

#### **Agenda Item #5: Crystal Meth and HIV**

*Mr. Larson:* I want to thank Mr. Oldham and Ms. Nagy for inviting us to present to the Planning Council on this important issue. The Planning Council and the Alcohol and Other Drugs Workgroup have been very responsive to the use of heroin and crack cocaine in the communities of New York City. DOHMH is now responding to the health and mental health issues around crystal methamphetamine (crystal meth).

Crystal meth (also known as "tina" or meth) is a highly addictive stimulant that produces a short-term sense of euphoria, with feelings of increased strength, improved confidence, and invulnerability. Like cocaine, crystal meth is highly addictive, leaving users physically and psychologically dependent. It is relatively easy to make and less expensive than cocaine. It can be smoked, snorted, orally ingested or injected. The drug originally gained popularity on the west coast, spread to rural areas, and now has made inroads into the nation's urban centers. Its use is a growing public health problem in New York City, where diverse populations use it. It has especially infiltrated the gay community as a party drug and stimulant. Crystal meth use has been associated with high-risk sexual behavior. Men may use it because it lowers sexual inhibitions and results in intense sexual experiences, thus the ramification of its use in the gay/MSM community is not just drug addiction, but also the potential spread of HIV. Researchers have theorized that crystal meth may have fueled the recent rise in HIV infections among men who have sex with men aged 18 to 45 by increasing the likelihood of engaging in unprotected sex while under the influence. Also, there is obvious HIV transmission risks associated with using crystal meth intravenously.

A comprehensive strategy is needed to address this important issue. Crystal Meth may be most prevalent now in the gay community, but we know that epidemics spread. Not only must we address all communities that are at potential risk from crystal Meth addiction, but we must also try to address all the problems that an individual user has.

Peter Staley was a bond trader on Wall Street who joined Act Up in 1987 soon after its founding and led the struggle to lower the price of AZT. He was the opening plenary speaker at the 6<sup>th</sup> International AIDS conference in 1990, and in 1992 founded the Treatment Action Group. President Clinton appointed him to the National Task Force on AIDS Drug Development in 1994, and he is a member of AmFar Board of Directors since 1991. In 2000, he launched a Website AIDSMEDES.com, which offers easy to read information on AIDS drugs and receives about 250,000 visits a month. In January 2004, he launched an ad campaign on crystal meth, using his own funds.

*Mr. Staley:* Thank you for this opportunity to speak about this relatively new healthcare crisis among gay men in New York City. I've spent most of my adult life fighting AIDS, including some very empowering, wonderful, yet

tragic years being one of the leaders in ACT UP then TAG, the Treatment Action Group. Since coming out publicly as a recovering crystal meth addict, first in the gay press, then in The New York Times in January, I've been contacted by many of my fellow HIV-positive friends from the ACT UP years. Most wanted to tell me about their own addictions to crystal meth and how it almost destroyed their lives. I was amazed at how many people from my past had been through what I had been through, and none of us had known each other's stories. There is an immense amount of shame about this drug, which helps hide the extent of its damage.

Crystal meth is the perfect drug for an HIV-positive gay man with a mid-life crisis. In fact, many of the studies about meth and gay men have shown that over half of those using the drug are HIV-positive. After years of dealing with a death sentence, daily pill regimens, side effects, and most importantly, sexual stigmatization, this drug lets you forget all of these things for the first time. When I was using, I used to do something very unusual in the crystal meth underground – I'd ask my sex partners what their HIV status was. Almost all were positive and most were on therapy. Since a crystal meth sex binge can last many days, most of the guys would run out of meds and end up skipping doses. Most, like me, would get syphilis and other STDs. Most were unaware of the studies that have shown that meth impairs CD8 T lymphocyte function, causing immune suppression, or that the drug can interact with their HIV meds in dangerous ways. Scariest of all, most are not aware of the studies that show that meth can increase HIV's ability to replicate and mutate in brain cells by 15-fold.

I wish I had known these things before trying the drug for the first time 4 years ago. After a very long struggle to get clean, I'm happy to say I will have a year and half sober on Saturday. Recently, I have tried to make some much-needed noise about the risks of crystal meth by paying for some politically provocative ads on a few phone booths in Chelsea. I have my doubts that any of this will make any difference in the end. As you know, people don't like talking about drug addiction or HIV. I don't presume to have any answers to this problem. I'm here to share my personal experience with this drug, and how I think it might be impacting gay men living with HIV. I hope I can help this planning council as it seeks to understand and respond to the risks of crystal meth, and I want to leave time for any questions you may have. Thank you for giving me this opportunity.

*Mr. Larson:* Dr. Andrew Kolodny is a psychiatrist who works at the office of Executive Deputy Commissioner for Mental Hygiene and will present on the psychiatric consequences of Methamphetamine use and addiction and discuss treatment options.

*Dr. Kolodny:* Crystal methamphetamine is a chemical that has stimulant properties and can be snorted, injected, smoked or taken orally or anally. It affects the brain by causing a huge rush of dopamine, which causes feeling of pleasure. Initial feelings of the user are elation, euphoria and satisfaction, followed by a crash and an intense desire to replicate the feelings of pleasure by administering another dose. Adverse reactions include: addiction, convulsions, heart irregularities, high blood pressure, fear, fatigue, depression, tremors, wasting, skin lesions, paranoia and may lead to coma and death. Diagnosis of addiction follows the DSM-IV manual. There is no pharmacological treatment for crystal meth addiction. Addiction is treated with psycho-social approaches (e.g. 12-step programs, relapse prevention), although medication can be used to treat some effects of addiction (e.g. anti-depressants).

*Mr. Larson:* At this point, we do not have a lot of quantitative data on the use of crystal meth in New York City. The Center for HIV Educational Studies and Training (CHEST) of Hunter College/City University of New York, represented by David Bimbi, will present their research data. For the past eight years, Mr. Bimbi has worked and conducted research in NYC on health behaviors among gay/bi men and MSM and published on such topics as the personal and contextual factors related to sexual risk taking, substance abuse and sex work.

*Mr. Bimbi:* CHEST conducts research on social and psychological factors that contribute to HIV transmission and to identify and promote strategies that prevent the spread of HIV and that improve the lives of people living with HIV. Various studies include: Drug Street survey 1998; Seropositive Urban Men's Studies 1997-2002; Youth Drug Study 2001; and Sex and Love Studies 2002-3. The studies recruited gay men/MSM at gay venues (e.g. clubs, bathhouses, social/community events). Conclusions from the studies are that recent crystal use (i.e., within the last 3 months) increased almost 4% over the last two years (from 7.4% in 2002 to 11.0% in 2003). Crystal use among MSM is an emerging issue that needs to be addressed now before it becomes unmanageable. Questions to address in HIV prevention include: How can we assist individuals to increase safer sexual behaviors when using crystal and other

drugs? How can we help individuals to reduce or cease crystal and other drug use and increase safer sexual behaviors? How can we involve affected communities in implementing these interventions?

*Mr. Larson:* DOHMH believes that only a comprehensive strategy will succeed in confronting the problem of crystal meth, the same as is needed for addressing the problems presented by any drug. First and foremost, prevention provides the most impact in confronting this drug. Our goal is to raise awareness, increase access to care, broaden outreach for people who use and are addicted to crystal meth, and coordinate care across the city.

*Dr. Catapano:* Within the subset of PLWH, who is targeted for prevention?

*Mr. Bimbi:* We have to target PLWH first, as mixing crystal meth and HIV drugs is contraindicated. Then, we need to target highly sexually active MSM. Sex environments, like bathhouses, have become crystal meth dens, and that is where users are most easily reached.

*Mr. DeLeon:* What accounts for greater increase in receptive anal intercourse, as opposed to insertive among users. Also, what is the data on MSM of color? Studies show the greatest increase in HIV infections among young MSM of color. How is crystal meth contributing to that?

*Dr. Kolodny:* Like cocaine, crystal meth causes vascular constriction, which causes impotence (which is also why some users will combine crystal meth with Viagra, which is dangerous), and so users will often take the receptive role in anal intercourse. There are also psychological reasons.

*Mr. Bimbi:* Many HIV-positive MSM will take the receptive position as a harm reduction strategy to reduce the chance of infecting others. Crystal meth also makes being penetrated easier. However, binge sex parties, where people engage in repetitive sex, causes abrasions that can put the insertive partner at higher risk. There is no statistically significant difference in crystal meth usage rates between white MSM and MSM of color. We need to do more work specifically on MSM of color and crystal meth. We do know that MSM of color in our studies are from all over city.

*Mr. Chavez:* Given that we need multi-pronged strategies and that working around crystal meth has legal implications, what is City doing to help CBOs address this?

*Dr. Hill:* DOHMH has identified funds for targeted campaigns. We have also requested funding from SAMHSA. If we get more funding, we want to do a broader campaign that includes crystal meth and other substances as challenges in HIV prevention in many communities. There is a crystal meth task force at DOHMH, and representatives from OASAS will attend the next meeting. They want to collaborate with DOHMH STD clinics around crystal meth.

*Dr. Kolodny:* DOHMH's Mental Hygiene division is applying for SAMHSA funding for treatment.

*Ms. Melore:* Are there any clinical trials that show interactions between crystal meth and HIV drugs? Will enforcement officials pursue pharmacies, as the chemicals to make crystal meth are from over-the-counter medicines?

*Dr. Kolodny:* There is one recent study on interactions, but I do not have the data handy.

*Mr. Larson:* The Drug Enforcement Agency is working on the supply issues. In NYC, we are seeing a pure form of the drug from large labs in California and Mexico.

*Ms. Melore:* As member of the Communities of Color Coalition on HIV/AIDS, I have the same concerns as Mr. DeLeon. Did DOHMH respond to crack this way? Also, I think this is a biased presentation. There are only numbers of men of color, but not of white men for comparison's sake. I am also concerned that money allocated to fight HIV in communities of color will be diverted when there is no data on CM in COC.

*Dr. Kolodny:* This administration is data driven and most health programs target COC, which have the biggest health disparities. No funding targeted to minority communities is being redirected for crystal meth work.

*Mr. Bimbi:* The percentage of MSM of color is of the whole cohort, and the percentage of crystal use is for the entire cohort. When broken out, there is no statistical difference between groups.

*Dr. Hill:* When we met with SAMHSA, they asked us to send a proposal. We have always been clear that the \$5M in communities of color funds was never part of the small amount identified for crystal the meth initiative. During the crack epidemic, I was in meetings in communities of color where they said HIV is not our issue, and unfortunately we are seeing the results. Even If there are no men of color using crystal meth, then we still have get the message out to them to ensure that they do not start.

*Ms. Melore:* I agree, but I just want to make sure that the data is balanced.

*Ms. Nagy:* we have known about other drug use patterns for a while. We do not want them drowned out by the crystal meth discussion. We know that needle exchange works for IDUs but have not fully supported those efforts. I am glad to hear that DOHMH is targeting all forms of substance use.

*Dr. Hill:* DOHMH's efforts on needle exchange have been extensive and we can update the Planning Council on it.

*Mr. Pressley:* DOHMH did a presentation for organizations working with communities of color a while back. Your data shows no difference between white MSM and MSM of color. What venues did you go to, and when you look at MSM, do you see if they are also in sexual relationships with women (to detect future patterns of transmission)?

*Mr. Bimbi:* The largest number of study participants were recruited at community events, which were well attended and diverse. We do ask for home ZIP codes, as people have pointed out that many men of color do not socialize among white gay men.

*Mr. Pressley:* You're not going to clubs in Jackson Heights, underground sex clubs, etc., where there are anecdotal reports of MSM of color using crystal meth.

*Mr. Bimbi:* To conduct this kind of study, you need to establish community trust. It took 6 years to get into one club. But people at Manhattan venues are from all over the City.

*Dr. Kolodny:* It should be noted that CHEST is not part of DOHMH, and we are going into all neighborhoods.

*Mr. Pressley:* You should use connections with CBOs that are already in those neighborhoods

*Mr. Petro:* Medical providers need to assess patients for crystal meth use and updated standards of care for prevention for positives need to incorporate this. Also, as planners, we can make the medical community more comfortable discussing this with their patients.

*Mr. DeLeon:* We need to fund gay-specific drug treatment programs and clear public education campaigns aimed directly at gay men. Also, we need more data on communities of color.

*Mr. Oldham:* From my experience in Los Angeles and Chicago, crystal meth is used by gay men of all colors and spreads quickly. We need to prevent it spreading to gay men of all colors.

#### **Agenda Item #6: Policy Committee Report**

*Mr. Lesieur:* In your packets is the Communities Advocating Emergency AIDS Relief (CAEAR) advocacy kit. Please sign the postcards and return them, as we will hand deliver them to our Congressional representatives' offices. We are asking for increases in CARE Act appropriations. Flat funding results in swings in Title I awards, which is painful for EMAs. The kit also asks CBOs to ask their Congressional representatives to visit their agencies, to allow them to see the connection between the CARE Act and services provided in their district.

*Mr. Ng:* The Policy Committee recommends approval to send a letter to Mayor Bloomberg on the City's executive budget. In light of today's discussion, I propose broadening the section on substance use issues beyond crystal meth.

*Rev. Troia* moved to accept letter with Mr. Ng's amendment. [Seconded by Mr. Chavez]. Motion carried unanimously.

*Rev. Troia:* I wish to propose another motion. Whereas Mr. Oldham is a gentle man of sincerity, generosity, optimism, wisdom and humility; whereas he emerged as a steady leader of the Planning Council during a time of fiscal crisis; whereas his gifts and skills have guided this diverse body and the City it serves to receive the largest Title I award ever granted and helped shape the future of HIV service delivery; whereas he crafted a talented, creative, committed and hard working staff; be it resolved that this Planning Council extends to Mr. Oldham our deepest gratitude for his exemplary service, and we extend our heartfelt wishes for success in his new position, and for strength, health, happiness and blessings in his days ahead. May the seed of fellowship sown here yield the fruit of lifelong friendships, fullness of life and, in your lifetime, a cure and an end to HIV/AIDS.

The motion was accepted unanimously with a standing ovation.

#### **Agenda Item #7: Client Level Data**

*Mr. Jensen:* On March 22, 2002 the Planning Council directed DOHMH and MHRA to initiate the process for collecting client level data. On June 6, 2002 DOHMH and MHRA submitted a pilot plan for implementing client level data collection. In April 2004, DOHMH and MHRA proposed a pilot project to collect client level data to the P&E. Client level data contains basic demographic and service information of each unique client in the EMA. All data is de-identified and unduplicated using the HRSA Unique Record Number (URN) which is generated by the Uniform Reporting System (URS). The data elements that each agency must collect are defined in by the Ryan White Title I Minimum data set. (RWMDS), which is defined by HRSA reporting requirements and contractual obligations to MHRA for program monitoring. The current RWMDS is developed from the CARE Act Data Report (CADR) and Monthly Program Monitoring Reports (MPR). The pilot a client level data collection process took six months, including training needed committees and workgroups on the data elements captured, working with providers to collect client level data extracts, providing the P&E with a summary of the data collected, assessing the analysis and reporting needs based on client level data, and producing a costs assessment and summary of implementing a client level data collection system. 22 agencies, which represent 52 contracts, participated in the pilot project and were selected to include a broad range of sizes and technical capacities. An aggregated report was developed with client level data.

The impact on providers of participating included required data cleaning and hardware requirements. It does not change current reporting requirements. For MHRA the impact included server and network upgrades to manage the full scale client level data collection and the update of data analysis. Issues that arose include: incorporating non-URS agencies, data cleaning and management, and agency data on service sites and groups and programs needs to be kept up to date.

*Mr. Jensen (in response to a question from Mr. DeLeon):* If an agency does not use URS, they have to demonstrate that they have a data base that captures the data we require.

*Mr. DeLeon:* We were critiqued in our application about our epidemiological data (i.e., that too many PLWH had no identified risk).

*Dr. Hill:* That referred to citywide epidemiological data collected through surveillance and reporting, which is totally unrelated to this project. DOHMH surveillance is taking steps to get medical providers to provide that information. Many medical providers think of this as an intrusion into patients' privacy, and so do not ask.

*Ms. Melore:* In the template review our workgroup is talking about outcome measures. Is there a process to collect that data? Aside from MHRA's server needs to collect data, did any other issues come up, and will we be asked to provide more funding to help you analyze the data?

*Mr. Jensen:* Many groups are looking at outcomes. If we are required to collect outcome data, we would have to go to the Data Committee to see what would be needed. We have already incorporated all we need to collect this data.

#### **Agenda Item #8: Grantee Report**

*Ms. Hilger:* We still have to finish our FY 2003 close-outs, but we expect \$3.5M as a preliminary number for the carry-over. MHRA sent out a satisfaction survey, and have had a 20% return rate so far. Awards from the FY 2004 RFP have been made and contracts will begin either July 1 or September 1. All contract renewals are complete.

#### **Agenda Item #9: Public Comment, Part II**

*J. Farrell:* I am Executive Director of Positive Health Project. Drug use is driving this epidemic. Syringe exchange is the most effective prevention program for all drug users, not just those who inject. We serve all users and are currently addressing crystal meth. People are shifting from snorting to injecting it, including in the gay community. Medical providers need to understand substance use issues and become ESAP providers. Comprehensive care should include syringe exchange.

*A. Richards:* The needs of blind and visually impaired PLWH are not being met. I know of people in nursing homes who died because of lack of services. I empowered myself and founded a non-profit organization to serve visually impaired PLWH. PLWH with special needs need services.

#### **Agenda Item #10: New Business**

*Ms. Curry:* Thank you, Mr. Oldham. It was a pleasure to get to know you. You are patient, supportive and helped people understand the Planning Council. Thanks for encouraging me to do what I do.

*Mr. DeLeon:* Mr. Oldham is always someone who could get things done. The Latino Commission on AIDS was recently selected to provide capacity building services to CDC- and locally-funded agencies that are doing prevention, including adapting CDC approaches for those targeting Latinos. The CDC is very serious about epidemiological data, and agencies that get funding have to demonstrate a basis in research. We are here to help those targeting Latinos. Also, the Harm Reduction Coalition was funded to provide this service.

*Mr. Cordero:* I would like to recognize the exemplary staff that Mr. Oldham have put together. He did everything he could to get people hired to support the planning process, which is very difficult to do within the City system. The OAPC staff is grateful to Mr. Oldham for his leadership and sad to see him go, but happy that he leaves a positive legacy. He has been a mentor, a colleague and a friend.

*Ms. Melore:* I agree. Also, what is the status of a search for a replacement?

*Dr. Hill:* There is no search committee. We are going through the same process we generally use for all hires and there will be a national search. We will post the position and make it available, and will encourage Planning Council members to help us identify qualified candidates to apply. Mr. Oldham will have to go farther than Harlem to get away from me. I look forward to working with him in his new position. We are only as successful as those around us, and Mr. Oldham has assembled outstanding team that will continue to support us so well under Mr. Cordero's leadership during the transition.

*Mr. Oldham:* Thank you for all your wonderful comments. I am glad to leave things in charge of Mr. Cordero, who does an outstanding job. Thank you also to Ms. Nagy for her wonderful work, and to Mr. Watts, who led us through the difficult period of the cut in 2003. Finally, thank you to the under-appreciated Mr. Klotz.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on June 17, 2004

Robert Cordero  
Acting Governmental Co-chair