



Meeting of the

## HIV HEALTH AND HUMAN SERVICES PLANNING COUNCIL

Thursday, June 17, 2004

2:15-5:15pm

Brighton Community Church, 320 St. Mark's Place  
Staten Island

### MINUTES

**Members Attending:** R. Cordero (Acting Governmental Co-chair), N. Nagy (Community Co-chair), S. Hemraj (Finance Officer), A. Ali, P. Avitabile (for E. del Campo), S. Abramowitz, Ph.D., P. Berrios (for J. Pedraza), L. Bishop, R. Bonilla, K. Butler, F. Carroll (for R. Abadia), R. Chavez, C. Cobb, C. Craig, B. L. Curry, L. Fraser, R. Gonzalez, A. Gutkovich (for D. Marder, MD), S. Halperin, J. Hilger (for M. Hill, Ph.D.), R. Joyner, H. Mateo, P. McGovern, D. Ng, J. Pressley, A. Raiola, E. Santiago, T. Troia, D. Woodard

**Members Absent:** M. Bacon, M. Barnes, G. Brown, MD, F. Carbone, H. Cruz, B. Chu, MD, D. DeLeon, C. Dzubilo, I. Feldman, E. Handelsman, MD, H. Melore, A. Paige-Bowman, T. Petro, M. Reynolds, P. Stabile, M. Wainberg, MD, B. Watts

**Staff Attending:** *OAPC:* D. Klotz, S. Dwyer, G. Moon, I. Gonzalez, C. Miller, R. Molina, B. Cohen Barusek, R. Shiau; *DOHMH:* J. Park, S. Forlenza, MD, F. Machlica; *MHRA:* R. Miller, P. Jensen

**Guests Attending:** E. Gantz McKay (Consultant), S. Lehrman, Ph.D. (Consultant)

---

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

*Mr. Cordero:* This is the Planning Council's first meeting ever on Staten Island (SI).

*Rev. Troia:* On behalf of the people of SI, welcome to the Planning Council. I want to acknowledge the tremendous work of Rebecca Ortiz, Coordinator of the SI HIV CARE Network and the Co-chair of the Network's Steering Committee, China Chung. Also I want to recognize Wendy Hoeffler, Director of Client Services at the SI AIDS Task Force. Welcome to all SI residents who are here. Also, this is the first time such a body has met in a Reformed Church in America facility. This church gave birth to Project Hospitality. I also present a gift to Mr. Cordero to extend to you and this body grace.

*Mr. Cordero:* This is my first meeting as Acting Governmental Co-chair since Frank Oldham left to take up his new position in Harlem. We will continue the momentum and energy he generated; he first announced that we would go to every borough. The agenda will change to have the by-laws presentation after the public comment to accommodate Emily Gantz McKay's schedule. Also, we have distributed the first update of the EMA's needs assessment for 2004, which Dr. Sue Lehrman will present.

*Mr. Joyner* read the rules of respectful engagement.

*Ms. Berrios* introduced the moment of silence.

*Mr. Cordero* reviewed the meeting packet.

*Ms. Nagy:* The next major steps in the priority setting process for fiscal year 2005 planning are: presentation of the reassessed templates to the Planning and Evaluation (P&E) Committee, with the P&E voting on all workgroup templates on June 25<sup>th</sup>. 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. We have scheduled an additional Planning Council meeting on July 29<sup>th</sup> to vote on the restructuring of the Council. We can also use this meeting to complete work on the FY 2005 priorities if necessary. It is very important that we continue to stick to this timeline.

Today, preliminary recommendations from the By-laws Task Force on restructuring of the Planning Council will be presented for discussion. The expectation is to provide suggestions and feedback regarding the proposed new committee structure at today's meeting. Planning Council members may also submit suggestions to the By-laws Task Force via Sean Dwyer by Monday, June 14<sup>th</sup>. There will be a community forum on the proposed restructuring on July 16<sup>th</sup> to allow the public to comment on it. It will be brought back to the Planning Council for a final vote on July 29<sup>th</sup>.

Needs assessment is a critical part of our priority-setting process. Dr. Sue Lehrman will provide an overview of our updated needs assessment, which includes unmet need. Following workgroup and committee reports, Deputy Assistant Commissioner Jan Park will discuss "Take Care New York", an initiative of the Department of Health and Mental Hygiene.

The minutes of the May 20, 2004 meeting were approved with no changes.

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

*C. Chung:* There is only one HIV dental clinic on Staten Island – on the south shore, which can take an hour to reach for people on the north shore. Another clinic is needed on the north shore.

*R. Rosario:* I need acupuncture to help me quit smoking, which complicates health for PLWH.

*M. Gold:* I am excited to be in Staten Island for the second time this week. The coming HIV Over 50 Forum is an important event because HIV incidence is rising sharply in people over 50. Questions need to be answered, including: Who will take care of senior PLWH? What is the nation's commitment to Medicare and Social Security? Will institutions like nursing homes support PLWH over 50? The Planning Council, State and City departments of health and the federal government need to respond.

*J. Livigni:* There is a great need for housing for PLWH, especially supportive housing.

*R. Paul:* I was injured on the job and forced to reveal my HIV status. I have had numerous illnesses and have had to spend down my income to qualify for benefits. I appreciate the help I have gotten, but more accessible programs are needed.

*B. Sussman:* SI needs more access to clean needles and safe disposal sites. SI has the highest percentage of cases that are from IDU transmission. Needle exchange is the most effective prevention method for IDU, and coupled with linkages to health programs can get people into care.

*Ms. Nagy:* Thank you to everyone for their public comment and for speaking up. While we traditionally do not respond to public comment at the meetings, we do listen to what people have to say.

#### **Agenda Item #3: By-laws Task Force**

*Ms. Nagy:* The By-laws Task Force has worked hard over this past year. Mr. Oldham's and my goal was to make the Planning Council more effective, which I hope this structure will accomplish. Thank you to Mr. Dwyer for his hard work supporting this process.

*Mr. Dwyer:* The Planning Council's by-laws and structure have not been substantially updated since their inception in 1991. To ensure compliance with the CARE Act and responsiveness to local needs, the Planning Council began a

comprehensive reassessment, starting with a joint working session of the Executive (EC) and Rules and Membership (R&M) Committees in August 2003. A By-laws Task Force was then created with 11 Planning Council members and our wise and patient consultant, Ms. McKay. The Task Force met through May 2004, including meeting with HRSA project officer Sheila McCarthy.

The highlights of the proposed committee structure are: the PWA/HIV Advisory Group, R&M, Finance and Policy Committees will stay as is; the Data Committee will be beefed up into a Needs Assessment Committee (duties include: manage all aspects of data gathering and analysis, assess effectiveness of funded services in addressing Planning Council's priorities and allocations); a Care Integration Committee that will overcome the "silo" effect of planning in groups of discrete categories (this committee will oversee the six content-specific workgroups); a Consumers Committee of non-aligned PLWH who are full Planning Council members to oversee efforts to ensure meaningful involvement of PLWH in the Planning Council; and a Priority Setting and Resource Allocation Committee to fulfill those CARE Act mandates. The Executive Committee would lose its CARE Act legislative mandates and provide broad oversight of the Planning Council's business. Membership on all committees is described.

*Ms. McKay:* The 2000 CARE Act amendments have new requirements, especially getting people into care. Given limited resources and people living longer, hard decisions need to be made. The Planning Council needed broader participation in the CARE Act's legislative mandates and in the decision making process. In the current structure, the same small group (EC/P&E) is doing all the work. The EC should oversee and support the work of the entire Planning Council, not the legislatively mandated functions. This structure resolves that issue.

*Ms. Nagy:* I want to emphasize that this is a draft and can still be revised. Please forward your comments and suggestions to Mr. Dwyer. We will also hold a forum for public input before bringing it to the full Planning Council for a vote on July 29<sup>th</sup>. There is always room for improvement.

*Mr. Halperin:* Thank you for including my suggestion for a public forum and I hope we consider my suggestion for a "sunset clause" requiring re-authorization after a one-year assessment. This structure requires many participants for it to work. It will require us to look at membership rules, e.g. looking at members who do not show up and enforcing attendance. Also, there is a lot of talent on the workgroups, and we should find a way to use it and to move workgroup members up to the new committees.

*Ms. Nagy:* I agree, and we have been looking at attendance issues. Also, workgroups are open to public participation, and I urge people to participate on workgroups, which is where templates are created.

*Mr. Joyner:* The Task Force did talk about member participation issues, including the better use of alternates and committee co-chairs to spread work around more.

*Mr. Chavez:* Why is resource allocation and integration of care separated? Developing a coordinated system of care needs to be linked to how much money we put into each priority. Also, not all chairs have the same level of knowledge of the process or the ability to commit the time and energy to meetings, and so some things might fall through the cracks. Also, we have removed workgroups from resource allocation functions, but they often know best how much a program costs.

*Mr. Cordero:* This structure puts us more in line with HRSA's approach to pass the work along rather than concentrate it in one place, and so there was a conscious decision to separate the functions. As for the workgroups, the Task Force felt that there were too many conflicts of interest. We want to use the content expertise of workgroup members, but we wanted a "firewall" between providers of Title I services and resource allocation decisions. The Integration of Care Committee will put experts in health, mental health, social services, etc. together on content.

*Ms. McKay:* The intent is to say: we want to be data driven, thus an independent needs assessment committee is needed, which will get information from workgroups, but we will separate functions to allow us to look across service categories. It will require workgroups to collaborate.

*Mr. McGovern:* There is much that is insightful in this structure, but it reminds me of the tax code, which has ballooned exponentially. It is already difficult for leaders in the field to participate given the time commitments. The new structure requires even more meetings and hours. Did you consider the impact on participation? Can workgroups be combined or subsumed into committees to address this?

*Mr. Santiago:* As a Task Force member, I was always concerned with roles and conflicts of interest. The same person can be the chair of a workgroup and on the P&E and EC, and if they are articulate enough, they could get their pet priorities ranked high. This is not data-driven planning and it is not integrated (e.g., health programs were not looking at the impact of AOD issues). As for participation issues, there is a large pool of talent, especially PLWH, and we need to bring more people into the system so that it is not just the same faces doing all the work.

*Ms. Nagy:* On a recent conference call with Ms. McCarthy we spoke of conflict of interest issues. She suggested looking at other EMAs' by-laws for models. Also, we can do outreach to bring PLWH to the table. Again, there is room to improve this; please send suggestions to Mr. Dwyer.

*Mr. Hemraj:* We should take into consideration that this structure has better checks and balances. We will not have total control by a small group of people. We also looked at the structure and know that it will require more people, which is why we want co-chairs so one person is not too stretched.

*Mr. Cordero:* The next steps are: submit comments to Mr. Dwyer by June 25<sup>th</sup>. The Task Force will consider all comments. The public forum is on July 16<sup>th</sup>, and the proposal will come to a vote at the July 29th Planning Council meeting, which will be dedicated mostly to consideration of this.

#### **Agenda Item #4: Needs Assessment Update**

*Mr. Pressley:* All workgroups are reassessing their priorities. Four have presented so far – AOD, Housing, Mental Health and Infrastructure. There has been a good discussion on what each workgroup is doing to address unmet need and access to and maintenance in care. Health and Social Services will present on June 25<sup>th</sup>, following which the P&E will vote on ranking and resource allocations. We will present to the EC on July 1<sup>st</sup> and then the full Planning Council July 15<sup>th</sup>. On June 25<sup>th</sup> the P&E will also have a discussion with the Data Committee on lessons learned from this year's planning process.

Last year the Planning Council voted to update the 2002 Needs Assessment. McClain and Associates were contracted to develop it, and Dr. Lehrman is here to walk us through it. Please provide comments to Ms. Moon by June 25<sup>th</sup> for the final draft.

*Dr. Lehrman:* The tasks of the needs assessment update (NAU) were: to create an update to the 2002 Needs Assessment for New York City, and to complete a mid-term EMA-wide review of Strategic Plan objectives. Evidence in both documents exists to make changes and improvements through priority setting and resource allocations. The focus is on: how service needs have changed since the 2002 Needs Assessment, and the relevance of these findings to those "not in care" with a particular focus on "at risk" populations. The NAU includes updated epidemiological data focusing on new information since 2002; "unmet needs" findings; other changes by workgroups since 2002; and implications and recommendations for planning.

The NAU team met with key informants, abstracted about 80 documents, and had an ongoing dialogue with key informants. Broadly speaking, data available to the researchers for the Needs Assessment Update 2004 are consistent with the data presented in the 2002 Needs Assessment, but there is evidence to make improvements to priorities and allocations. The update looks at epidemiological data, delayed entry into care and findings related to service gaps and utilization by workgroup area. Recommendations in the documents include: refine the unmet need estimate, select new P&E initiatives to expand knowledge of program effectiveness, and take steps to decrease delayed entry into care.

*Mr. Halperin:* This document is impressive because it brings together much of what we have been discussing and makes a strong point that we need new P&E initiatives to demonstrate effectiveness of service models. There is a misunderstanding of what this means. We need to look at program monitoring and how it can collect some information to measure effectiveness in the interim.

*Ms. Mateo:* The document says that women are more likely to delay care and be unsure where to go for care, but it is my experience that women often know where to go because they take care of other people, but not themselves. Also, what does it mean that women are over represented among new clients?

*Dr. Lehrman:* It should be noted that we did not collect the data but only reported on other studies that have been done, thus there should have been a citation (e.g. CHAIN) so that you can see where data comes from and you can go to the source document for clarification. Women used larger proportion on services than their proportion of the HIV-infected population.

*Mr. Cordero:* All data sources are listed in the document. The 2002 Needs Assessment had 129 references, so the sources listed in the 2004 update are numbered 130 to 206.

*Rev. Troia:* The factors that lead to delayed care have been the same for a long time. This restates that all of our templates should make services accessible to people who have those factors that cause delayed care.

*Mr. Cordero:* Thank you to Dr. Forlenza for providing all the epidemiological data and the information on persons not in care. This document is useful for workgroups, as it breaks out data by workgroup areas and makes recommendations for possible Planning Council actions and changes to services.

*Dr. Lehrman (in response to a question from Mr. Santiago):* The document provides a definition of service gaps (p. 49); the larger the number the bigger the gap. According to CHAIN, people are using drug treatment services less, but we need to look at the study to see sample size.

*Mr. Santiago:* This seems to imply that if people are not using treatment, then they are using substances and need services. Also, it needs to define service models.

*Dr. Lehrman:* Service models refers to all aspects of how services are delivered. The document does not report which models are more effective than others.

*Mr. Cordero:* That is important data to know for planning, but this is only an assessment of need. The Strategic Plan would examine service delivery models.

*Mr. Santiago:* HRSA has said that we are good at identifying need but we need to identify the most effective programs, and it requires political will to fund the most effective service models.

*Rev. Troia:* To re-emphasize that, we need to break down institutional barriers and integrate care (e.g., one-stop shopping, strengthen institutional linkages).

*Ms. Moon:* The P&E is funding an outcomes evaluation project, which will address service models as well as effectiveness. This will require many data sources (MHRA, CHAIN, HIV QUAL).

#### **Agenda Item #5: Committee and Workgroup Reports**

*Ms. Carroll:* The PWA/HIV Advisory Group (AG) met in June at Project Hospitality (PH) on SI. Thank you to Rev. Troia for hosting us. We toured the PH food pantry and health clinic. 20 SI residents attended the meeting, and AG Co-chairs Rafael Abadia and Dorothy Walker presented about the AG and Planning Council. We hope that SI PLWH will continue to attend the AG and Planning Council meetings. Randy Scott of PH presented about the transportation program. Mr. Oldham was thanked by the AG for his outstanding work. Although he is no longer Planning Council co-chair, he is still part of the AG and we hope to see him at meetings. Finally, the AG will table at the LGBT Pride March and will host its annual picnic in August.

*Mr. Cobb:* The Rules and Membership Committee (R&M) received 89 applications (82 of them new), only 4 less than last year's record. Thank you to Mr. Dwyer for his support. R&M meets tomorrow. The Title I award came with the provision that we comply with HRSA mandates on demographic reflectiveness and non-aligned PLWH on the Planning Council. We specifically needed more Latino men, which was the focus of this year's recruitment

process. There is a small window to appoint new members, and the R&M is considering asking governmental representatives to make room for more community members. This should also be reflected in my comments in the June 3<sup>rd</sup> EC minutes.

*Mr. Joyner:* Please clarify “non-aligned”.

*Mr. Cordero:* Non-aligned PLWH are not paid staff, consultants or members of a board of directors of an agency that receives Title I dollars. Also, the number of governmental seats on the Planning Council is up to the Mayor as CEO and any change would require a change to the Mayoral executive order that establishes the Planning Council. The R&M can make a recommendation to the Mayor.

*Mr. Hemraj:* The Finance Committee met on June 2<sup>nd</sup>, where MHRA presented the FY 2003 close-out report. At the end of FY 2003, the EMA had spent 97% of its total grant award. This is possibly a record level of spending, and DOHMH/MHRA should be commended for working so diligently to ensure such a high spending rate. This guarantees that we will get the maximum points on our application for spending. About one third of the under-spending is in one category – Ambulatory Outpatient Care, and the Committee has asked MHRA to report back on why this is the case.

The Committee also discussed the implementation of the reprogramming plan to ensure maximum spending in this fiscal year. If there is an enhancement to a category, the grantee will not enhance programs that are under-spending, only those that are spending fully. Thus, if not all of the funds allocated in the reprogramming plan can be allocated to a category, the funding automatically falls to the next ranked priority on the list. The Finance Committee supports this and feels that this should be explicitly authorized by the Council, similar to the authorization to move funds up to 1% within the large category groupings (“the bubbles”). I present a motion to this effect.

*Mr. Cordero:* There is no longer a quorum for a vote, but I will ask OAPC staff to help you put the motion into writing for the July 15<sup>th</sup> meeting.

*Mr. Hemraj:* The Committee will also recommend to the By-laws Task Force that they formalize which committee in the new structure will oversee the allocation of funds for Planning Council support. This has been done in an ad-hoc fashion by the EC, but the Finance Committee feels that a specific committee should be charged with this task. Finally, the survey of the administrative mechanism went out last week. The results will be reviewed at the August Finance Committee meeting and will be presented to the EC the next day for approval for the application.

*Rev. Troia:* The Social Services Workgroup is almost done with its template review. The final one is Adult Day Care. Sub-committees worked hard, as did Mr. Klotz and Ms. Gonzalez. With Mr. Klotz departing as staff support to the workgroup, I want to thank him for all his help as I learned this process.

*Mr. Ng:* The Housing Workgroup finished its template review, making sure that all templates addressed unmet need. We recommend enhancing Emergency Rental Assistance and a new template for Harm Reduction Outreach in SROs for MAI funding.

*Ms. Curry:* The Infrastructure Workgroup finished its work and submitted its templates to the P&E.

*Mr. Shiau:* The AOD Workgroup presented at the last P&E meeting. Five templates were rolled into one. At the request of the grantee, we will look at rolling Escort/follow up Services into the Harm Reduction template.

*Ms. Gonzalez:* The Mental Health Workgroup completed its work and presented to the P&E.

*Mr. Miller:* The Health Workgroup finished its reassessment and began the process of ranking new priorities for presentation to the P&E.

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

*Ms. Hilger:* The FY 2005 application guidance should be available July 1<sup>st</sup>, with the application due October 1<sup>st</sup>. We will follow the same process for review as last year, but will have to adapt to the new timeline. The grantee has

been reviewing templates and providing comments to the workgroups. This process has worked very well, with us getting comments back to workgroups before their presentation to the P&E.

The FY 2004 spending plan includes restoration of last year's across-the-board cut, and this is being implemented, along with the inflation adjustment of up to 3%. \$1.3M is being spent for restoration of the across-the-board cut, \$1.95M for the COLA, and \$350,000 for restorations of contracts reduced for poor performance but showing improved spending. The process will last through the end of June.

Five new contracts will begin July 1<sup>st</sup>, one on August 1<sup>st</sup>, and 8 on September 1<sup>st</sup>, plus a number of enhancements approved by the Planning Council to begin on August 1<sup>st</sup>. The Finance Committee recommended that we look at what it really costs to start a contract to avoid under-spending, and we are taking that seriously, only negotiating contracts for what can realistically be spent this year, thus allowing us to apply unspent funds to items in the FY 2004 reprogramming plan.

Finally, MHRA's consumer satisfaction survey has gotten a 38% response rate (higher than expected), and they are evaluating findings, which they will share with the Planning Council.

#### **Agenda Item #7: Public Comment, Part II**

*T. Brewer:* When I was diagnosed I was isolated. St. Elizabeth Ann Hospital reached out to me. I received treatment education, social support, recreation and food services. We need more places like this.

*C. Frierio:* I facilitate a women's support group. We need to help women get treatment and services, including prevention and gynecological care. SI needs gynecological care for HIV-positive women.

*P. Hatchett:* SI is losing hundreds of units of affordable housing. With that, plus Section 8 frozen, poor families are losing housing, especially those affected by HIV and mental illness. Also, SI does not have the array of services available in the other boroughs. Finally, we need to make the Planning Council and RFp process more accessible to PLWH and we need more money for PLWH scholarships to conferences and events that educate and empower consumers.

*L. Holley:* I challenge the Planning Council and grantee to educate PLWH on how to get involved in the planning process. Also, security at 5 Penn Plaza prevents people who are not on a list from going to public meetings.

*D. Martin:* I am an HIV-positive single mother of a 12 year-old HIV-positive boy. There is only one pediatric HIV clinic on SI, and they have too large a client load to give appropriate attention to patients. Also, schools professionals need to improve the way they treat HIV-positive children.

*R. Rosario:* I go to a clinic on the Lower East Side of Manhattan where I get food, women's services, recreation, etc. we need a similar one-stop service place in SI.

#### **Agenda Item #8: New Business: "Take Care New York"**

*Mr. Park:* "Take Care New York" (TCNY) is a new initiative of DOHMH to address broader social and economic forces affect health (e.g., poverty, housing, empowerment of women, food policy, lack of health care access, poor preventive practices). TCNY focuses on areas that cause substantial disease burden among New Yorkers and where there are proven interventions. TCNY is a vehicle to set an agenda, establish priorities, provide framework for action and a call for policy/legal changes at the City, state, and federal levels. The ten areas it addresses are: having a doctor, tobacco, blood pressure, cholesterol, obesity, HIV (getting tested and into treatment), depression, substance use, cancer screening (colon, breast, cervical), immunizations, healthy babies, and healthy environment (e.g., lead paint).

*Mr. Cordero:* Please read the Institute of Medicine report on financing of HIV/AIDS care. Thank you to the Brighton Heights Reformed Church staff for their help.

There being no further business, the meeting was adjourned.

Minutes approved by the HIV Planning Council on July 15, 2004

---

Robert Cordero  
Acting Governmental Co-chair