

HIV Health and Human Services Planning Council

Meeting of the

SOCIAL SERVICES WORK GROUP

September 17, 2003

3:00pm-5:00pm

NYC Dept. of Cultural Affairs

330 West 42nd Street, 11th floor Conference Room A

DRAFT MINUTES

Members Present: Diane Arneth, SJ Avery, Cameron Craig, Jason DeCuir, Myron Gold, Spence Halperin, Sehu Jeppe, Rosemary Rando-Chanon, Howard Schwartz, James Shields, Deborah Simon, Amy Winsarsky

Non-Members Present: Mathew Bruno (HASA), Peter Avitable (HASA), James Jorge, (RW Care Services), LaVerne Holley, and Steven McLean

Members Absent: Amadj Ali, Socrates Caba, James Canosa, Darlene Cheek, John Diccico, Sharen Duke, Soraya Elcock, Ray-Andrew Giddings, Rachel Gordon, Elaine Greeley, Patricia Haversham-Brown, Kevin Huang-Cruz, rosemary Lopez, Paula Merrick-Lewis, Ariel Negron, Jr., Carline Numa, Teresita Rodriguez

Planning Council Staff: Brittany Allen, David Klotz

I. Welcome/Introductions

Spence Halperin welcomed members and visitors, and everyone introduced himself or herself. Because we didn't have a quorum, we were unable to approve the minutes from July. We will do this next month.

II. Planning Council Update (D. Klotz)

M. Gold: Can we have an update on the transfer of MOAPC to OAPC.

D. Klotz: The function of the Planning Council remains the same, and the transfer should enhance PC support and coordination of services. Our office and Citywide Coordinator now report to the Health Commissioner, rather than Deputy Mayor Dennis Walcott, effective July 1, 2003. Mr. Oldham still serves the same function, which is City Chair of the Planning Council.

Summary Report of 08-07-03 TA session with HRSA.

Emily Gantz had presented several models of Planning Council structures from different EMAs. In some of the models, it was noted that functions of the P and E committee are spread across different committees, i.e., one committee to do needs assessment, one to do priority setting, and one to do allocations. In this EMA, the P and E committee executes all of these functions except for allocations, which is done by the executive committee; however, the two committees have almost identical membership. The Planning Council decided to form an Ad-Hoc committee to look at different PC models, the by-laws, and they had their first meeting last week. Currently, the workgroups have narrowly defined service areas, and there isn't the kind of coordination to which a Title I planning would lend itself.

M. Gold: Is there PWA involvement in the Ad-Hoc committee?

D. Klotz: Yes, E. Santiago, H. Melore, and R. Joyner. All workgroups are represented.

SJ: Have the workgroups had been solicited for specific comments about the frustrations or positives that have arose in workgroup discussions?

D. Klotz: yes, types of committee structures, their functions and how they are reported will all be procedures that would follow the by-laws

Measuring unmet need

HRSA wants all EMAs to focus on getting people into care, and they contracted with UCSF to develop a model for coming up with a measurement of unmet need in the EMA e.g., viral load test, CD-4, and ART in the past 12 months. We know this isn't the standard of care, but this is HRSA's definition, and it is a proxy for ensuring that people who have been identified as HIV + have been brought into the care system. HRSA is implementing the changes from the 2000 re-authorization of the CARE Act, which emphasized a medical model of care. Services that aren't directly primary care services or clinical services funded by Title I should be for the purpose of getting people into care and keeping them in care.

S. Halperin: There wasn't enough language about support services, I sent a memo listing research demonstrating that supportive services do improve health outcomes.

D. Klotz: It [the need for supportive services] is explicit in the application; both where we list our accomplishments from the last program year and our program plan for the next program year, that the AOD services, Mental Health services, and Social Services are all an important part in the continuum of care in that they are all linked to identifying those who are not in care, getting them into care and keeping them in care.

D. Arneith: Did anyone question the definition of unmet need?

D. Klotz: Yes, we did. The NIH developed the national standards of care, but this definition is more of an indicator for unmet need, rather than a strict definition for standards of care. The application will be reflective of the priorities developed, which is the role of the OAPC and the Grantee. This also ties into something the Planning Council has mentioned this year: that we have had the same basic service system with little amendments or changes in a long time, not since 1996-97. He further noted that this year the discussion is starting at the level of the P and E committee, and at the October meeting, the first thing they will review is the "bubble diagram" (the diagram that groups all of the service categories into larger categories with the central one being physical and life sustaining services) or the conceptual framework for viewing the Title I service system which was developed when they last reordered the priorities in 1996.

Delayed Entry Into Care Study

This is a two-year study commissioned by the Planning Council, and the summary of the first year of the study just came out. This study will be a good source of data for planning. On another note, HRSA and the CDC are coordinating more closely and part of this initiative is in response to the CDC's new focus on getting people tested, using rapid testing, prevention for positives, HRSA wants the Title I system to be ready to bring into care the people who will be identified as HIV + through the CDC's new initiatives.

M. Gold: What are their guidelines for pre-counseling and post counseling with regards to the rapid test? This is one of the concerns of the community that people must have assurances that there will be counseling both before and after the rapid test.

D. Klotz: I don't know, but I agree.

Application update

The PC reviewed the first draft and comments went to the writer and DOH, the second draft will be ready for PC members' review by Sept. 25. After the second review, the application will be reviewed by outside experts, and signed so that it can be submitted by October 24. The PC approved a spending plan for Yr 14 that asks for restoration of the cuts for this year and an additional 7 million, so we are asking for a total of \$ 120 million, which is an increase of about \$17 million over this year's grant.

III. Summary and Discussion of Transportation Models

DOH and MHRA are searching for a provider to take over the contract between now and 2005. The goal is to ensure that there will not be a gap in services. We will re-vitalize our transportation sub-committee under Diane Arneith, and will make recommendations to the full PC as to what type of transportation model the PC should fund in 2005 and how the templates should be changed.

Question: S. Halperin: Should we recommend that Title I metrocards be more integrated into the transportation portfolio?

Discussion:

SJ: Opposed. At her agency, there are methods set in place to avoid this exact thing. It is easy to monitor b/c van services are not as big a part of transportation assistance, and they help a discreet client who is not mobile in the public transportation system.

P. Avitable: asked J. DeCuir if the monies from the AIDS Institute are taken from Am. Red Cross as well? Or is that tied to some other activity that the Am. Red Cross will be doing. Is the money that went to AIDS Institute also up for review once you end this contract?

Nobody knew the answer to this question.

SJ: Two questions: how much do individual contracts put towards transportation, and metrocard economics, which I don't think is within the purview of this committee. I might suggest that we narrow the scope of the transportation contract and identify who is really eligible to receive those monies.

M. Gold: If people are accessing Am. Red Cross, is it the obligation of the agency to give them a metrocard?

Transportation models

S. Halperin reviewed the discussion points of the various transportation models: city-wide, de-centralized, two providers covering five boroughs, or two providers covering two services, i.e., one provider does van, the other does bus. If CBOs and providers were the ones who made the appointment for this transportation service, the coordination would be that much better. This would help to prevent duplication of services.

D. Arneith: Disagrees. In terms of logistics, if you have an agency with 200 clients, who have many appointments, and you, have to hire 6 additional staff just to make van appointments. It would be a huge burden, and we are trying to gear people towards independence, so both logistically and philosophically I have a problem with it.

S. Halperin: it may be a way of avoiding duplication of services, meaning that if there are two funds of transportation monies as there are now, and if same individual is drawing from two funds of transportation money on the same day for the same visit.

C. Craig: This does happen on a frequent basis. One possible solution could be that the transportation provider notifies the CBO. At my agency, we used to give carfare for appointments for the day before. Who says they aren't calling a van to pick them up? Now, however, we ask for proof that the client has a medical appointment. Now, with that proof, we still don't have the proof that they are not going to call for van service tomorrow. So now what we did is stop the carfare altogether.

LaVerne: added that if a lot of CBOs collaborated with the MTA to get half-fare metrocards, the duplication of services would stop b/c first of all, you cannot sell a 2-dollar metrocard, whereas you can sell a 4-dollar metrocard that is sealed in plastic.

J. DeCuir: agrees with Cameron and LaVerne. If this contract were looked upon as servicing a certain portion of the transportation needs to the HIV/AIDS community, then we need a larger picture of all transportation options and dollars out there. If we were doing more service with a particular organization, that was running a specific service and I have come to the table and said that we know from changing needs that that is the case, what amount of transportation dollars are they using in excess? I think the duplication issue is a minimal one, b/c if we knew that that was the case, we would intervene in some way, which is why working with the CBOs is very important. I think that concern will be answered when the eligibility is worked out. The person who should be using van service or whatever model implemented is a person who wouldn't benefit from a metrocard. That is where the real priority should be: to give the transportation sub-committee its charge to design a model around that issue.

Eligibility

SJ: proximity to a subway or bus line, and also some sort of criteria around mobility. Age should be considered also. We have 70 year olds in our pantry who may not be totally disabled, but for them to have the ability to carry to large pantry bags is more compromise than someone who is 40. Most CBOs have tried to use vans for those who cannot access public transportation b/c it is in our interest get people into care. If we were clear about the criteria and if it was understood to be a focused supplement to people unable to access public transportation, that would make a lot more sense.

S. Halperin: It makes sense to fold the metrocard dollars into a template is because it enables us to monitor it well. The program reporting goes back to one transportation template, and when we get reports, we will know the numbers of rides, and metrocards, etc.

SJ: There have been times when clients have decided to forgo their metrocard option or just take it one-way, through the advisory committees that supposed to be part of the Ryan White programs to use that money for program.

S. Halperin: You want to have the flexibility of taking that money if you aren't going to use it for metrocards, and use it to buy food.

SJ: correct, and we have done that concurrent with the groups and the groups have supported that.

Diane Arneth Future Steps, timetable

For the sub-committee meeting, we can discuss some of the ideas we heard today and also to see if we can get some information from other EMAs and cities, what they fund and how they fund it. The

SJ: when you are looking for information, which MHRA should have, do not aggregate this information, rather look at ranges and see if there is a difference in boroughs or in other areas. The data will be useful to the extent that there can be an analysis by program type or by something specific.

D. Arneth: I would like MHRA to identify all of the different types of transportation funded under the Ryan White portfolio and then by area. And then to break it down by boroughs, by contract type, etc.

Volunteers for the sub-committee on transportation are Jason DeCuir, Myron Gold, Cameron Craig, LaVerne Holley, and SJ Avery.

Calendar

S. Halperin proposed to the group that the next meeting be a joint meeting between the Mental Health and Social Services workgroups. In order to identify mutual areas of common interest.

Rosemary: So many of the social services templates are lacking in mental health. They seemed not to be effective if you had to make a mental health referral. It would be helpful if it were a combined template. That is goal #1. On the other hand it can be a way to keep shrinking the group.

D. Klotz: while we don't know the outcome of re-structuring, you can absolutely go ahead with your planning and formulate the template based on documented need for service. There will still be a process for presenting recommendations for priorities and allocations.

SJ: All of this restructuring is intended to create more effective entities that will prioritize limited resources based on data. There is an absence of current data. Unless someone is willing to make the investment in looking into creating data books. The data collection is important. It would be helpful if the data committee would distribute its minutes to members of other workgroups, so we can get some immediate feedback.

Motion: Joint meeting with mental health? 8 yes

2 opposed

2 abstained

Motion: Joint meeting on October 16, at mental health scheduled meeting.

9 yes.

Resolution: The re will be a joint meeting with mental health and social services on October 16, at 9:30 a.m.

To do: MHRA to give us the dollar amount spent on transportation from each agency. Find out how many rides the community utilizes in the form of metrocards, and in the form of van service.