Greater Hartford Ryan White Part A Planning Council
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June 4, 2014

MINUTES

Members Present		
Myrna Millet-Saez	Fernando Morales	Barbara Mase
Maria Lasada	Virginia Ruiz	Denise Morin
Kate Bassett	Mary Prince	Moneca Liz
Loyd Johnson	Cameron Crosby	Danielle Warren Dias
Janier Caban Hernandez	Miranda Baldwin	Yolanda Potter
Hugo Nunez		
Members Absent		
Anthony Rodrigues	Carlos Vazquez	James Armour
Izolda Miranda (A)	Kasey Harding (A)	Shawn Lang (A)
Ricardo Cruz	Celia Alamo	Joseph LeMay
Beth Moshier	Francisco Rosa	
Staff		
Yolanda Benjamin	Angelique Croasdale	LaShaunda Ware
Lennon Hite	Peta-Gaye Nembhard	
Guests		
Joseph Ornato	Janette Rodriguez	Dorine Testori
Elia Vecchitto	Keysha Starks	

Action Items Completed:

- Reviewed and Approved April 2, 2014 Meeting Minutes (Page 2)
- Tabled review and approval of May 14 Meeting Minutes (Page 2)
- STI Presentation (Page 3)
- Review Meeting Ground Rules (Pages 3-4)
- Review Priority Setting Principles & Criteria (Page 4
- Epi Profile Presentation (Pages 4-5)
- Service Utilization Presentation (Pages 5-6)
- 2013 Needs Assessment Presentation (Pages 6-8)
- Affordable Care Act Update (Pages 8-9)
- Other Funding Streams Presentation (Page 10)

1. Welcome & Announcements

Co-chair Fernando Morales called the meeting to order at 12:15 p.m. Fernando reminded everyone that Planning Council meetings are open to the public, but some of the information discussed in these meetings, including people's HIV status, is of a confidential nature, and everyone is expected to honor and respect that confidentiality. Fernando then reviewed today's agenda. The major agenda items are data presentations in preparation for the priority setting and resource allocation voting. Planning Council members must attend the June 4, 2014 Data Presentation Meeting and the July 9, 2014 Priority Setting meeting in order to vote on priorities and allocations for fiscal year 2015. The data presentation notebooks were distributed at the meeting.

2. Moment of Silence/Introductions

Fernando asked the group to observe a moment of silence to remember persons we have known and loved who have been lost to the AIDS epidemic and to remember all individuals living with and affected by HIV/AIDS.

To comply with the Planning Council Conflict of Interest policy, Fernando asked those in attendance to introduce themselves, state what organization they work for, and what funded Ryan White Part A services their organization provides, if any.

3. Council Meeting Minutes: April 2, 2014

The committee reviewed the April 2, 2014 Planning Council meeting**. MOTION:** To approve the revised minutes of the May 14 Planning Council meeting minutes made by Janier Caban-Hernandez, seconded by Mary Prince and approved by a vote of 13 Yeas, 0 No, with 3 Abstentions.

4. Council Meeting Minutes: May 14, 2014

The committee was informed that more time was needed for the internal review of the minutes.
The Co-chairs asked for a motion to table the May 14, 2014 Planning Council meeting minutes.
MOTION: To table the May 14, 2014 Planning Council meeting minutes made by Andre McGuire seconded by Lyod Johnson and approved by a vote of 16Yeas, 0 No, with 0 Abstentions.

Planning Council Co-chair Fernando Morales, opened the session by noting that today's meeting was the first step in the priority setting process. Members who attend today's meeting and the next Planning Council meeting scheduled for July 9 are eligible to vote on priorities for the Ryan White Part A Planning Council at the July 9 meeting.

Meeting Ground Rules

Co-Chair Fernando Morales then reviewed the meeting ground rules: 1) **Respect:** Planning Council Members should show respect for each other and the public during Planning Council meeting related activities. Use kind language in responding to the dialog shared by each Planning Council Member and always feels comfortable to ask for clarification of ideas expressed that concern all Ryan White Funding matters; 2) **Confidentiality:** Planning Council Members should respect each other's confidentiality in areas pertaining to HIV/AIDS status or any other medical condition; 3) **Listen and ask to understand:** Planning Council Members should always ask questions if they do not understand any part of the process. The Council co-chairs and committee/caucus co-chairs share the responsibility of making sure that everyone understands the process, what is being discussed, and the results and outcomes; 4) **Welcome differences and learn from others**: An important part of Planning Council and committee work is the diversity around the table and the recognition of that diversity. The Council can benefit greatly from the diverse voices and ideas represented through its members: 5) **Support and suggest, not blame or guilt or attack**: Members should not personally attack each other at meetings. Co-chairs have discretion to call a meeting to order at any time if the discussion should become unruly or go off topic; 6) **Agree to disagree – solve it privately**: Members should discuss issues and concerns with each other privately and not during Planning Council meetings Leave egos and baggage at the door and concentrate on Planning Council business; 7) **We're all equal here; everyone counts:** Each Planning Council member has an equal voice in the process, and everyone's opinion counts; 8) **K.I.S.S. – Keep It Short and Simple**: Try to keep questions, answers and presentations short and to the point. Don't wander off the discussion at hand; 9) **One speaker at a time to avoid derailment:** To avoid misunderstandings and loss of focus, Planning Council members should honor the "one speaker at a time guideline". Members should allow the speaker to complete his/her statement and not interrupt; 10) **Priority of Discussion** - Council co-chairs will handle order of speaking priority and may limit or discontinue discussions if speakers move off track. Voting members shall have first opportunity over guest when speaking at meetings; 12) "**Keep the focus:**" Remember that the goal of the Greater Hartford TGA Ryan White Part A Planning Council is to create a seamless continuum of care that addresses the needs of the infected and affected populations in Hartford, Middlesex and Tolland Co; 13) **We are all in this together.** *Let's keep a united voice and a focused front* and 14 **Do your homework**

Priority Setting Principles & Criteria

Co-chair Fernando Morales then reviewed the following Priority Setting Principles and Guidelines approved at the April 2013 Planning Council meeting: **1) Priorities and Allocations Are Based on Data**. Decisions are based on the data not on personal preferences; **2) Required Meetings.** Planning Council members must attend the June 4, 2014 Data Presentation Meeting and the July 9, 2014, Priority Setting meeting in order to vote on priorities and allocations for

fiscal year 2015; **3) Setting Priorities and Allocations**: The priorities and allocations in the current fiscal year serve as the base for decisions on priorities and allocations for the next fiscal year. Changes in priorities and allocations are based on documented changes in service needs, service gaps, and the availability of services; **4) Decisions:** Priority and resource allocation decisions are expected to address overall need within the service area not narrow advocacy concerns. Anecdotal data and "impassioned pleas" become part of the priority setting process through focus groups and surveys, but such presentations are not appropriate during priority setting and resource allocation meetings; **5) Continuum of HIV Care**: Priorities and allocations should contribute to strengthening the continuum of care, by providing access to HIV primary medical care and support services necessary to maintain persons in medical care, reducing duplication of services, and engaging persons with HIV in care; **6) Conflict of Interest**: Planning Council members must disclose at the beginning of each meeting and in writing any conflicts of interest by virtue of their association (as an employee or board members) with an agency that receives Ryan White funding; **7) Ballots**: Voting on priorities is done through the completion of individual, confidential ballots to minimize the likelihood that any member feels pressured to take a particular position; **8) Provider Input:** Service providers may answer questions and provide information about the service category for which they provide services but must disclose their association with the agency and the specific service that the agency provides; 9) **Interpreting and Using Data**: Data sets are more or less reliable. No data set is perfect. Conclusions that are supported by multiple data sets are more likely to be sound than those based on limited or narrow data. In final analysis, weighing and interpreting data is subjective and the responsibility of each individual; and **10) Directives:** The Planning Council is responsible for developing instructions for the grantee on how to deliver HIV services funded by Ryan White.

Fernando introduced Heidi Jenkins the Department of Public Health's (DPH) Sexually Transmitted Infections Unit.

STI Data Presentation

Heidi Jenkins of the Department of Public Health's (DPH) Sexually Transmitted Infections Unit opened the presentation with a discussion of Sexually Transmitted Infections (STIs) in the TGA. She noted that the data came from the DPH's Sexually Transmitted Diseases Control Program**.** She presented on reported Chlamydia and Gonorrhea cases in the Greater Hartford TGA by gender and race/ethnicity and age during a three-year period from 2010-2012, primary, secondary and early latent, Syphilis by race/ethnicity, Syphilis among MSMs in the TGA from also during the three-year period from 2010-2012 and, Syphilis among MSM and MSM/HIV+ in the TGA by race/ethnicity. Heidi explained that Gonorrhea is a strong bug and the over the years develops resistance to treatment. The current treatment is an injection. She distributed state STI statistics for to those attending the meeting. Heidi also noted the high number in the unknowns in the race/ethnicity category and attributed it providers do not collecting the information on a consistent basis. Heidi pointed out the high percent of cases in the 15-24 age range for Chlamydia and Gonorrhea. She also pointed out the City of Hartford has more STI cases than any city in the state and that zip code 06112 in Hartford is a "hot spot". When asked about prevention efforts in the 06112 area Heidi noted that the state is collaborating with Community

Health Services in Hartford and that the budget for the STI unit has been significantly reduced. Heidi closed her presentation by noting that Partner Notification Services was an underutilized service in state and encouraged providers present for refer clients.

2013 Needs Assessment

Co-chair Fernando Morales presented an update on the Needs Assessment. Fernando noted that the Needs Assessment (NA) was a collaborative effort of People Living with HIV throughout Connecticut, the Connecticut HIV Planning Consortium (CHPC), the Department of Public Health (DPH), Ryan White Parts A and B and the Connecticut AIDS Drug Assistance Program (CADAP). The Needs Assessment was based on the Statewide Needs Assessment survey, and has been revised to make the survey shorter and more user-friendly.

Fernando noted that over 2,000 English surveys sent to CADAP clients via mail, that the Connecticut Department of Social Services (DSS) provided mailing labels and no other information and clients could request Spanish version. Clients needed to fill out a separate card with address to get their incentive. 1,250 English and Spanish surveys were distributed to providers for data collection. The provider target numbers were established by each Part (A or B) using proportion of clients provider served. Over 1,400 surveys were returned and 1,349 Surveys were valid and analyzed by DPH.

Of the 490 individuals who completed the survey, 86.7% were from Hartford County, 4.6% were from Tolland County and 8.6% were from Middlesex. Forty-eight point two percent were from the City of Hartford, 11.8% from New Britain, 4.8% from Middletown, 4.8% from East Hartford and 4% from Manchester. Sixty-one point four percent were male and 36.9% were female. The race/ethnicity breakdown was 37.5% Latino, 29.4% African-American and 31.4% white. Fifty-one point one percent reported their HIV exposure as sex with an HIV positive man, 16.8% as sex with an HIV+ woman, 3.4% sharing syringes with works and 16.1 didn't know. Co-morbidities included the following:

Psychiatric/Mental Health Problems	27.4 %
High Blood Pressure	26.7 %
Substance Abuse Problems	25.1 %
Hepatitis C	22.4 %
Alcohol Problems	18.8%
PCP Pneumonia	13.7%
Diabetes	12.7%

Forty one percent of respondents indicated that their insurance is paid thru Medicaid, 36% through Medicare, 22% through private insurance, 20% through Ryan White, 6.5% no way to pay. 4% had no insurance, pay for medical and less than 1% through the Veterans Administration. Slightly over fourteen percent (14.4%) reported an unstable living situation today.

Fernando noted that 21% of respondents reported having unprotected vaginal or anal sex in the past 12 months. Nine point six percent had unprotected sex vaginal or anal sex with someone they know is HIV negative, 8.3% had unprotected sex vaginal or anal sex with someone they know is HIV positive, 2.8% reported having unprotected sex vaginal or anal sex while using alcohol or drugs., 2.8% reported having unprotected sex vaginal or anal sex with a man who has sex with other men, 1.8% reported having unprotected sex vaginal or anal sex with someone they met on the Internet and 1.2% reported having unprotected sex vaginal or anal sex with someone who has injected drugs.

Housing (18.8%) remained the biggest need that respondents could not get, followed by Dental Care (18.2%), food assistance (15.1%), utilities assistance (14.5%), health insurance assistance (12.7%), nutrition services (11%) and transportation (10.6%).

Respondents cited the following reasons for not getting the services they needed: Couldn't afford it (8.2%), Afraid people would find out HIV+ (7.2%), Transportation (6.3%), Income too high (5.5%), Didn't know where to find services (4%), Not ready to deal with HIV (4%) and Didn't have stable housing (3.6%).

Fernando concluded his presentation with a table comparing service gaps in the 2008, 2010 and 2013 Needs Assessment by the three major racial/ethnic groups and a table comparison of services needed from the 2008, 2010 and 2013 Needs Assessments. In the service category table, Angelique Croasdale noted that Dental Care was a primary need for the three major racial/ethnic groups (African-American, Latino/a and Whites). She also noted that African Americans also cited help paying rent, Emergency Finance Assistance and medical transportation as categories of major need. Whites cited help paying co-pays, help paying rent and Emergency Finance Assistance as categories of major need. In the services needed table, Dental Care, help paying rent and medical adherence support were still the three primary categories where respondents said help was needed. The percentage of need was down in each category from 2010, Dental Care (15.9% in 2010 to 8.9% in 2013, Help paying rent (20.1% in 2010 to 9% in 2013) and medical adherence support (16.6% in 2010 to 7% in 2013).

Epidemiological Data/Treatment Cascades

Lennon and Suzanne Speers of the Department of Public Health presented epidemiological data in the TGA from the Department of Public Health's AIDS Surveillance Program. He pointed out that the TGA will use 2012 data and he noted that the AIDS Surveillance Program feels that the 2012 data gives the Planning Group a more accurate picture of HIV/AIDS in the TGA. There were 104 HIV/AIDS diagnosed cases in the Hartford TGA in 2012 and 295 in the entire state. As of December 31, 2012 there were 3,562 Persons Living with HIV/AIDS in the Hartford Ryan White TGA. Lennon noted cases by gender stayed roughly the same from 2009 to 2012. He also noted the increase in HIV/AIDS cases the Latino population, a decrease in Men who have sex with men (MSM) as a transmission category and that the TGA has an aging HIV/AIDs population. Lennon pointed out that there were 104 new cases in 2012 in Hartford County, a majority of the cases (62) were in the City of Hartford. He also noted that there were 13 new cases in New Britain in 2011 and that New Britain had more HIV/AIDS cases in 2011 than New Haven. Suzanne explained that CDC counts HIV cases in the area they are diagnosed, but if the

client moves to another state where he or she is diagnosed with AIDS then they are counted in the state of the AIDS diagnosis. Lennon noted that maps on pages 13 and 14 of the data presentation books provide of visual representation of the epidemic from 1981 to 2012 and cases in 2012. Lennon also noted that page 19 of the data presentation books contains an overview of the 2012 TGA HIV/AIDS case demographics.

He presented statistics about People Living with HIV/AIDS in the Hartford TGA through December 31, 2012: 67% of cases were male, 33% female; 31% of cases were white; 28% Black/African-American and 40% Hispanic. In the transmission mode category, 23% of cases were MSM; 39% were Injection Drug Users (IDU); 20% heterosexual and 15% did not report a transmission mode. AIDS cases by age in the TGA included 1% less than 20 years old, 6% 20-29 years old, 13% 30-39; 34% 40-49 and 46% over 50.

Angelique Croasdale of the Grantees Office reviewed the TGA's treatment cascade or continuum of care for 2012. Angelique noted that the cascade illustrates the proportion of individuals living with HIV/AIDS engaged in various steps in continuum of care. It includes an estimation of the number of HIV infected individuals in the TGA, the number of individuals unaware of their status (a formula created by the Centers for Disease Control and Prevention), number of HIV diagnosed, number with one doctor's visit, number with two doctor's visits and suppression. The number of doctor's visits is based on information collected by the Department of Public Health. Angelique outlined the various programs designed to reach those individuals including Early Intervention Services (EIS).

Service Utilization Information

Peta-Gaye Nembhard and LaShaunda Ware of the Grantees Office presented the City of Hartford's service utilization information. Peta-Gaye reported that 2,330 clients received Part A Hartford services and 1,451 clients were HIV positive. Of the HIV positive clients, 60% of clients were male and 40% were female. Thirty-eight percent of clients reported they were of Hispanic origin. Sixty-two of the clients who reported their status as Not Hispanic, 41% were Black and 28% were white. Ninety percent of clients were from Hartford County, 4% were from Middlesex County and 2% were from Tolland County. Fifty-five percent of the clients report heterosexual contact as their risk factor, 21% IDU and 16% MSM. Sixty-five percent of HIV+ clients were over 45 years old.

Of the HIV negative clients, 64% of clients were male and 36% were female. Thirty-two percent of clients reported they were of Hispanic origin. Sixty-eight of the clients who reported their status as Not Hispanic 50%were Black and 17% were white. Ninety percent of clients were from Hartford County, 1% were from Middlesex County and 1%% were from Tolland County and 8% were unreported. Fifty-seven percent of HIV- clients were over 45 years old.

There were questions concerning the race/ethnicity categories and whether Latinos were being counted in race category. In the epidemiology profile and 2013 Needs Assessment Latinos are included as a race and removed from each racial category (for example Black Hispanic, White Hispanic are removed). The Planning Council asked the Grantees Office to clarify if Latinos were included as a race or not.

LaShaunda Ware of the Grantees Office outlined the number of unduplicated clients by service category (see below), number of client encounters, the cost per client of services and the demographic breakdown of clients by service category.

1) Early Intervention Services 3324
2) Outpatient/Ambulatory Medical Care 1150
3) Medical Case Management 468
4) Food Bank/Home-delivered meals 410
5) Oral Health Care 293
6) Medical Transportation Services 265
7) AIDS Pharmaceutical Assistance 203
8) Mental Health Services 179
9) Substance Abuse: Outpatient 164
10) Non-Medical Case Management 151
11) Housing Services 135
12) Legal Services 90
13) Emergency Financial Assistance 41
14) Health Insurance Premium & Other 23
15) Linguistics Services 16

Information on Other Funding Streams

Barbara Mase of the Department of Public Health presented information on other funding streams for fiscal year 2013. She noted that her presentation only includes the partial funding award. Each of the parts received a cut due to the recent budget sequestration in 2013. She explained that there may be a cut of between 10%-15% when all the final awards are announced. She encouraged agencies and Parts to collaborate. She commented that the Affordable Care Act might have some impact on the Human Resources Services Administration's required 75% Core Services/25% Non-Core services split, more funds might be allocated to support services. Barbara also noted that the reauthorization of the Ryan White Care Act has been postponed until Congress understands the effects of ACA. Barbara outlined funding from Ryan White B, C and D, state funded HIV services and programs, HIV prevention funds and other federal programs (e.g., SAMSA grants and Recovery Act funding).

Fernando Morales reminded everyone that Planning Council members must attend the June 5, 2014 Data Presentation Meeting and the July 8, 2014 Priority Setting meeting in order to vote on priorities and allocations for fiscal year 2015.

Meeting adjourned at 2:20 p.m.