

Seattle HIV/AIDS Planning Council

Monday, August 10, 2009-- 4:00 p.m.–6:30 p.m.

2100 Building: 2100 - 24th Avenue South

AGENDA

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|-------|---|-------------|
| I. | Welcome, Introductions & Announcements | 4:00 |
| II. | Meeting Agenda (2 min)
➤ Action: Review and Approve | |
| III. | Minutes: (3 min) 📁 Attachment: white
➤ Action: Review and Approve | |
| IV. | C-LINC Follow-Up (Tony, Jeff) 📁 Attachment in last month's packet
➤ Action: Review C-LINC spreadsheet and determine next steps | 4:10 |
| V. | HIV/STD Program Integration (Gary Johnson)
• An opportunity to have questions answered about this change at Public Health | 4:30 |
| VI. | 2010 Care Mini Prioritization Prep (Gerrie) 📁 Attachment: yellow
➤ Action: Motion to suspend standing rules and operate by modified consensus for the September, October and November Council meetings
➤ Action: Review, approve and sign ground rules and process document | 5:00 |
| VII. | Break | 5:20 |
| VIII. | Testing and Counseling Costs (Frank Chaffee)
• Follow up on question about cost difference between STD Clinic and Gay City | 5:35 |
| IX. | Membership Report (James, Gerrie)
➤ Action: Vote on new member candidate Doug Erhardt | 5:55 |
| X. | Consumer Caucus Report (Ron, Higinio) | 6:10 |
| XI. | Grantee Reports | 6:20 |
| XII. | Adjourn | 6:30 |

Barrier-free location
Reasonable accommodation for persons with disabilities
available upon advance request.

Seattle HIV/AIDS Planning Council

Minutes ☿ Monday, August 10, 2009

4:00 – 6:30pm

2100 Building – 2100 24th Ave. S., Seattle 98144

Council Members Present: *Richard Aleshire, Amy Bauer, Ryan Ceurvorst, Sergio Cueva Flores, Kate Elling, Brandie Flood, Joseph Grant, Kieu-Anh King, Robin Langdale, Gerrie LaQuey, Darren Layman, David Lee, Higinio Martinez, Andrew Murphy, Ruth Njoroge, Kris Nyrop, Arthur Padilla, Kevin Patz, Jodie Pezzi, Tony Radovich, Michael Raitt, James Redel, Germán Rodríguez, Erick Seelbach, Bob Wood*

Council Members Absent: *Shireesha Dhannireddy, Philip Doles, Melinda Giovengo, Sarah Kent, Marcos Martinez, Ron Padgett*

Council Staff Present: Jesse Chipps, Diane Ferrero, Courtney Speigner (minutes)

Public Health Staff Present: Frank Chaffee, Barb Gamble, Gary Johnson, Jeff Natter

Guests: Doug Erhardt, Christine Oyaro

Italics denote Planning Council Membership.

I. Welcome and Announcements

The group did a round of introductions. There were no announcements.

II. Review Meeting Agenda

- Kevin requested the group discuss the Medicaid waiver option at the end of the meeting.
- Jesse announced that C-LINC follow-up will take less time than allotted and that additional time will go to the HIV/AIDS program integration discussion. The prevention report may be early, if possible, as Barb Gamble has to leave at 5:00.

☑ *The agenda was approved as amended by acclamation.*

III. Review Meeting Minutes

☑ *The minutes were approved as written by acclamation.*

IV. C-LINC Follow-up

Tony reported that members of the Consumer Caucus have been discussing the possibility of a C-LINC program. Tony expressed concern over lack of consumer participation in the area. The Consumer Caucus had discussed multiple possible

reasons for this. The group had decided they would like to focus on increasing consumer participation before trying a program like C-LINC. They believe it's possible to create some momentum with the Quality Management training.

Jeff noted that this kind of project seems most relevant to areas where there are more barriers to care. Because Seattle has a relatively low percentage not in care, this project would have been much more focused on specific populations. Because Latinos have the highest percentage not in care, Jeff had approached Consejo to see whether they would be interested in C-LINC. They considered it and responded that they hadn't had a single consumer drop out of care in the last year and a half, so the program wouldn't be needed at their agency.

Tony noted that if there were a mechanism to bring the pockets of consumers doing good work (such as BABES, Project Neon) this might create some energy around consumer participation. Robin agreed with Tony and added it's important to learn more about the needs of consumers. Bob suggested the group set a time to revisit the discussion, so it doesn't get lost.

MOTION: Arthur moved to table discussion of C-LINC until August 2010.

Friendly Amendment: Jeff noted that August of 2010 would be too late if the group wants to consider C-LINC for the 2011-12 Prioritization Plan. He suggested revisiting the discussion in April 2010. Arthur accepted the amendment. James seconded. There was no further discussion.

☑ The motion passed unanimously.

V. Prevention Grantee Update

Barb reported that on August 6, they received six proposals for the MSM RFP. Three applications are for stimulant-using MSM (SUMSM), and five for MSM (non stimulant-using), so there was some overlap. Barb went over the funding requests (these are for 2 years).

- SUMSM:
 - \$1,151,953 requested
 - \$812,600 available
 - \$339,353 over-requested
- MSM (non stimulant-using):
 - \$1,565,634 requested
 - \$1,317,400 available
 - \$248,234 over-requested

<Gary Johnson entered at 4:15pm>

The review panel will meet on September 11. The IDU and FBB proposals are due on Tuesday, August 11.

Jesse stated that at the last meeting she had said that the preliminary letter of concurrence with reservations only went to the state and not to CDC. Although this has been true in the past, may not be the case for this year. The review panel meets on September 11, so the final approval by David Fleming and notification of the agencies cannot happen before the next Council meeting, on September 14. However, the letter of concurrence must be completed before October 5, when the grant is due to the CDC. The group has the following options:

- Let the letter of concurrence with reservations (which was originally thought to be a preliminary letter) stand as the official letter. Justin Hahn has stated this will not have an adverse impact on the grant.
- Designate the Co-Chairs or another group to review the allocations and write a letter of concurrence without reservations, if appropriate.

The group discussed the different options:

- Kris agreed a letter of concurrence with reservations would not have an adverse impact because of the way it's worded. He noted that the letter of concurrence specifically relates to expenditure of CDC funds, which the Council has already been informed of, except for \$96,000 still to be determined. Kris stated his feeling to group should create now a letter of concurrence without reservations. Barb stated the prevention grantees have historically gone over the expenditure of 50% of Omnibus funds as well with the Council, and Kris responded that while that is important, it is not related to the letter of concurrence.
- Bob suggested that the Executive Committee review the allocations at their meeting on September 28; any Council member could attend and vote at this meeting. Kris disagreed with this option, noting that it is the Council's responsibility to approve the letter; however Bob pointed out the Council has the right to delegate that responsibility to a committee.
- Gerrie suggested that the group approve a letter of concurrence now, and delegate the Executive Committee to review the \$96,000 award and make changes to the letter, if necessary.

<Kate entered at 4:25pm>

- Erick advocated for the letter of concurrence with reservations to stand because it's the most accurate representation of the Council's position, and it will not have an adverse effect on the grant.

<Sergio entered at 4:28pm>

MOTION: Erick moved that the Council allow the letter of concurrence with reservations stand. Brandie seconded. There was no discussion.

☑ The motion passed with 19 in favor, Amy, Bob, Richard, and Gerrie opposed, and Jodie and Kris abstaining.

There will be a review of all expenditures at the October meeting.

<Frank Chaffee entered at 4:30pm>

VI. HIV/STD Program Integration

Jesse introduced Gary Johnson, Prevention Division Manager at Public Health. Gary explained that the hand-out distributed at the meeting and emailed earlier that day contains information gathered regarding Dr. Bob Wood's replacement and the integration of the STD and HIV programs. Gary explained that since the last time he had met with the Planning Council around Bob's retirement and replacement, finances have changed dramatically. Losses in county, state, and federal funding have impacted both the HIV and the STD programs. Budget changes in addition to recommendations from the CDC informed the decision to integrate the STD and HIV programs. Gary noted that in the minutes from the September 2008 Council meeting, at which Council members were asked for input on Bob's replacement, many of the key concerns – experience with

HIV, knowledge of the community, experience working with the community – were addressed by the integration of the programs, and the selection of Matt Golden as the Disease Control Officer (DCO) and director for both of these programs.

Council members asked questions, and Gary provided the following responses.

- Erick asked three questions:
 - He noted that in the interview with the other directors about integration, there is a quote that states that most directors did not see a substantial cost savings.
 - How would Bob's work in the HIV program be captured in only .4FTE of Matt's time?
 - He noted there had been an understanding that there would be a national search and community involvement in the search for Bob's replacement. Now, the Council is hearing there will be community input in the integration of the programs. He asked how Public Health specifically envisions this community input.
 - Gary explained there would be .4FTE of Matt in addition to .3FTE of two other individuals that will work as deputy DCOs. One will focus on mainly clinical work at the STD clinic; the other will focus on the community work. Overall, there will still be the equivalent of a full-time physician working. Paying for the equivalent of one physician rather than two will save about \$200,000 a year. This will mitigate staff reductions and service reduction as a result. At the time of the September 2008 Council meeting, it was the intention of Public Health to have a national search, but finances changed. There will be opportunity for community input on how the staff of HIV and STD programs will integrate their work, physical location of staff, and hiring of the deputy DCOs.
- The deputy DCOs and Matt will be on the University of Washington's payroll and the remaining portions of their FTE will be dedicated to the university. Matt has brought grants into the STD program, mainly for research, and it's expected that deputy DCOs will bring in grant resources as well.
- It was clarified that Matt's .4 FTE is for both HIV *and* STD. Currently, Public Health pays for a total 1.2 FTE from two people (Matt at .2 FTE in STD and Bob at 1.0 FTE in HIV). Public Health will continue to pay for 1.2FTE for the HIV/STD program, but this will pay for three people, instead of two. Gary clarified that the two deputy DCOs, will dedicate .4FTE to Public Health which will be divided between HIV and STD programs (as opposed to .3 FTE for each mentioned earlier). All three will do some clinical work, be involved in HIV and STD program direction and management, and be involved in research for the university.
- Brandie shared her view that even with three people, there's less time devoted to HIV/AIDS. Gary noted that HIV funds have already been going into the STD program and to the lab, and this will continue. He emphasized that the HIV program will get time and effort from three physicians, and the experience with Matt Golden so far has been that he gives more than the fraction of FTE for which he is contracted.
- Andrew asked for Bob's opinion. Bob stated he is in favor of the integration – it not only provides cost savings, but also will bring in new ideas and new approaches to prevention and care.
- Kris expressed reservations about splitting positions across different individuals, because there may be breaks in communication, issues come up that need full-

time attention, etc. He requested a flow chart of work responsibilities. Gary agreed to provide the Council with this flowchart.

- Erick returned to the question about community involvement, and asked for specific plans for this, timeline, etc. Gary responded that Matt will be at the next Council meeting and can speak to the group about his vision and take input from the Council.
- There has been a meeting about the deputy DCO hiring process. Matt understands that the health department, the Council, the greater community, and the staff of both programs all have a stake in who is hired. The group can ask Matt more about this at the next meeting. The deputy DCOs will have to be hired soon, as the transition will occur at the end of this year or early next year. The deputy DCOs will meet with the Council. The deputy DCO with a focus on the community will have to be a regular participant in the Planning Council meetings. Jesse noted that Matt had agreed to be a Council member for at least one term.
- Gary reported that Matt is considering one doctor currently for a deputy, but this has not yet been finalized. This doctor is an employee of the university; at this time, Gary does not know whether Matt is considering another doctor at the university.
- Bob suggested the group may not want Matt on the Council for a full two-year term, because it may not be the best use of his time for the HIV/STD program to run effectively. It may be better to have the community-focused deputy DCO as the Council member, and be flexible to see what will work best. Gary stated that if the Council feels strongly that Matt should be the representative on the Council, that can happen. He added his suggestion that the Council will be open to the possibility that the community-focused deputy DCO could be the most appropriate representative. Gary commented that frequently members leave the Council before fulfilling a full two-year term.
- Robin asked that Matt look at diverse candidates for the deputy DCOs.

<Gary Johnson left at 5:05pm>

VI. 2010 Care Mini Prioritization

Gerrie explained that the steering committee agreed to use modified consensus for decision-making in the mini-prioritization process. She explained that the Council can choose to set aside a portion of the Council meeting to be a Prioritization Committee meeting, and during those committee meetings they will use modified consensus (and for the Council meeting portion) the Council will use Robert's Rules.

Gerrie asked that each member choose today whether to opt-in or opt-out. She explained that those who choose to opt-out will have to pay careful attention to which portions of the time are scheduled to be committee meetings, and which full Council meetings, because missing the Planning Council portion of the meeting will be counted as an absence. Jesse added that the product of care mini-prioritization will have to be approved by the full Council. Because of this, it's very important that those who opt-out attend the Council portion of the November meeting (which will be after the Prioritization Committee meetings) so that a quorum of Council members is present.

Brandie asked whether non-Council members will be invited to participate, and Gerrie explained that they would not because it is a mini-prioritization. She went on to explain that this process is just to see if there's pertinent new data and make minor tweaks to the current plan, not to make sweeping changes. The September meeting will include an

orientation. If a member who wishes to participate in the process misses the orientation, s/he will need to attend a make-up orientation. The October meeting will be a longer meeting, from 2:00 to 6:00pm.

Gerrie went over the ground rules (a new version was distributed at the meeting) and the group discussed the following points:

- As facilitator, Jesse will check in with the group whether a “concern is based upon the principles and goals of the process” and whether it “justifies a block to consensus.” No one individual can hold up consensus.
- The Conflict of Interest rules are different than past Care Prioritizations. They are now more similar to Prevention Prioritization – someone who is conflicted in one category is conflicted in all categories.
- Andrew asked whether a consumer lobbying for an agency from which they receive services is considered to have a conflict. Jesse stated that HRSA guidance specifically states that consumers of services are not conflicted (unless they work for or are on the board of the agency). Gerrie pointed out that if someone is lobbying based on self-interest, it is considered a “foul”, whether or not that person is conflicted. Additionally, members should not discuss particular agencies but rather service categories.
- While conflicted members cannot vote or hold up consensus on any category, they are barred from recommending funding amounts or caveats *only in that category*.
- Jargon cards should be used freely for acronyms, lingo and other jargon.
- Andrew stated his feeling that because almost all providers are conflicted, with these new conflict of interest rules, providers become consultants, as non-voting members. Kris shared his experience that if someone has a legitimate concern, others likely share that concern, and these will be addressed. The goal is to make decisions by consensus and not need to go to a vote, so that all concerns are heard.

MOTION: Andrew moved to amend the ground rules such that COI be category-specific. There was no second.

MOTION: Kris moved to approve the ground rules. Kevin seconded. There was no further discussion.

☑ The motion passed, with Andrew opposed, and no abstentions.

Anyone wishing to opt-out of the process should let Jesse know.

BREAK: 5:35 – 5:45

VII. Testing and Counseling Costs

Jess noted there was a question that came up during Barb’s presentation at the last Council meeting about the difference in cost of testing at Gay City and the STD clinic. This prompted Frank’s presentation today.

Frank began by explaining that the main reason the STD clinic receives much more funding is that those funds pay for more than just testing. Frank addressed the funding for specifically high-risk testing (for MSM, MSM/IDU, IDU, and sex partners of any of those people):

- The STD clinic receives \$414,655 for high-risk testing. The rest of the funds go to things like Partner Counseling and Referral Services (PCRS) and data management for both the STD Clinic and Gay City. Gay City's pot of money goes to testing only.
- People at highest risk are also getting RNA testing, which identifies infection earlier. This additional test costs \$27 per test.
- There are also rapid tests, usually for high-risk folks, at \$12.50 per test.
- When all of these are factored in, the STD clinic does about 3,200 high-risk tests, and Gay City, 2,000 per year. The unit costs are about \$172 and \$140, respectively.
- Per the literature, under \$18,000 per positive is cost effective, but Public Health conservatively states that under \$12,000 is cost effective. The STD clinic is at about \$10,000 per positive and Gay City, at about \$8,700.
- The rest of the funds that go into the STD clinic are for other services and moderate-risk testing.

Members asked questions and Frank provided the following clarifications:

- These numbers are projected for 2010, and are based on the past three years.
- The STD clinic tests in total about 7,000 people per year. The other people that are tested are moderate risk, which is paid for with another pot of money.
- With rapid kit tests, clients get a preliminary result within 20 minutes. This gives them some idea of where they stand before leaving the office and ensures they receive at least preliminary results.
- The STD clinic has a much higher overhead than Gay City, because it is a medical clinic and also has higher rent.
- The number of positives is unduplicated. Anonymous tests are accounted for by doing demographic deduplication. Those who test anonymously have a code that is created from their demographics and date of birth. The health department looks for duplication in demographics and date of birth. They also rely on people's self-report that they have never received a positive test before.

Kris stated that he originally asked the question about cost differential in an effort to look at ways to get the "most bang for the buck" in this era of declining budget. He noted that the rate of seropositivity is almost identical, with the STD clinic at .017 and Gay City at .016. He stated his hope that the health department will look into possibilities of providing testing out-of-house, if cheaper. Frank noted the other hidden costs that Public Health incurs:

- Creating the database for Gay City and cleaning the data to meet funding requirements.
- Staff for the One-on-One program to follow up with medical care, and Gay City refers to this.
- Infrastructure for PCRS.

Frank noted that Gay City testing took over Seattle Gay Clinic, who was seeing 500 people per year. Gay City started doing more shifts, with more convenient hours, and have attracted high-risk people. He pointed out that what we don't know is how many people go to Gay City who would not go to the STD clinic and vice versa. Client satisfaction surveys show that clients are satisfied at both clinics, so it's difficult to know why some people choose one over the other.

Members continued to ask questions and Frank, Bob and Amy provided the following clarifications:

- The majority of the STD clinic tests were done in the clinic; about 400 of them were in bathhouses. Interestingly, the bathhouse tests yielded very few positives; however, the sample wasn't large enough to draw a conclusion.
- Testing at the Center for Multicultural Health (CMCH) is not included in the chart, as it is largely funded by the City of Seattle. They are focusing on African American men and African immigrants, regardless of sexual orientation. They have had a small number of tests, but a high positive rate – almost 2%.
- Bob commented that the STD clinic is the only other place besides private doctors that does STD testing. Also, the STD clinic has medical staff to follow up with any health issues that may go along with HIV and STDs.
- Frank stated that with the current testing options, a resident of Seattle who is high risk can get a subsidized test within a week, most times within a day. Additionally, high risk folks get the most advanced testing. Of the 88 positives found, 10 would have tested negative on a standard test.
- Typically, one third of people receive a “late diagnosis” (defined as an AIDS diagnosis within one year of HIV diagnosis). Foreign-born PLWH are more likely to get late diagnosis, and people of color tend to have lower CD4 counts at diagnosis of HIV. A good portion of these numbers are anonymous, so they cannot be matched later with CD4 counts and AIDS diagnoses. For the subset of confidential tests, it would be possible to see how many are late-diagnosis.
- Surveillance tracks whether people were tested through the emergency room; however, while they know how many HIV tests in the ER were positive, they do not know how many tests were negative.
- MMP stands for the Medical Monitoring Project, which included an advanced chart abstraction and interviews with a random sample of PLWH. It is an enhancement to the general surveillance system.

Jesse noted that Council members appear interested in late diagnosis, ER tests, etc., and that this should possibly be another presentation. Council members agreed they would like to see a presentation on these questions.

<Frank Chaffee left at 6:00pm>

VIII. Committee Reports

Membership

James let the group know that the Council needs consumers, specifically African American Consumers. He also presented Doug Erhardt and Christine Oyaro, both unaligned consumers, for membership.

Doug Erhardt introduced himself. He is HIV positive and volunteers at several organizations including Strength Over Speed, as a facilitator, and Shift Recovery Network. He has also gone through the GIPRA training. He stated he would like to join the Council to learn more and contribute to the community.

MOTION: James moved to approve Doug Erhardt as a member of the Council. Kate seconded. There was no discussion.

☑ *The motion passed unanimously.*

Christine Oyaro introduced herself. She has been living with HIV for 13 years. She is from Kenya and moved to Washington a year ago. She has been working in HIV for 10

years in prevention, care, and support in Africa. Jesse added that Christine fills the gaps of unaligned consumer, foreign born Black and Snohomish County representative (she also serves on the Region 3 Planning Council).

MOTION: Kevin moved to approve Christine as a member of the Council. Robin seconded. There was no discussion.

☑ *The motion passed unanimously.*

Gerrie announced that she is going to .32 FTE for Part D, and the rest of her work will be in non-HIV/AIDS programs. Because of this she will not be able to participate as much in the Council and is resigning from the Membership Committee. James is the new Membership Co-Chair, and Phil has indicated he will resume the Co-Chair position.

★ The Membership Committee is in need of new committee members. The group meets the first Tuesday of the month, from 1:30 to 3:30 at Evergreen Treatment Services – 1700 Airport Way S., Seattle 98134.

Consumer Caucus

Higinio reported the group had discussed different recruitment possibilities, including a Facebook page. Meetings are the Wednesday before the Council meeting. For future meetings, the caucus is considering meeting at different locations.

★ Other consumers on the Council are encouraged to join the caucus. The next meeting is Wednesday, September 9, from 4:00 to 5:30pm, at the Yesler Building – 400 Yesler Way, 3rd Seattle 98104.

IX. Care Grantee report

Jeff reported HRSA has not yet released the guidance for the 2010 Ryan White grant application. He plans to ask for about a 5% increase.

He also announced that the 3rd quarter of the Consumer Awareness Campaign will be released soon: this campaign reminds consumers of the importance of re-upping for EIP.

X. Medicaid Waiver

Kevin proposed putting this issue on the agenda for the next Council meeting as well as the next Executive meeting, and the group agreed. Jesse offered that any members with questions about this in the meantime should talk with Jesse or Richard.

NEXT MEETING: Monday, September 14, 2009, 4:00 – 6:30pm, at *the 2100 Building – 2100 24th Ave. S., Seattle 98144*