I. Call to Order

4:40 PM

II. Roll Call

See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda

The agenda was reviewed and approved.

IV. Review and Approval of Minutes

4/23/01 Council Meeting Minutes – no corrections were requested. It was moved to adopt the Minutes. By voice vote, the Council Meeting Minutes were approved. Two members abstained.

V. General Announcements

Mark Dunlop, who is working on the definition of "Not-in-care," announced a work group meeting. *Jim Mitulski* announced a presentation by Amber Hollibaugh on HIV prevention for women. **Proxy forms** were announced: *Greg Edwards* appointed *Stephan Oxendine* to be his proxy voter. *Greg Neumark* appointed *Robert Whitford* to be his proxy voter.

VI. Public Comment

A large number of people from the public attended the meeting. A major topic of concern was dental care and the availability of quality services for people living with HIV and AIDS. *Lucky Choi* spoke about the care he had received in the past and stated that he felt that dental care should be decentralized. He felt that recent decisions involving community-based dental care had not taken into consideration the clients that receive the services. *Brian Vouglas* spoke next and stated that he was there to put his voice into the decision-making about dental care services. *Rick Manring* stated that receiving service from the dental school was frustrating and resulted in long waits for appointments and problems with service. *Michael Meehan* echoed these complaints. *Curtis Turpeau* felt that he had been discriminated against by a housing agency because he uses medicinal marijuana. He has been kept out of a housing opportunity and is therefore forced to remain in his current situation of emergency shelter.

VII. Reports

VIII. San Mateo County

John Conley gave a prioritization report for San Mateo County. He spoke about how the HIV epidemic in San Mateo is similar to the epidemic in San Francisco and also how it differs. An example of the differences that he gave was how a host of contractors in San Francisco will respond to available dollars as compared to very few contractors in San Mateo that will respond to available dollars there. *JC* stated that the political position that the fight against HIV holds in San Francisco is not part of the political landscape in San Mateo County. If a cut to Title I funding was to hit the San Mateo service system, he said it would be an uphill battle to get any of that funding restored out of the County health budget. There are very few visible and vocal proponents for HIV-related issues.

He highlighted how the impact of AIDS has also differed from San Francisco by offering these findings: AIDS cases in the County since 1981 equal 1,889. Living AIDS cases are 712. San Mateo County Health Department HIV services see 554 clients per year. Emergency Financial Assistance was extended to 126 clients. The Food Program served 238 clients. Community dental care serves 85 people. Residential services served 184 clients. Substance abuse treatment (which includes detox, inpatient and outpatient services) is provided by about 15-20 different agencies on a fee-for-service basis. San Mateo County services for people with HIV include substance abuse treatment on demand.

Gender distribution of cumulative AIDS cases was 88% male to 12% female. In living AIDS cases, the ratio is 84% male and 16% female. In the County's primary care services, the ratio is 73% male and 27% female. In food services, the ratio is 58% male and 42% female. Higher percentages of women with HIV utilize the funded services than the men. There was a similar pattern based on racial/ethnic distribution. While 64% of cumulative AIDS cases and 58% of living AIDS cases were among Whites, they make up 37% of those using the County's primary care services. African Americans make up 18% of cumulative and 21% of living AIDS cases compared to their percentage of 34% of the clients in the County primary care program and 50% of clients in the food program. African Americans make up just 5% of the County's population. There is a vastly disproportionate impact, as shown by the AIDS case rates by race and year of diagnosis, on the African American community. The geographic distribution is that the northern part of the County (Daly City & South San Francisco) is where PLWH are mainly gay men, while the southern part (East Palo Alto primarily) is where there are higher numbers of injection drug users and their heterosexual partners.

Mary Jane Wood compiled survey response information for San Mateo County's AIDS program. She said that San Mateo County is unique in that their prevention services and care services are very highly integrated. The survey is for the entire AIDS program of the County. When someone tests positive on one of their mobile testing vans, a health outreach worker is on the van at the time of the testing. Should they choose, the person has the option of seeing the outreach worker right then and there. It is the responsibility of the outreach worker to enroll that client into housing and food programs, substance abuse counselors, and establish a primary care plan. *JC* stated that the health outreach team is another cornerstone of the AIDS program that they are proud of. Primary care services and ancillary health services are centralized, so transportation services are necessary to get clients to their appointments.

In closing, *JC* invited all Council members to come to San Mateo and see their services first hand. He clarified an earlier point that San Mateo has only in home hospice services and no residential care facilities. They are working on a plan where a person with AIDS from their county can be admitted to a hospice in San Francisco and paid for through HOPWA dollars. The Mental Health Association is their housing provider and the residential services are varied—shallow rent subsidies are one example. The county currently places HIV clients in non-HIV specific housing. He stated that housing is a major problem in the county and that San Mateo has lost more clients to its housing crisis than to HIV/AIDS itself because they couldn't find section 8 housing or if they did, they are subject to sudden landlord evictions. There is no form of rent control in San Mateo County and rental housing is decreasing.

IX. Dental Care presentation

Beginning in 1998 the Planning Council allocated funds for decentralized dental services based on needs assessment data from clients and public testimony. Prior to this time, Ryan White CARE funds were utilized only for centralized dental care at a University dental school in San Francisco. *Celinda Cantu* from the AIDS office gave a break down of the Dental Care Budget: $1,194,928. This figure represents 11% of the overall health care sub-category, 3.5% of the overall CARE budget, and 2.8% of the overall HIV Health Services continuum. Centralized care is what she referred to as "one stop shopping" where a consumer can access all of their medical needs in one location. De-Centralized service means that multiple locations are available. Her budget shows that Title 1 funds were split almost evenly between the two modes of Dental Care services with De-Centralized receiving slightly more funding than Centralized, which appears to be more cost effective. Dental Services UOS by Percentage, showed the target and actual units of service were achieved, (a unit = an encounter), between Centralized and De-Centralized Dental Services. She said that one current aspect of the dental care funding picture is the partial dental reimbursement that can be gained from CARE Title F and from ALFA. Another current project has to do with standards of care for dental services. Overall, the main goal of dental care is to eliminate dental infections, pain and discomfort, improve general health and well being, and minimize side-effects of medications.

Charlene Pugh from UOP Dental School spoke next. In May of 2000 the Surgeon General came out with a report that found that 14% of people within the HIV community had unmet dental needs. This was 5% more than the general population in previous studies. Bad oral health for PLWH reduces quality of life because some people lose the ability to chew food. Oral health services are an integral part of the continuum of care that must be provided for those infected with HIV/AIDS and a special effort has to be made in outreach to people of color. Both Centralized (offers a variety of dental practitioners under one roof) and De-Centralized (offers care at multiple service sites) dental services are equally concerned about the standards of care that they provide. *Rob Whitford* addressed the many complaints that have surfaced concerning quality of care at the Dental School CARE Program. Charlene Pugh responded that UOP Dental School is trying to counter the lengthy amount of time that some patients have to wait in order to have their dental work completed and the seeming lack of sensitivity towards the patient.

Gene Gowdey objected that the Prioritization process was not considering the possibility that the previously approved division of dental services between Centralized and De-Centralized alternatives is not being implemented properly in the current year. *Jim Mitulski,* Council Co-Chair, directed the discussion to the agenda item of dental care or service. A member of the public objected to policies about missed dental appointments. *Margot Antonetty* asked for clarification surrounding the differences between Centralized and De-Centralized services. *Charlene Pugh* stated that there was probably not much difference in the service, but there was a need to provide alternative locations and some variation of procedures. The differences and the locations are outlined to the consumers and they pick which will be most effective for them. She asserted that both Centralized and De-Centralized services strive for the highest quality standard of care.

Julian Ponce, UCSF Dental School Dean, commented that he knew that there existed a lot of community concern over the awarding of dental contracts and he wanted to share his perspective and offered to answer any questions that people may have. He confessed that the clinics where pre-doctoral students practice are somewhat slower in service than those that have regular dental practitioners. He also said that some clinics where slower in rendering some of their services because of the populations that they served and the teaching techniques for special populations. Comments came from the public about needing an alternative to "assembly-line style" care in the dental schools. Someone asserted that one appointment in the De-Centralized location could equal the amount of work accomplished in four or five appointments at the Centralized locations. He also commented on the high amount of noise pollution in the environment of the Dental School facilities, with lots of people and machinery in one large space. He called for more one-on-one contact between client and dentist. *Ali Riker* asked for clarification about the process and whether the controversy was due to a programmatic issue that the Council would need to examine. *Michele Long-Dixon* replied that since the former Contractor had threatened legal action due to a grievance about the Review Panel process, she had been advised not to comment on any matters related to the process for selection of a Contractor. She commented later that the change of contractors is a change that will result in a facility located in the Tenderloin neighborhood, where a large number of consumers live.

Larry Cruz asked to clarify that dental services are contracted to the dental schools, and the role of dentists in providing the actual patient care. *Celinda Cantu* replied that the DPH is also a service provider in this category, so not all the dental services are contracted to the dental schools. The care provided at the schools by student dentists is monitored by dental faculty who are dentists themselves. Specialists are also available to patients receiving care at the dental schools. The DPH facility is staffed by licensed dentists, and patients have the option of going to that dental clinic. *Jim Illig* asked the dental providers present (and by extension other providers speaking later about other service categories) to address how they assure that the patients they see don't have other insurance, such as MediCal. *Dan Vuic,* from UOP CARE program, said that they were recently equipped to go online to access MediCal

information. Upon intake, clients are asked about MediCal and private insurance, in order to assist in developing their treatment plan.

X. Break

XI. Steering Committee Report

Stephan Oxendine called for consideration of the Council Support budget leading up to a vote. *Gary Harrell* introduced an amendment that had been forwarded to the Council by the PWA Caucus. He said that the rates to be paid to consultants were too high in this budget. Monies saved from lowering consultant fees could be reallocated to hiring outreach consultants and to producing outreach materials. Also, reallocated funds would be applied to the salaries of the Administrative Coordinator and the Administrative Assistant. The amendment was passed by the PWA Caucus on a vote of 3 to 1. In support of the amendment, *Greg Neumark* read a provision from the Ryan White CARE Act, which said that Planning Council support includes "reasonable and necessary marketing activities associated with publicizing the Planning Council's work and programs for the HIV infected population and sub-populations, which enhance community participation in the Planning Council." He went on to say that it is the responsibility of the Council as mandated by the CARE Act to increase outreach efforts and to increase membership from among unaffiliated consumers and historically under-served populations. He felt that not enough support for such activity was currently included in the budget. Greg complained that the Council last year spent less than half of the money it had budgeted for materials and did not expend $41,000 of its total budget. He said he would have brought this proposal sooner had he known that there was going to be money left on the table at the end of the fiscal year. He said that since that opportunity for funding the Council's outreach efforts was lost, he had to look for money to move from some other line item. He chose consultants fees to reduce, feeling that $100 per hour was too high.

Michele Long Dixon said she felt this amendment went beyond the Council establishing a budget to fulfill its scope of work and came close to dictating the terms of a contract. The Council doesn't have authority over contractual documents, and this budget is a contract exhibit that is close to certification. A query was raised as to the validity of the Council making fiscal decisions for the Grantee, DPH. In response, *GN* quoted from the Ryan White CARE Manual stating that, "while the Planning Council may not select particular entities to receive CARE Act funding, it may be involved with selecting particular entities and people to carry out activities directly related to Planning Council functioning and responsibilities." He said that the Council, in his opinion, does have the power to change line items and budgeted amounts. He wanted this process of approving the Council Support budget to be accountable to the Council. *MJW* clarified the amount for salary to the Consumer Rights Advocate and asked for a rationale to increase staff salaries, which *GN* provided. *Fernando Gomez-Benitez* said he supported the amendment, but had some doubts about under-funding the projects on which the Council needs consultants. *Brad Hume* asked if the people doing the outreach work would be Council members? *GN* answered that he hoped Positive Resource Center would find Council members and others who could do this type of outreach for the Council. *SO* said there was no assurance that PRC would accept this change in the budget or would do this work. *CG* said an alternate option was just to reduce the Consultants line items, then the decision could be made by the Contractor whether to accomplish this by a reduction in hours or in rate of compensation. *Mjay Sanders* said that the Council had learned very late in the process that there was $41,000 that was left unspent last year. It may be too late to spend that money, but it will help in the current year to have a budget that is more consistent with the Council's plans. To him, it didn't change the overall budget picture to adjust line items. *SO* replied that it was a change in the scope of work in the contract. *MLD* didn't want to get into a position where no one wanted to do this work and the contract had to be put out in another RFP. *Joseph Cecere,* from DPH, said the original budget for this contract had been approved in a vote of the POC/Steering Committee. He said the Contractor would try to negotiate the best rate. The amendment was re-phrased by *AR* to say that the point was to reduce the consultant-subcontractor's line items proportionately by an amount of $7,350 in order to create this outreach plan that was being advanced by the PWA Caucus. *AR* said

the other point that she needed to make was that there should have been some notification by the Contractor about unspent money or an "Unfunds Alert" in the Council's vernacular. *Jeff Byers* seconded this amendment. The meeting proceeded to a Roll Call vote *(see Attachment A, Column 2).* The motion carried 21-4, with two abstentions. With no additional discussion, a Roll Call vote was then held on the Council Support budget after the amendment is incorporated *(see Attachment A, Column 3).* It also passed by the same tally of 21-4, with two abstentions.

XII. Contractual Budget, Current Fiscal Year

Russ Zellers presented the budget for the current fiscal year. Basically, this is a continuation budget with the exception of the reductions already approved by the Council to bring planned expenditures down to available dollars. Delays in Title I and Title II award dollars and some reduction in Title II created a lag in the budget. He reviewed the categories and the sub-categories of the Planning Council and CARE Title 1, totaling nearly $27 million. These are the funds that are available from the Title I award for contracts; it does not include the administrative money. He detailed the other funding from CARE-Housing and the CBC that bring the total to more than $33 million (the amount that corresponds to the purview of this Council), then other sources that bring the grand total to more than $42 million for contractual purposes. The OMH grant for Technical Assistance programs is new money. He said this was presented in this format as a planning tool.

There were questions pertaining to the untimely manner in which the budget was presented, but this second Reauthorization to the Ryan White CARE Act brought delays similar to the first reauthorization five years prior. Unfunds is another topic that came up in discussion, but was related to last year's funding. Again, a Roll Call vote was taken to approve the Current Fiscal Year Contractual Budget (see *Attachment A, Column 4).* It passed by a vote of 24 to 0, with one abstention.

XIII. Reports: Primary Care

Joseph Cecere stated that $4 million from CARE funding is spent on Primary Care, a sub-category of the health care category. The client's first encounter with the service system is generally with a primary care practitioner in tandem with a multi-disciplinary team of services. He could not provide demographic data due to problems with Reggie. He explained why some psychotherapy is considered part of the primary care package at some facilities, and a high percentage of primary care is actually case management. He provided five recommendations to improve primary care: 1) HRSA requirement to provide services to those not in care will be extremely challenging for most primary care programs since they are already at capacity and will therefore require additional funding. 2) Implement a system-wide plan for reviewing records and quality assurance at all CARE contracted programs. 3) Encourage and support improvements to multi-disciplinary team services. 4) If funding remains flat and costs for providing services continue to rise then reductions in UOS should be allowable. 5) Encourage the philosophy that human resources within the system should be respected and valued.

Charlotte Bobeck, with the Provider's Network, presented a summary of Primary Care Provider input. She reviewed some of the emerging trends that providers are seeing and said that these have created gaps in services. She said that all services work together and if there is a deficiency in one area of service it affects primary care. HIV has become a medical specialty in infectious disease. Viral resistance and "burn out" on drugs have become quite a problem. There are severe nursing shortages and an increase in demand for Complimentary Therapies. Continuity of care has been affected by funding being slashed and this too diminishes the effectiveness of primary care providers working in tandem to create a cohesive care unit. The work force is decreasing because of funding shortfalls. This definitely affects Primary Care. The amount of work that needs to be done in a range of administrative functions as well as actual patient care does not fit the dollar amount that is received. There were complaints about the amount of reporting required by the AIDS Office, beyond the funded services. Overall, the providers would like to see an effort to build upon of the system that already exists. She recommended a streamlined contract process, mental health training for providers, and a hard look at

housing issues. *JC* asked about the $1 million secured in this year's federal budget for HIV care at San Francisco General Hospital. *MLD* said a planning group is working on it. There are significant restrictions in how the funding can be utilized, for example it cannot be used for primary medical care. There is an extra application process, so this money will not become available until later this year.

At this point a motion was made to extend the time of the meeting to deliver the remaining schedule of reports. It was passed.

XIV. Reports: Complementary Therapies

Marshia Herring stated that the four programs in complementary care are: 1) The American College of Traditional Chinese Medicine, 2) The Marin AIDS Interfaith Network, 3) The Immune Enhancement Project, and 4) Quan Yin. The funding for this program was $732, 202. Approximately 2,399 individuals received services: 33 were transgender, 809 were females 1,535 male, 80 % were adults and 20% were seniors. Two recommendations that were made at the last prioritization remain as they were as there was not available funding. There is a great demand for these four programs as people are living longer and there are significant waiting lists to access services. Her recommendations: 1) Set time limits for these services or think of ways to spend less time with these clients to push the wait lists along but also maintain current funding so as not to disrupt service as it exists. 2) The impact of these services should be evaluated. 3) Continued funding is recommended.

Elyse Graham, with IEP, said the most urgent issue affecting complementary therapy is lack of funding. She stated that it is an effective alternative treatment option that benefits immune systems diminished by HIV disease and is an important component of substance abuse treatment. However, the average wait is 6-12 months to access these services. Some people have died before they ever received service. Most people are not aware of what these therapies are or can do for them because the funding for education does not exist. Studies have shown that 90% of complementary care clients have not been hospitalized in the past six months. She stated that they are in a double bind because if they take funding away from existing patients then their health will suffer. However, there is a need to reach the newly infected too. Complementary therapy is a cost effective treatment modality. Only 1.9% of CARE funding goes to this category of complementary care. Yet, with that funding, they were able to treat 65,000 since 1993. Her main recommendation was that the Council recognize and prioritize complementary health care as essential primary health care. 67% of their clients indicated that they receive this therapy in conjunction with their antiretroviral therapies. An increased level of funding would decrease wait lists and reduce hospitalizations. She also asked for a streamlined contracting process in order to allow resources to be used for the benefit of clients. A question was asked pertaining to the loss of funding to this sub-category during the past two years and how that has affected services to traditionally under-served populations.

XV. Home Health Care Services

Hilda Jones began by stating that the two main services included in Home Health Care are Facility-based Home Care and the Home-based Home Care. Both have over-achieved in their Units of Service goals. She distributed a narrative about the specific services provided. One challenge has been providing services at residential hotels to clients with very low income.

Dianne Jones, who works with Help at Home, delivered a presentation that highlighted the limits of MediCal and Medicare. She said that MediCal and Medicare will only fund home care services for home-bound people and they will only fund nursing care services for what they narrowly define as skilled nursing, which does not include medication management. CARE dollars and the General Fund contributions have expanded access to home care services that include attendant care, nursing case management, skilled nursing care, physical and occupational therapists and social workers for people who are uninsured/underinsured but not homebound. However, the number of people served is limited because clients need to have a payer source (usually MediCal) to pay for the medications and

equipment. Home Care agencies provide nursing care, IV site care, blood-draws, and teach clients how to become independent with their infusions. However, Valgancyclovir, a new drug in pill form that is awaiting approval to go on formulary lists, will transition clients off IV treatment. Funding issues are huge with home care service, and it is a complex system to navigate. *Larry Cruz* testified that he had successfully utilized infusion therapy for five years and said he would not be alive without it. He asked how a patient would get this treatment, if not covered by some form of insurance. The response was that these people lose their ability to stay at home because therapy can only be provided at SFGH outpatient infusion or at Laguna Honda. *Sam Kaplan* commented that MediCal will pay for some services in this area. *Dianne Jones* continued that Nurse Case Management in the Home is medication management and linkage to primary care.

David Powell, from Westside AIDS Case Management and Home Care, presented the Attendant Care section of the presentation. He said that Home Care is much cheaper than institutionalization and it increases the quality of life for those that receive services. In addition to funding struggles, another barrier that Home Health agencies face concerns the many clients that providers assess as needing attendant care to assist with personal needs in the home and are resistant to receiving the service because of concerns around loss of independence, privacy, and disclosure to neighbors and friends. He also suggested that flat funding has eliminated their ability to provide additional services when needs increase or new consumers need services. He closed by stating that if Home Health Care Services were not provided, then higher levels of care would become necessary.

Susan Shea asked who certifies "home-bound status." The response focused on the lengthy medical assessment that the agencies must fill out and send to MediCal. The certification is done by a computer, using formulas and rules. The information has to be constantly verified and updated. *SS* also asked what changes would result from the oral form of drug therapy replacing infusion. The amount of IV therapy should decrease, but the agencies are currently seeing a rise in the use of short-term IV antibiotics and hydration therapy. *Dianne* anticipated greater numbers of clients being served for shorter periods of time. There is no breakdown of clients by income or housing status, but many clients are receiving their services in SRO rooms. *Russ Zellers* said San Francisco was lucky to have three MediCal waiver programs that provide services to PLWH. This means that Home Health Care can be provided without CARE funding.

XVI. Adjournment