Planning Council

Minutes of the **Meeting** of **July 18, 2006**

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Meeting Attendance

Present[1]	L. Green	D. Brewer
	K. Allston	S. Ashley
	D. Baker	H. Carter
	M. Cole	L. Creditt
	I. Davis	N. Drew
	B. Flint	A. Foyles
	B. Grant	M. Graves
	T. Gray	N. Guest
	R. Haden	P. Hall
	R. Hamlett	R. Johnson
	B. Cheek-Jones	J. Keller
	J. Keruly	G. Manigo
	C. Massey	W. Merrick
	W. Miller	M. Reese
	W. Samuel	K. J. Taylor
	B. Tucker	
Absent	W. Belle	L. Chapman
	D. Henson	S. Jones
	D. McKelvin	M. Obiefune
	A. Santiago	R. Shattuck
	S. Woods	
Proxy	S. Smith	D. Cooper
	C. Thomas, Jr.	R. Green
	P. J. Gouldmann	L. Herrera
	G. Nelson	
Counties Committee	M. Mazzuca	P. Balducci
	S. Ernest (proxy for A. Burke)	M. Emerson
	B. Fitzsimmons	J. Gerwig
	D. Goforth	S. Kopins
	J. Levy	D. Middleton
	B. Culver (proxy for D. Middleton)	L. Green (proxy for M. Nelson)
	L. Wilson	
ABC	B. McKeithen	C. Edmonds

[1] Attendance is based on sign-in sheet

BCHD	R. Brisueno J. Ungard	R. Matens D. Ganachari
Visitors	A. Allen B. Thomas-EL J. Jones W. Fenwick M. Guest L. Anders K. Matthews H. Roberts, Jr. C. Flynn J. Keita C. A. Bauman	J. Winslow M. Becketts P. Jones D. Robinson W. Bultmer J. Kahn D. Hunter J. Stockdale J. Bartlett W. Frank
Staff	N. Curtis D. Munro M. Peterson	C. Lacanienta D. Gorham
Handouts	Agency Presentations Planning Council Agenda Informational Flyers	

Introductions

L. Green convened the meeting at 6:30 p.m. with introductions.

Review of Minutes

The planning council deferred their July minutes to the August meeting along with all council and committee business.

FY 2007 Planning Council Data Presentations

Lennie introduced D. Munro of IGS who talked about housekeeping matters related to the contingency matrix.

Epidemiological Data and Unmet Need

Colin Flynn of the State AIDS Administration was the first presenter. Mr. Flynn's handout on what is going on with the epidemic in the Baltimore EMA was distributed to the council. Below are the findings:

Baltimore EMA has 61 percent of the cases in the state; 9 percent are from corrections. Baltimore is the 5th highest in AIDS cases of all metropolitan areas in the country. Within the last 5 years, the state changed the way we reported AIDS cases in the city so from 1999 to 2001, we jumped from 9th to 3rd.

Deaths have been fairly stable. In the city, the number of deaths by AIDS surpassed that caused by crime. Eighteen thousand eight hundred and ten are living with HIV/AIDS in the EMA.

Where are the cases? 78 percent are in Baltimore City. Baltimore County's percentage of cases is increasing. Colin showed a map representation of prevalence data in the region.

Our population is aging. The bulk of our cases are now in the 40-49 age range.
Gender: Male 63 percent, 37 percent female. Exposure category: IDU 47 percent. (This has been declining.) Heterosexual contact. (This is increasing.)

Unmet need: HRSA defines unmet need as those persons who are known to be HIV infected but who are not in HIV/AIDS primary medical care. PMC is further defined as persons receiving CD4 test, VL test, and ARV medications during the last 12 months.

Currently, we use counts of persons in care from various reporting sources. Now, we will be able to get counts of persons with ARV meds. We have counts for all the meds throughout the entire state from all sources. We can now count all folks getting antiretroviral in the state. Coming soon, counts of persons with viral load tests. Viral labs will be reporting to state on viral load tests using unique identifiers.

Question/Answer Session
Question (Dale): the funding system is moving to names reporting. Where is the state in this process?
Mr. Flynn: budget allows the state to make the transition plan if there is new legislation that is in place. Internally moving things in place so that we can move quickly.

Question (Herman): We are missing some proportion of folks who are in care but are not ready yet for treatment. How do we count them?
Mr. Flynn: good point. We will have to work with folks to try to identify how to project the number for these folks.

Question (Carnell): With the daily changes, how do we know that we can wait until January?
Mr. Flynn: Congress has been talking about changing RW for the past year. We don't know what is going to happen. We are making the internal plans that we can. But we can't act unless the state legislature approves. Hopefully, the general assembly will address this in January.

Question (William): We are supposed to have a plan in place to get a proxy. In order to get a proxy that is in the reauthorization, we need to have a plan.
Mr. Flynn: If the proxy becomes law, we have sufficient time to submit the appropriate paperwork.

Medical Trends and Challenges

Dr. John Bartlett of Johns Hopkins University was the next presenter. Dr. Bartlett's handout on medical trends and challenges was distributed to the council. Below are the findings:

This is the momentous year for HIV. This is the10th year for antiretrovirals. In 1996, we didn't really have anything that worked. Nineteen ninety-seven was the momentous year that everything changed. When you take what happened then (suddenly with triple therapy) with significant gain and then take the incremental gains thereafter, what a remarkable change. What a significant progress to get two pills from two different companies to one pill a day.

You added an average of 13 years to the average life of a person living with HIV/AIDS. There is no other field of medicine that can boast this progress. Three million life years saved during this progress of medical gains.

We are up to 26 pills for addressing HIV. Our rules are the same. We start with three drugs. The notable advance in the last few years is our ability to treat those who have failed other therapies.

Regular HIV testing should be something we should do. We've been used to the system that had been born in 1985 but I know that regular HIV testing will be a contentious prospect.

Failed: We talked about success. I do want to talk about where we failed. We do not have a cure. We have not been very good at prevention. The number of cases has doubled worldwide. What we can do is to test. Knowing the serologic status has a significant impact in decreasing transmission. This would be up to 3 to 4 fold. Are there enough providers for people to get care? Is there going to be enough? If we have the patients, then we will have to find the slots for treatment and the medications to treat them.

Question/Answer Session

Question (Mary): What is your sense of the development of medical practice?
Dr. Bartlett: We are still under the medical consent form for practitioners. I am hoping that we can change the Maryland law; we can make this more of a routine test. Signed consent forms slow down the provider and intimidate the provider.

Question (William): Why would you say that there is not a focus on finding the cure?
Dr. Bartlett: The problem is that this is a challenge that is unsurpassed because the virus is inculcated within the clients' genes, in the DNA. To be fair, there has been research in ways of releasing the virus from the DNA. We have been very good at learning to treat the disease but not a cure…but not for the lack of trying.

Question (Carnell): Tell us about adherence.
Dr. Bartlett: We will continue to say that there ought to be a 95 percent adherence to medication.

Question (Markton): Do we have a common name for the single pill.
Dr. Bartlett: Atripla will be in drug stores on Monday. The cost for the one pill is that of three pills. However, the pill will only cost the client one co-pay.

HOPWA

Jamila Keita, Program Manager for Baltimore Homeless Services was the next presenter. Ms. Keita announced that K. Briddell has left the agency and the replacement is Karen Booth who will begin in September.

2005 allocation for EMA is $7,649,000. Rental assistance: 481 units currently occupied, 16 more than 2005.

Support services: Described

SPNS will have additional funding for units for HOPWA.

Question/Answer Session
Question (Markton): At this point, what is your view of alleviating the challenge starting with the waiting list of housing?
Ms. Keita: We are filling in vacant units with the waiting list. I can send that out to be answered.

Question (Markton): Are you adding new clients to the wait list?
Mrs. Keita: No.

Question (Diane): Does this include county figures?
Mrs. Keita: No.

Question (William): For those who can't get on the waiting list, how do I get on the waiting list or access services?

Mrs. Keita: Anyone can access shelter plus care units. There are 14 providers and anyone with disability is eligible. Can distribute this to you.

Question (William): When will the waiting list open up?
Mrs. Keita: Don't know. Unless we get additional units, then I don't think opening the list will happen. However, we are filling out vacancies with the waiting list.

Question (Melanie): The study will continue the 105 participants enrolled?
Mrs. Keita: No, the study has ended. However, there is funding enough to continue to slots that are currently there.

Unduplicated Client Count

Client level data will be available at priority setting.

Title II and Title IV

Jessica Pollak-Khan of the State AIDS Administration was the next presenter. Her presentation on Title II and IV was not available for the council to review but it will be placed in the Priority Setting binder.

FY 2006 Title II Award is $36,055,252. Title II Base Funding for Baltimore city: $3,058,090, which is 39 percent city based.

Minority AIDS Initiative award is $303,301.

Transitional case management is brand new. CDC reduced prevention funding. Title IV is the only RW title that is not going to get an increase. State funds: $1,900,000 help pay for sero-positive clinics.

Accomplishments:
- CAREWare technical assistance – wrote a joint TA (title I, II and 4)
- Initiation of 3 new transitional case management contracts
- Treatment adherence provider round table
- Director team model

Hot topics:
- Case management certification program (Title II and 4 will be providing a course)
- RWCA reauthorization
- Youth initiative services include HIV care, case management, psychosocial support, youth CAB, peer advocacy and life-skills training. Stigma is one of the reasons why the family-centered care is so important for youths.

Question/Answer Session
Question: Is the training required?
Answer: The training will be offered throughout the state. If folks just want to take the test, then they don't have to take the course. AETC will be providing the training and get CEU. The training will be free.

Prevention Services

Kip Castner of the State AIDS Administration was the next presenter. His presentation was not available for the planning council to review but it will be placed in the Priority Setting binder.

Maryland – HIV incidence is declining. There was a dramatic decline in IDU since 1994. Nineteen ninety-four is also when needle exchange started.

Heterosexual contact is now the leading mode of transmission for newly diagnosed HIV cases. It is the foundation for the prevention priorities.

PWP – interested in the studies of LIFE (Learning Immune Function Enhancement) by Dr. Jeff Leiphart; will ask PC to fund this initiative.

Question/Answer Session
Question: Will you send us the LIFE info?
Answer: Yes.
Question: Supply facilities to have the classes? What type of dollar figure are you looking at?
Answer: Depending on if you want to do a pilot anywhere from 25k to 75k.

Question: Can this be incorporated into the care site?
Answer: Yes, can enhance existing training.

Question or comment: Some of the things that LIFE has bulleted; this should be things that are provided for case management. I don't understand why we pile on new things. We leave so much room for not hitting the mark.

Melanie and Richard: reminded that there is a positive self-management training being funded.

AETC: we have two new programs funded that could provide training.
Jean: We haven't done prevention very well and I think it's time to look at innovative items.

MADAP and AIDS Administration Insurance Programs

Linda Anders of the State AIDS Administration was the next presenter. Her presentation was not available for the planning council to review but it will be in the Priority Setting binder.

We enrolled numerous people into Medicaid Part D. In the last 12 months, MADAP has added 29 drugs to the formulary. Done a good job of keeping things price neutral. The advisory body meets four times a year. In 2002, there were 76 drugs put on the market. FY 2006, our drug rebates are at 11 million dollars.

MADAP PLUS is an insurance assistance program for MADAP clients. Enrolled 1000 of our clients into Medicare Part D. Open enrollment starts November 2006. With the Medicare subsidy, we are able to pay for MediGap coverage. The AIDS Administration is looking at trying to pay for doctor visit co-pays.

Medicare Part B premium will be $98 per month – eligible clients with Medicare should be referred to QMB and SLMB to get assistance paying for this benefit.

Estimating that pharmacy assistance clients are 30,000, 2 percent are HIV clients. 540 clients for the EMA would go into MADAP or MHIP.

Comment (Mary): MADAP does a good job helping us. There is still a group of people that do not fall into these pots and therefore go uninsured except for MADAP.

Medicaid

Betty Flint of OHH-Medicaid was the next presenter. Her presentation was distributed to the council. The presentation described those who are qualified for Medicaid.

We are always trying to maximize the dollars.
Primary changes:

- Deficit Reduction Act (DRA) signed into law Feb 2006. The Act shows citizenship and identity for those reapplying for medical assistance programs.
- Primary Adult Care (PAC) program is an extension of benefits. There is no pharmacy assistance program and primary care program. This is a limited medical benefit. We received from Maryland $15 million additional dollars.
- Employed Individuals with Disabilities (EID) was the other change.

There were no questions for B. Flint.

Service Continuum

Jeanne Keruly of Johns Hopkins Hospital was the next presenter. Her presentation was distributed to the council. Trying to support the co-morbidities is becoming more challenging.

Overview of the Baltimore EMA system model
When we plan, what are the issues:
1. Reauthorization and allocation of dollars still unknown.
2. System change (names reporting) may be necessary to avoid the loss of funds in Maryland.
3. Resources constrained.
4. Titles1, 2 and 3 will be competitively bid this year.
5. HRSA emphasis in core-medical services

Challenges:
- Recommendations for HIV management are always changing.
- Maryland is bringing in new money for primary care; concern that there isn't emergency care and specialty care.
- As gains in HIV are made, other co-morbidities surface that are representative of health challenges in non-HIV infected poor communities.

There were no questions for J. Keruly.

Client Satisfaction Survey

Jaime Stockdale of State AIDS Administration was the last presenter. Her presentation was distributed to the council.

Maryland AIDS Administration and the Baltimore City Health Department jointly worked on this survey. The State AIDS Administration has conducted this survey every year since1999. The survey study period was from April to May and almost 2600 surveys were sent out to the Baltimore EMA and 1292 were returned. The new survey will be completed in 2007.

There were no questions for J. Stockdale.

Meeting ended at 10:00 p.m.

I certify these minutes to be accurate and inclusive record of the planning council meeting as amended and approved by the Greater Baltimore HIV Health Services Planning Council.

Lennwood Green *August 16, 2006*

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