New York EMA - H89HA00015
Ryan White Part A
MAI Annual Report Narrative
FY2013

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Prepared by: Amber J Casey MPH
Care and Treatment Program | Bureau of HIV/AIDS Prevention & Control
New York City Department of Health & Mental Hygiene
acasey@health.nyc.gov – (347) 396-7406

MAI General Overview

The FY2013 MAI award was $9,412,436 with expenditures of $9,754,457, including approved carryover in the amount of $347,690. MAI funds four (4) service categories.

Medical Case Management – 7 programs. MCM programs served 1,151 clients (including Tri-County region). The allocation for this category was $4,453,115 and final expenditures were $4,435,742.

Early Intervention Services – 8 programs. In FY2013, 14,602 individuals received EIS services. The EIS allocation was $ 1,715,747 while final expenditures were $1,654,949.

Housing Services – 2 programs. 210 clients received housing services. The original allocation for housing was $1,052,027; final expenditures were $1,068,408.

Outpatient/Ambulatory Medical Care (ADAP Plus) – 1 program. 1,001 clients were served in FY2013 with Part A MAI funds. The allocation was $1,250,304 and total expenditures were $1,654,115, including the entire approved MAI carryover.

Other than ADAP Plus, agencies/programs are selected for MAI funding based on their location and ability to provide services in disproportionately affected communities such as the South Bronx and Central Brooklyn. The criteria are outlined in the annual MAI Plan.

Progress Toward Achieving Goals/Objectives

MAI funded service categories represent only a portion of all Part A funded services in the EMA. All four of the MAI funded service categories also have base-funding allocations. Part A funded services that round out the New York EMA portfolio, include substance abuse services - outpatient, mental health services, oral health care, food bank/home-delivered meals, medical transportation, legal services, case management (non-medical), health education/risk reduction, home and community-based health services, and psychosocial support services. MAI services specifically target high-need, racially diverse communities.

Medical Case Management/Treatment Adherence. Care Coordination and Tri-County Medical Case Management programs are required to assess and document levels of treatment adherence among clients prescribed antiretroviral medication. These programs continue to meet or exceed targets for the proportion of clients achieving optimal (95% or greater) adherence on their most recent non-baseline adherence assessment. In FY2013, 87% (659) of all 755 MAI MCM clients with a qualifying post-baseline adherence assessment showed optimal adherence by self-report or other measure on their latest adherence assessment. This represented an increase from the result (84%) in FY2012. New York EMA MCM programs utilize standardized forms for adherence assessment, including monthly pill count and, where applicable, DOT logs.

For MAI Care Coordination and MCM programs, DOHMH analyzed client retention in primary care, using the HRSA/HAB (and NHAS-based) measure requiring at least two visits at least three months apart during the reporting year. Among clients enrolled throughout FY2013, served at least once in that year, and with no greater-than-six-month suspension of services, 95% met the HRSA HAB definition of 12-month retention in care. High levels of documented retention in primary care, exceeding national and local target levels, are attributed to a combination of (1) service model guidance/manuals and their implementation by the providers; (2) technical assistance from DOHMH and support through the quality

management program; (3) requirements built into eSHARE for data entry of primary care visits or attestation to the absence of primary care visits during the period; and (4) ongoing Primary Care Status Measures (PCSM) monitoring and feedback provided by the grantee.

Early Intervention Services. Early Intervention Services were assessed in terms of their demonstrated ability to a) deliver new HIV diagnoses to clients and b) link newly- and previously-diagnosed but out-of-care clients to primary care. Overall, these MAI programs newly diagnosed 74 individuals in FY2013. Among black and Hispanic newly diagnosed individuals, 91% received their confirmatory positive test result – evidence that our contractors are particularly suited to working with the clients MAI funds seek to serve.

For Black and Hispanic newly diagnosed clients documented as having confirmatory positive test results from an MAI program in FY2013, 70 (95%) had documentation of linkage to primary care within three months of diagnosis. In addition, these EIS programs promptly linked 40 (98%) of 41 MAI clients who presented as previously diagnosed but disconnected from HIV primary care at the time of enrollment. These are the highest linkage rates to date, and substantially exceed the NHAS target of 85%.

Housing Services. The MAI housing placement program was assessed for housing stability and short-term engagement in primary care, among clients enrolled in housing services for at least six months during the grant year and served at least once in that period. The ability to measure outcomes is limited for this service category, due to the relatively short-term nature of the housing services under Ryan White. Clients can only be followed by their providers for housing and health outcomes for the period that they are enrolled in the programs. Housing stability is defined as client receipt of at least one housing placement or rental assistance service type during the grant year. Among the active FY2013 MAI clients who remained enrolled for at least six months during the year, 65% specifically received stabilizing (housing placement or rental assistance) services. This just narrowly met the target for the indicator; however, additional clients received these services, but were not included in the denominator or numerator due to their shorter enrollment periods. Identifying appropriate, meaningful and representative indicators for these short-term services remains a challenge.

For FY2013, a new, short-term primary care engagement measure was utilized in place of the former linkage to care measure. The short-term engagement in care measure assessed those enrolled for at least six months and with some service activity during the grant year, for evidence of a primary care visit within the first six months of the grant year or (for new or re-opened clients) within the six months after enrollment. Of 35 MAI clients meeting the eligibility requirements for the indicator in FY2013, 21 (60%) had evidence of engagement in care in the six-month period. The small denominator for this indicator reflects the tendency for clients to move through these short-term housing programs in under six months; again, engagement in care may be common among those with shorter periods of enrollment, but we could not fairly assess clients for whom less than six full months of provider reporting were available in our Ryan White reporting system. Housing programs also have a greater challenge than clinically-based programs for documenting medical tests and visits, and serve clients who enroll with a severe unmet basic survival need and whose first priority may not be primary HIV medical care. However, DOHMH has incorporated and clarified the requirements for PCSM in all recent contract renewals and has shifted to greater uniformity in the expectation for provider assessment and reporting

on PCSMs. In addition to strengthening and communicating the policy, DOHMH has incorporated the above-mentioned PCSM-related checks and consequences for delayed reporting in eSHARE.

Outpatient/Ambulatory Medical Care (ADAP Plus). All clients who received MAI-supported ADAP Plus services during this period were uninsured individuals who completed at least one medical care visit in FY2013. Because of the reduction in the FY2013 grant, the Part A was unable to pay for any new clients on ADAP Plus, thus no new clients were served with this funding and we are unable to report on the Part A Standard Outcome Measure we had selected. A new measure, improved viral load suppression, has been selected for the FY2014 MAI Plan so that this is not an issue in the future.

Provider-level TA Activities

Medical Case Management. From March 1, 2013 to February 28, 2014, two DOHMH Technical Assistance (TA) Unit Project Officers provided TA to the four MAI-funded Care Coordination programs. In addition, one DOHMH TA Unit Project Officer provided TA to the one MAI-funded Transitional Care Coordination program. These three Project Officers also support base-funded Care Coordination and Transitional Care Coordination programs. MAI Care Coordination providers participated in two mandatory provider meetings of all Program Directors and other Care Coordination staff. During the year, provider meetings addressed topics such as eSHARE forms, coordination with Medicaid Health Homes, data entry guidance, and programmatic best practices. The MAI Transitional Care Coordination provider transitioned to the standard semi-annual (two per year) provider meeting schedule from the 6 per year that occurred in their initial contract year (FY2012).

In FY2013, all quality management activities have been formally integrated into programmatic technical assistance activities including review of all performance indicator data at provider meetings. These indicators were developed in FY2012, so FY2013 represents the first full year of using the quality indicators developed through the nominal group process.

In addition to annual site visits, the Tri-County MCM providers' workgroup meet quarterly to share best practices and receive group technical assistance from contract managers. The group also implemented a common quality improvement project.

Early Intervention Services. From March 1, 2013 to February 28, 2014, the DOHMH HIV Testing Unit Project Officers (POs) conducted site visits and monthly check-in calls, and organized 6 semi-annual meetings for testing providers. During the site visits and check-in calls, the Project Officers reviewed agency performance, identified program facilitators and barriers to service delivery, proposed strategies to address these barriers, and developed action plans to implement proposed strategies. The semi-annual provider meetings are opportunities for DOHMH to review performance data with providers within the different testing contract types (priority populations, social network strategy, and routine), discuss challenges and best practices with providers, share best practices, facilitate peer-to-peer consultation, and address quality improvement issues.

Housing Services. DOHMH is in the process of taking over technical assistance and contract monitoring from Public Health Solution for contracts beginning FY2014 and looks forward to providing more in-depth technical assistance and guidance to all Housing Services contracts, including the MAI contracts.

Challenges/Barriers Encountered by Providers/Grantee and Steps Taken to Address and Lessons Learned

The Grantee and all Part A and MAI programs experienced significant challenges in trying to implement the 14.75% reduction in the New York EMA award. The reduction in the FY2013 MAI award was less than the Part A formula award (3.16 % v. 21.84%, respectively), but the shock of the overall reduction was felt throughout the portfolio as the Planning Council worked diligently to implement a modified spending plan.

Reducing Administrative Burden. In FY2013, due to the reduction, the master contractor who oversees the Tri-County Region of the EMA, Westchester County Department of Health (WCDOH), lost staffing and thus administrative capacity, and a plan was needed to address the challenge this posed. Beginning in FY2014, there will be no MAI contracts in the Tri-County Region. The decision was made that WCDOH would receive their entire allocation of the award (4.71%) from the Part A award and none from the MAI award.

As a result of this change, the Tri-County Region still receives the same dollar amount and is expected to continue to provide culturally-competent and appropriate services to racial and ethnic minority populations, but will not have to participate in the separate reporting required by the MAI award. This frees up WCDOH staff time and also reduces the burden on DOHMH staff that have to coordinate and compile data from PHS and WCDOH for the reports.

Medical Case Management. Because Care Coordination requires strict adherence to the protocol, intensive technical assistance and training is provided to the agencies. Technical assistance continued to be provided regarding the required Care Coordination forms and protocols including the roll out of a 5-day Care Coordination training in FY2013, in addition to the intensive 10-day and the 1-day refresher training. The 5-day training is open to all Care Coordination staff who need a more thorough review of Care Coordination materials and forms, and have previously attended the 10-day training.

Early Intervention Services. During FY2013, overall, MAI-funded testing programs have maintained a rate of linkage to care within 90 days that exceeds the NHAS goals. In addition, the percentage of clients who received a confirmatory test following a reactive screening test improved; 91% of all black and Hispanic clients, and 100% of Hispanic clients, with reactive results had confirmatory testing. However, some programs struggle with lower-than-expected testing positivity rate.

Clinical facilities offering routine HIV testing and community-based organizations conducting targeted testing face different issues with regards to HIV testing positivity. Clinical facilities are to offer HIV testing to all eligible clients who present for medical services. Therefore, their testing positivity rate is dependent on the seroprevalence of the communities they serve. DOHMH preferentially funds clinical facilities in neighborhoods with high HIV seroprevalence, in order to better reach those living with HIV who are unaware of their HIV status.

For agencies conducting targeted testing, testing positivity rates are largely dependent on how well agencies are able to locate high-risk, priority populations. For agencies outreaching to priority populations that have lower testing positivity rates, DOHMH has identified that many of the persons

targeted for testing are not high risk. Project officers continue to work with agencies to better target priority populations, especially increasing the number of gay, bisexual, and other MSM tested.

Due to the large reduction received in FY2013, all EIS contracts (both Part A and MAI) with low seropositivity were closely analyzed to identify those that would be eliminated or reduced. The seropositivity rate expectations are known to all contracted agencies, but this reduction was the first times it was used to implement a reduction scenario plan as severe as this. After the implementation of the FY2013 cuts, the reduction measures were further refined – taking into consideration populations/special populations served and geographic distribution. These measures were used to implement the Planning Council's FY2014 Spending Plan, which reprogrammed significant funds out of the EIS service category. The implications and challenges/successes associated with this will be discussed in the FY2014 Part A Progress and MAI Annual reports.

Housing. Based on prior analyses and discussion with the Bureau of HIV/AIDS Prevention and Control Housing Unit and the NYC MAI housing contractor, program closure of client enrollment is no longer used as a proxy for the end of occupancy in a housing unit. Instead, the Research and Evaluation Unit uses eSHARE data on the placement end date for analyses related to placement duration/occupancy. Program closure of a placed client is generally due to client graduation/self-sufficiency and does not imply a housing unit vacancy date.

During FY2013, following the Planning Council's service directive process, a procurement for Part A and MAI Housing Services was conducted resulting in new contracts in New York City starting March 01, 2014. These new contracts will receive programmatic oversight and technical assistance from the Division of Disease Control Housing Unit, who also manages HOPWA funding, and fiscal oversight from Public Health Solutions. The FY2014 Progress and MAI Reports will include more detailed information on the successes and challenges of this transition experienced.

Evaluation. Agency-level reports were presented on PCSM completeness and the HRSA/HAB 12-month measure of retention in care, as measured through the NYC HIV Surveillance Registry (with CD4 and viral load test dates serving as proxies for primary care visits) for all service categories. In all such reporting of agency-level results, the DOHMH is careful to de-identify the individual agencies, and inform only the individual agency as to which are their results. This practice promotes awareness of the varying performance levels within a service category, without creating undue tension around individual agency scores.

As of March 2012, all MAI service categories were reporting Ryan White Part A data exclusively via eSHARE, the web-based HIV services reporting system developed and hosted by the DOHMH. Reporting through this system has already increased data completeness and quality. Challenges around transitioning to the new system were primarily addressed through collaboration by the Technical Assistance and Research & Evaluation Units on eSHARE-focused training, TA, user-oriented documentation/guidance, and data collection form standardization and distribution.

MAI Technical Assistance Needs

There are no MAI technical assistance needs identified by the EMA.