FY2013 Progress Report

New York EMA - H89HA00015

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Maintaining Clients in Care

Client Access to Provisions of the Affordable Care Act

During FY2013, the New York EMA worked to maintain clients in care by ensuring access to health care services through Medicaid Expansion and the NYS Health Insurance Exchange.

As per *Policy Clarification Notice (PCN) #13-01*, the NY EMA requires subcontractors to pursue Medicaid and Health Insurance enrollment for all clients at assessment and reassessment (every six months) and to document enrollment efforts for all clients. Since a subset of consumers (approximately 7% of Ryan White clients) was expected to be newly-eligible for Medicaid, DOHMH prepared a *Dear Colleague* letter advising providers that clients may be newly eligible for Medicaid and requiring that clients be referred to state-funded navigator programs to assist with consumer enrollment. The provider letter was followed by presentations at all Ryan White service provider meetings about applicable ACA provisions and assisting clients with enrollment.

Components were added to all contracts regarding enrollment in Medicaid, as per HRSA's policy and guidance. They were also advised that they may contact their Technical Assistance Project Officer with any questions about Medicaid Expansion. All providers are now contractually required to list a contact at a State-funded Navigator Program as well as to assess possible client eligibility for expanded Medicaid and either assist clients with enrollment or refer clients to a Navigator.

Since a subset of consumers (~10%) was also expected to be eligible to purchase a QHP, with or without premium and co-pay assistance, the *Dear Colleague* letter also addressed enrollment of clients in QHP. The letter advised providers that some clients may be newly eligible to purchase QHPs on the exchange and referred them to State-funded Navigator programs to assist with consumer enrollment with specific information on the NY State Uninsured Care Program (NYS ADAP).

Medical Transportation (Tri-County Region)

Unlike NYC with its expansive transit system, the Tri-County Region spans over 900 square miles of urban, suburban, and rural terrain with very limited public transportation. The need for this service continues to grow; Medical Transportation (TRN) provided 9,838 one-way rides to 390 unduplicated clients in FY2013.

The program is centralized whereby case managers send ride requests to a single agency - this agency screens for whether the trips are Medicaid eligible and for the purpose of the ride and denies ineligible rides. All ride requests include the date of the patient's last HIV primary care visit allowing the provider to report on retention in care. Data from eSHARE on clients enrolled throughout FY2013, with no greater-than-six-month suspension during that period, and with at least one TRN service, indicate that 91% of such clients met the National HIV/AIDS Strategy (NHAS) measure of retention in care (at least 2 medical visits at least 3 months apart during the year).

Improving Quality of Care

Care Coordination Program (Medical Case Management) Training and Resources

To ensure that programs funded with Ryan White funds provide high quality services, ongoing training and access to innovated tools is a key component of all our programs. The Care Coordination Program funded with Medical Case Management funds is a clear example of this.

The Care Coordination Program is one of our largest programs with $27,607,179 in expenditures, 28 programs, and nearly 6,000 clients in FY2013. Care Coordination Programs benefit from two NYC DOHMH Technical Assistance Project Officers that provide support throughout the year in addition to bi-annual provider meetings and intensive skills-based training.

In FY2013, DOHMH developed a new five-day introduction training to the Care Coordination model for program staff with advanced knowledge of HIV and case management, and 28 participants received this training. 29 attended the standard ten-day introduction training for program staff. Additional trainings were also provided to program staff:

- 75 received a one-day Care Coordination protocol refresher
- 43 received a one-day Co-occurring mental health and substance use training and/or LGBT sensitivity training
- 23 received a half-day Clinical Supervision training
- 29 received a four-day Training of Trainers (TOT) on the health promotion curriculum

Many of the MCM programs in NYC participated in the pilot of the HIV Care Status Reports Application, a web-based application that acts as a mechanism for informing clinical providers of the current care status of their out-of-care HIV-infected patients based on HIV-related laboratory tests reported to the DOHMH HIV registry. This application will enhance the MCM programs' ability to link, retain and re-engage patients into care.
In response to the programs' request for revised quality indicator definitions, DOHMH convened a workgroup comprised of funded programs to review the definitions and make recommendations for revised definitions that more accurately align with the program model.

Program Evaluation and Quality Management Indicators

FY2012 marked the completion of the transition of NY EMA programs to eSHARE for reporting to DOHMH. As a result of eSHARE implementation, BHIV has far greater ability to (1) evaluate program impact; (2) monitor service delivery according to standards of care; (3) track clients across the continuum of HIV care; (4) match clients with the NYC HIV Surveillance Registry for merged analyses of programmatic and surveillance data; and (5) de-duplicate clients across programs for accurate counts and descriptions of the population served. Required primary care utilization and clinical data form the basis for several core indicators that allow BHIV to effectively evaluate its funded programs in accordance with the National HIV/AIDS Strategy and other major strategic planning initiatives.

In FY2013, eSHARE-based reports on outcome and process evaluations were presented to the provider Quality Learning Networks and to the HIV Health and Human Services Planning Council of New York and its committees. The quality indicator workgroup processes for a number of provider learning networks culminated in FY2013, with the first eSHARE-based results presentations on the new provider-prioritized indicators, as well as some second rounds of data on the same indicators to offer feedback on progress.

The core indicators being used to evaluate New York EMA services include receipt of confirmatory positive HIV testing results, delayed diagnosis, prompt linkage to HIV medical care, retention in HIV medical care, receipt of antiretroviral therapy, adherence to antiretroviral therapy, viral load suppression, demographic disparities in a subset of core outcome indicators, and immune functioning (CD4) stability or improvement. Housing situation is now being measured more

rigorously with required updates over time in eSHARE, which permits tracking of housing stability as a core indicator as well. Monitoring on the 2013 Implementation Plan focuses mainly on a subset of these core indicators: linkage to care, retention in care, and adherence to HIV treatment.

Improving Data Quality and Completeness

In 2012, HRSA notified all Ryan White grantees that service providers would be required to manage their own RSR process, including the client-level data upload, starting with the 2013 annual reporting period.

Also in 2012, the New York City Department of Health and Mental Hygiene (NYC DOHMH) applied for and was awarded a HRSA Special Projects of National Significance (SPNS) grant under the Health Information Technology Capacity Building Initiative for Ryan White HIV/AIDS Program providers. Specifically, the project was launched to integrate an RSR Validations Report and an XML extract generator feature into the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE), which houses local Ryan White Part A data for the NY EMA. The project's aims were to enable providers to conduct data quality assurance seamlessly within the web-based system by which they report to the NYC DOHMH, and to empower them to access their own data on demand and submit directly to HRSA.

In May and June of 2013, in preparation for the 2013 RSR emails were sent to providers with de-identified lists of clients, for whom eSHARE data was missing or needed review and correction. The data corrections were then monitored by NYC DOHMH Project Officers assigned to each provider agency.

In July of 2013, six-month RSR completeness Reports, with corresponding de-identified client-level data, were distributed to all funded agencies. These completeness reports were produced from HRSA's software application X-ERT using eSHARE data and provided a data completeness report card to each service provider. RSR presentations at provider meetings also stressed the importance of data correction and data completeness.

Between October 2013 and January 2014, a subject matter expert team worked to develop specifications for the eSHARE RSR features which were then implemented by RDE Systems and hosted by the NYC DOHMH's Division of Informatics and Information Technology and Telecommunications. Specific project worksheets, templates, and specification tools were used to ensure federal compliance and to coordinate project execution among disparate project teams.

In January 2014, information on the new RSR reporting feature was disseminated to service providers through webinars and emails. Downloadable documents describing the feature were also made available in eSHARE.

During the RSR process, service providers were able to use the RSR Validation Report to obtain a list of data validation issues for a selected reporting period. Each validation failure is categorized in one of three ways corresponding with the validations in the RSR: an Error, a Warning, or an Alert. An Error will prevent XML generation until data are corrected; a Warning requires a comment on the HRSA RSR website; while an Alert requires no action.

The Validations Report incorporates a user-friendly breakdown of validations and a Client System-Assigned ID, so that records displayed with validation issues can be retrieved and updated in eSHARE, facilitating efficient data correction. Through an Excel export, service providers can review their data using their own approach. Once all Errors are corrected in the underlying data, service providers can use the second RSR feature to produce the XML file of client-level data for upload to the HRSA website.

Preliminary analysis comparing 2012 and 2013 shows a dramatic decrease, from 60% to 12%, in the proportion of Part A NY EMA service providers exceeding the 10% threshold for unknown or missing data on any of the five RSR data elements HRSA routinely monitors.

Strategies for Bringing PLWHA Who Know Their Status into Care

DOHMH has been routinely examining the outcome of linkage to HIV primary care among those newly diagnosed or else known to be positive but out of care at enrollment for all programs that offer HIV testing. In a substantial improvement from FY2012, 85% of Base-funded testing clients (and 100% of MAI testing clients) who received a new confirmatory positive HIV diagnosis in FY2013 were linked to primary care within 3 months of that diagnosis. Of those with a new confirmatory positive HIV diagnosis in FY2013, over 85% (92% in MAI testing programs) were documented as having received that positive confirmatory result in the period.

Re-engagement of known positives within three months of enrollment (following a greater-than-six-month gap in primary care) was slightly lower in Base-funded testing programs, at 75%, but reached 98% in MAI-funded testing. These clients represent some of the most difficult to reach, as they have already disengaged from primary care for an extended period despite knowing their HIV status. Support Services programs tended to have less success with promptly linking previously diagnosed clients who had been out of care for at least six months (34% in Legal Services and 54% in Psychosocial Support services), which relates mostly to the focus of their support on clients' more immediate, practical support needs, for purposes of stabilization.

Further information on reengagement in care can be found in the EIIHA Update section.

Ensuring Fiscal Accountability

Grantee Administration

The combined Part A and MAI grant award for FY2013 was $102,711,769. The total unobligated balance at the close of FY2013 was $621,400. This represents a total under spending of $615,731 (.9%) of Part A formula funding and $5,669 (.06%) of MAI funding.

Further details on underspending will be provided in the carryover request submitted after the FFR submission.

Carryover funds from 2012 in the amount of $2,399,976 (combined Base and MAI) received in 2013 were applied to and 100% spent by the New York State Department of Health administered AIDS Drug Assistance Program (ADAP Treatments) and ADAP Plus (Outpatient/Ambulatory Health Services).

The Grantee reported quarterly to the Planning Council's Finance Committee on the overall expenditure rate and the implementation of the reprogramming plan. The administrative mechanism, as assessed through the use of a standardized tool by the Planning Council's Finance Committee, was found to be effective.

Reprogramming

During FY2013, the Tri-County region Master Contractor had to cancel three (3) contracts when they did not submit their A-133 audits after being given a reasonable extension on the due date. Services billed after the original A-133 due date were also not reimbursed. All these funds, as well as the balance of the contracts, were reprogrammed to medical transportation, medical case management, and housing service providers in the Tri-County Region. The Tri-County region Master Contractor worked with the remaining case management providers in the region to receive transferred clients as appropriate.

In New York City, the Master Contractor, reprogrammed $ 3.875 million from underperforming to overperforming contracts to ensure that funds were used to provide needed services. Reprogramming includes moving funds both within and between service categories according to the Planning Council's reprogramming plan that allows for reallocation between

service categories up to 15%. Reprogramming between service categories is reported to the Planning Council's Finance Committee as part of the Assessment of the Administrative Mechanism.

d. FY2013 Program Challenges

Ryan White Part A Budget Reduction

The 14.75% reduction in FY2013 RW Part A and Minority AIDS Initiative (MAI) funding in the NY EMA was the largest reduction ever experienced. The PC and the Grantee acted swiftly to preserve services that most directly impact the health of PLWHA to the greatest extent possible; however, the reduction has affected services to consumers. To assess the reduction, the Grantee conducted an online survey to solicit feedback from all NY EMA providers. One hundred forty agency staff responded to the survey, which assessed the reduction experienced, the impact on programs, and cost-containment measures implemented. One hundred thirty-four, or 96%, of the programs responding to the survey received a funding reduction in FY2013. Of those, 103 (77%) reduced RW-funded staffing; a cumulative staffing reduction across the RW portfolio of 118.6 FTE (full time equivalent). In addition, 99 (75%) reduced the number of clients they are able to serve through their RW-funded program, resulting in an 18.5% decrease in program capacity across the RW portfolio. In response to the funding reduction, 58 (59%) of the programs that responded to the survey and are reducing program capacity this year indicated they would be setting caps for client enrollments and 35% would be dis-enrolling the least needy clients this year. Seventy-one, or 54%, of the programs also indicated a reduction in RW program services, and 16 (12%) indicated that at least some services have been completely eliminated.

In response to the funding reduction, 77 (60%) of the programs have already implemented some cost-containment measures this year, including alternative staffing plans (81%) and service frequency caps (21%). Other reported effects of the funding reduction include a decrease in staff morale and diminished capacity to fund non-personnel items such as equipment and transportation. Eight percent of the current funded programs have considered discontinuing their contract during the current fiscal year.

In addition to the survey results described above, an analysis of FY2013 RW Part A providers' original service unit projections found that the reductions include: more than 8,000 fewer rapid tests; 425 fewer Care Coordination client enrollments; 30 fewer recipients of housing assistance; nearly 61,000 fewer meals; approximately 4,500 fewer hours of legal counsel; more than 6,000 fewer harm reduction encounters; more than 4,500 fewer encounters with Mental Health providers; and nearly 2,500 fewer supportive counseling sessions compared to flat funding projections.

Medicaid Certification of Mental Health Providers

Increasingly New York State Medicaid is expanding its range of Medicaid-billable service and provider types. Thus the need to be certified to bill Medicaid has becomes an issue for more provider types, and many of these providers are finding the certification process challenging. For medical case management, the requirement was relatively easy as many of them are co-located within medical facilities and were already providing Medicaid-funded case management services. While hospital and clinic based mental health providers had the same advantage as medical case management, community-based mental health service providers have had greater struggles to overcome in their process towards compliance.

At the start of FY2013, five (5) of our fifteen (15) mental health services providers were still in the process of completing the licensure requirements. The Master Contractors have a deliverables schedule that providers need to meet to remain in compliance during the pre-certification process. In addition to a lengthy application and review process, some of the providers had to make capital improvements to meet the New York State Medicaid certification requirements – a cost that could not be reimbursed by Ryan White. Furthermore, because Medicaid in New York State uses a managed-care system, providers have to contract individually with each of the major managed-care plans operating in their county. Ultimately,

one provider was told by New York State they were not eligible for certification – their contract was terminated at the close of FY2013. That provider had a small case load of 16 clients.

The Master Contractors, the NYC DOHMH Project Officer, and other NYC DOHMH Technical Assistance staff have worked closely with the providers affected by this requirement to prepare for the transition and limit the disruption to care. As a result, many clients that were newly eligible for Medicaid, post-Medicaid Expansion, did not see a disruption in either their mental health providers or services. The certification requirement also secures essential non-Medicaid billable mental health services through Ryan White and ensures Ryan White remains payer of last resort.

Care and Treatment Care Continuum – Viral Load Suppression

The merging of Ryan White programmatic and HIV Surveillance Registry data has enabled the EMA to further understand disparities in HIV care and treatment through the development of the Ryan White-specific HIV Care Continuum. The DOHMH compares this 'Ryan White Part A Client Care Continuum' directly to the 'NYC Care Continuum,' and also examines differential outcomes by sociodemographic subgroups. In 2012, Ryan White HIV-positive clients had high linkage (99% of enrolled) and any engagement in care (98%), and were most likely to fall off the cascade at the stages of antiretroviral treatment and viral suppression (89% and 67% completed these stages, respectively).

Overall in New York City, PLWHA tend to fall off at the linkage and engagement steps. Compared to New York City overall, Ryan White Part A clients who had ever started on antiretroviral therapy were less likely to have current viral suppression. The shape and distribution of the Ryan White and citywide continuums were similar when broken down by sociodemographic subgroup. In both populations, a clinical status of AIDS was among the strongest predictors for having started on antiretroviral therapy, but also for dropping out of the continuum between the stages of antiretroviral therapy and viral suppression. In Ryan White and citywide, younger, black, and injection drug-using PLWHA were the least likely groups to successfully complete the full care continuum.

The Ryan White Care Continuum is a helpful tool to identify successes and challenges in the key stages of HIV care and treatment, to compare these successes and challenges between jurisdictions and/or between different HIV services programs, and to highlight subgroups that are particularly vulnerable to experiencing poor outcomes. Use of this tool as an analytic framework is assisting the EMA in identifying unmet service needs and underserved segments of the population and developing and modifying program models to reinforce adherence to the HIV Care Continuum. In preparing its 2014 priorities, the Ryan White Technical Assistance and Research and Evaluation teams used the HIV Care Continuum to identify the area in which they would focus their efforts. Two of the four priorities are anti-retroviral initiation and viral load suppression to address the challenges identified in the HIV Care Continuum. We look forward to reporting on our efforts in the FY2014 Progress Report.

II. Planning Council Activities

a. Planning Council Accomplishments

The Planning Council (PC) bylaws require a minimum of 35 and a maximum of 50 members. In FY2013, the PC filled a number of open seats, appointing a group of nine (9) new members to 3-year terms, giving the Council new energy while continuing to be a diverse group who fulfilled all HRSA requirements regarding mandated membership categories and reflectiveness. In FY2013, the PC's 48 members were composed of 67% people of color (40% African American, 21% Hispanic, 4% Asian/Pacific Islander, 2% Native American) and 44% women. All five boroughs of New York City and the Tri-County region were represented, as were all HRSA membership categories. The PC was composed of 33% non-aligned people living with HIV/AIDS. A total of 40% of the PC membership, including the governmental co-chair, are PLWHA

(membership rooster submitted with Program Terms). Candidate interviews and reviewer rankings were utilized to further vet initial screened member applications.

The 9 new members appointed in 2013 received an extensive orientation to the PC, Part A, and the planning process at the beginning of the term. Continuing members were also invited to participate in the trainings. On-going training on planning for services, including understanding data and the use of the Priority Setting and Resource Allocation (PSRA) ranking tool were also provided. In addition, the PC has an on-line interactive training that was available to all PC and sub-committee members, as well as members of the public. Successful completion of the online training was mandatory for all new PC and sub-committee members. There were presentations, trainings, and program updates for members over the course of the year which addressed:

- Local HIV/AIDS epidemiology
- Update on the impact of the Affordable Care Act (ACA), NYS Medicaid Reform, a Continuing Resolution and Sequestration on the NY EMA Service Delivery System
- Invasive meningococcal disease among MSM and expanded vaccine recommendations for PLWHA
- NY EMA Client Satisfaction Survey Pilot Findings from a Portfolio-Wide Client Satisfaction Survey
- Update on Hepatitis C epidemiology, screening and treatment and co-infections among PLWHA
- Update on the impact of the decline in Ryan White Part A formula funding on providers, services and clients
- New service directives for Health Education and Risk Reduction, Supportive Counseling and Family Stabilization Services, and Non-medical Case Management
- Care Coordination patient navigators: a report from the field
- Annual update on indicators of success from the 2012-15 Comprehensive Strategic Plan for the Delivery of HIV/AIDS Services in the EMA
- Best practices for Community Advisory Boards
- HIV/AIDS policy briefing and updates

Consumer members were intensively mentored through their participation in the PC's Consumers Committee, where veteran members and staff assisted them in acquiring the knowledge and skills needed to participate fully in the planning process, including developing an understanding of the PSRA ranking tool, understanding the principles of HIV epidemiology, community planning, group dynamics and decision-making, the development of a time-phased work plan and several trainings and presentations during the planning cycle aimed towards maximizing meaningful and informed participation and decision-making; the Medical Monitoring Project (MMP) - for which the Consumers Committee was designated as the local Community Advisory Board for NYC; quality management and improvement; consumer involvement, feedback and participation in local community advisory boards; and national initiatives.

In August 2013, the PC approved new program guidance for three Ryan White Part A service categories: 1) Health Education/Risk Reduction (HE/RR), 2) Case Management (Non-Medical) (nMCM), and 3) Psychosocial Support Services [operationalized locally as Supportive Counseling and Family Stabilization Services (SCF)]. The new HE/RR service model is a health education program for PLWH focusing on engagement in care, adherence, goal setting, identification of barriers, social support building, and risk reduction. The model would allow the health education training to be provided by

community-based providers, and allows agencies to select from a menu of evidence-based health education programs inclusive of the existing Part A-funded *Positive Life Workshop*. Program requirements are required to: be grounded in theory and scientifically evaluated; increase understanding of impact of behavior on health; encourage behavioral change to improve health and decrease transmission; encourage timely entry into care, adherence, maintenance, and viral load suppression; encourage use of curriculum emphasizing health self-management; provide information and access to services within agencies and in the larger health/social support service system; and utilize trained peers.

The Council created an nMCM service directive to accommodate the existing Rikers Island Initiative for incarcerated PLWHA, and created an opportunity for service expansion. Ryan White Part A funding has supported non-medical case management for incarcerated PLWHA on Rikers Island for many years. CBOs participate in the Rikers Island Transitional Health Care Consortium and provide: post-release assistance with benefits and entitlements/restoration of Medicaid and ADAP; financial counseling; treatment education/risk reduction; and linkage to other Ryan White-funded services. The new directive calls for continuation of this program (Part A), and community-based, non-incarcerated nMCM (Part B). Both Parts will: provide assistance with accessing services including medical care, medical case management, and behavioral health services; access to existing and future insurance exchanges or new models arising from ACA and Medicaid redesign; promote strategies for improving health of PLWHA; and facilitate access to the continuum of care including medical and support services.

The revised SCF service model includes as allowable services: individual, family and group counseling; support groups; crisis intervention; peer and non-peer led interventions; drop-in activities; grief and bereavement counseling; pastoral care; transitional services to stabilize families following a death; relationship-building activities; education, training, and skills-building activities; and medical and social support services.

The PC continued its planning for Part A services using the guidelines and policies outlined in the Reauthorized Ryan White HIV/AIDS Treatment Extension Act (HATEA), while emphasizing the need to ensure that all services support improved access to and maintenance in HIV primary care.

In February 2013, the PSRA and PC went through a rigorous process to develop a plan for possible decreases in the base and MAI grant awards. The PC and PSRA used the priority setting tool as a basis for applying proportionate increases and/or decreases to the service portfolio. After the final award was received in June 2013, the PC approved a final FY2013 spending plan that addressed the historic reduction in Part A and MAI funding of $17,777,382 (14.75%) for FY2013. The drastic and unprecedented reduction in the award was first partially addressed by reducing the award to ADAP, which the Council pledged to restore through reprogramming during the year with the possibility of more should additional under-spending become available. An additional $2.8M in savings was identified by the grantee through reductions in the carrying costs of FY2012 programs. The rest of the decrease was done through proportionate decreases to all service categories, based on ranking scores assigned during the PSRA process for the FY2013 grant application.

In August 2013, the PC approved the FY2013 Reprogramming Plan, which restored the upfront reduction to ADAP and provided enhancements to over-performing contracts (capped at 15% above the allocation in the spending plan without Council approval) through accruals during the course of the program year.

In August 2013, the PC approved the FY2014 NYC preliminary base and MAI spending plans for the FY2014 grant application. During this planning process, the Council re-scored the data-driven, objective priority ranking tool that was first used to develop the 2006 priorities and revised in 2012. The priority ranking tool defined the set of weighted variables to be applied as evaluation criteria: 1) payer of last resort, 2) providing access to/maintenance in HIV-related primary medical care, 3) consumer priority, and 4) fulfills/addresses identified gaps/needs. The Council's Priority Setting & Resource Allocation Committee (PSRA) re-assessed the ranking for each category using available data, including: CHAIN report on consumer need for and adequate utilization of services; a revised and expanded Payer of Last Resort Tool, which attempted

to find as many other payers in the EMA for equivalent services as possible; and updated service category score cards, which give three years of data on spending, clients served, utilization, client demographics and more. PSRA also had a presentation of the three new service directives developed by IOC. All service category rankings for FY2014 are based on the new service directives. For the new non-Medical Case Management directive, PSRA split the service category into two distinct parts for the purposes of both ranking and the spending plan: 1) "Part A" – the continuing Riker's Island Transitional Case Management program, expanded to include services to recent releasees from upstate prisons returning to New York City; and 2) "Part B" – social services case management for the general population. The second part was scored for the first time.

In general, most rankings stayed similar to last year's. The major change is that PSRA decided that while all Part A programs are required to promote access to and maintenance in primary care, top scores for the Access-to-Care/Maintenance-in-Care criterion should only be assigned for services whose *primary* focus is ATC/MIC and that provide a direct access to medical care (e.g., testing, treatment, making doctors appointments, accompaniment, etc.). Services that help reduce barriers to care (e.g., Housing, Food and Nutrition) should be scored the second highest ranking. This resulted in a lowering of the relative ranking score for some supportive services. Early Intervention Services (EIS) also received an overall lower score due to lower scores for Payer of Last Resort, Emerging Gaps and Consumer Priority, due to the increasingly wide availability of HIV testing and the multitude of other payers for this service in the EMA. PSRA recommended reducing the allocation to EIS by $3M due to the low rate for finding HIV positives in testing programs and the continuing increase in the availability of testing from other sources. Those funds were reallocated in the plan to the newly revised/expended service directives. PSRA also asked for the full amount of ADAP funding (restoring the upfront cut of $2.76M). The preliminary spending plan resulted in a program that was under the 75% minimum for core medical services. Given this, plus the data on expanded Medicaid and implementation of Health Homes and the Affordable Care Act, the PC authorized the grantee to pursue a waiver of the core services requirement for the FY2014 grant year.

In August 2013, the Council issued a favorable assessment of the administrative mechanism. On a quarterly basis, the Finance Committee reviewed Base and MAI spending and close out reports, providing feedback to the PC and the grantee on strategies to achieve the highest level of grant funds expenditure, in order to minimize unspent grant funds and to assure that effective spending for the EMA would continue (the FY2012 base grant award was unspent by only 2% and the MAI award by 1%). The Finance Committee also successfully negotiated the PC support budget with the grantee for the second time, as indicated in the MOU.

In February 2014, the PSRA Committee completed its work on FY2014 spending scenarios, in the event of possible reductions in the Part A award while preserving the continuity of the highest ranked services that reach the most important target populations and geographic areas, preserving the system of care for PLWHA in the EMA. PSRA recommended that $4,689,755 be cut (under any funding scenario) from the EIS allocation that now pays for under-performing testing contracts, annualized going forward and pro-rated for FY2014, given the need to do contract close-outs and pay for services already provided since the beginning of the fiscal year. This amount is based on the amount that currently pays for programs that do not reach the threshold of positivity rates of 0.4% for routine tests and 0.75% for targeted tests. A $3M reduction had been approved the previous summer for the FY2014 application spending plan. The justification for the higher amount was based on extensive review of testing data, including other resources, national and local positivity targets for testing programs, and other changes in the environment such as the new NYS law that requires all clinical settings to offer HIV testing.

b. Planning Council Challenges

There were a large number of new Council members – nine (9) – appointed in September 2013. The PC staff conducted an extensive orientation and training that brought the new members up to speed on Ryan White legislation, the Part A

program, PC roles and responsibilities, etc. The PC also continued successful implemented of an online training that was mandatory for all new PC members, as well as new members of the PC sub-committees who were appointed later in the program year. The training was presented at the HRSA conference in November 2012.

By far, the biggest challenge for the PC in FY2013 was responding to the unprecedented and severe reduction in the grant award of 14.75%. The PC had never had to plan for such a large reduction before, but luckily had a process in place that allowed for rational, data-driven decisions. The strong collaboration with the NYS Department of Health AIDS Institute allowed the PC to offset the first $2.76M of the cut through a reduction in the ADAP allocation, with the agreement that the funds would be restored through unspent dollars accrued per the PC's reprogramming plan. The next $2.8M of the cut was offset through reductions in the carrying costs of FY2012 programs that were identified by the grantee and master contractor. The remainder of the cut to programs was done through the application of proportionate reductions to the rest of the portfolio of services using the weighted, data-driven ranking scores assigned by PSRA during the development of the application spending plan.

As a result of the implementation of the PC/grantee Memorandum of Understanding (MOU), the PC negotiated its own support budget (part of the 10% administration portion of the grant). The PC designated the governmental co-chair, community co-chair and finance officer to negotiate with the grantee staff. Due to the large reduction in the FY2013 grant award and the concomitant reduction in funds available for grant administration, a drastically reduced draft budget needed to be developed that would allow the PC to function optimally. Savings were found by cutting back on provision of audio services at meetings, holding meetings in donated spaces, and cutting back on food for consumers at advisory meetings. The draft budget was brought to the Finance Committee and full PC for review and approval. The process worked extremely well, with the grantee staff providing invaluable support through spending and fiscal reports.

The PSRA undertook its ranking and allocation process for the FY2013 application spending plan without knowledge that the core services waiver would be granted. This meant developing a spending plan based on need while being mindful that the careful, data-driven planning that they undertook would have to be revisited later. Fortunately, the waiver was approved and the PC was able to proceed as planned.

In February 2014 the PSRA Committee began its work on FY2014 spending scenarios, in the event of possible reductions in the Part A award while preserving the continuity of the highest ranked services that reach the most important target populations and geographic areas, preserving the system of care for PLWHA in the EMA. PSRA revisited the planned $3M reduction to EIS services and worked with the grantee to examine extensive data on the performance of testing programs and the availability of other resources for testing in the EMA. As described above, PSRA recommended an additional $1.7M reduction to EIS based on extensive review of testing data, including other resources, national and local positivity targets for testing programs, and other changes in the environment such as the new NYS law that requires all clinical settings to offer HIV testing.

III. EIIHA Update

a. Describe the activities of the EMA/TGA's EIIHA Plan that were implemented during FY13. Indicate specific outcomes of each activity. Indicate any challenges or successes for each activity.

As described in the EIIHA Plan, the EMA uses a two-tier approach to pursuing the EIIHA goals of identifying individuals who are unaware of their HIV status and linking them to care. To reach the broadest group of individuals, the EMA promotes and funds routine HIV testing in clinical settings. In order to ensure that high-risk and historically underserved populations receive testing services, the EMA also promotes and funds targeted testing in non-clinical settings.

In FY2013, DOHMH-funded testing programs (RW and other funding) conducted 85,086 HIV tests in clinical settings, identified 356 new positives, and linked 87% to medical care within 90 days, exceeding the National HIV/AIDS Strategy (NHAS) goal for linkage to care. While these clinical agencies continue to expand testing in their institutions, broad implementation of routine HIV screening has not been achieved. Through meetings and individualized technical assistance, the DOHMH works with agencies to address barriers to routine HIV screening. Through the CDC-funded community engagement testing initiatives, *The Bronx Knows* and *Brooklyn Knows*, clinical partners conducted 269,466 HIV test in FY2013, with at least 507 new positives identified and 81% linked to medical care. In a Gilead-funded pilot, DOHMH is working with six federally qualified health centers (FQHCs) in New York City to modify electronic health records and clinic protocols to support routine HIV testing.

The EMA promotes testing of high-risk populations through many avenues. In DOHMH STD clinics, high-risk populations receiving HIV testing services are further tested for acute and early HIV infections through the use of pooled-NAAT testing. Acute HIV infections identified in DOHMH STD clinics account for 20% of all acute infections diagnosed citywide. Through *The Bronx Knows* and *Brooklyn Knows,* health department staff engages with community providers, elected officials, community leaders, and faith leaders to promote and destigmatize HIV and HIV testing. In FY2013, community partners conducted 5,567 tests, identified 28 new positives, and linked 89% to medical care. DOHMH-funded non-clinical testing programs provided 38,416 tests, identified 199 new positives and linked 69% to medical care. Because persons diagnosed in non-clinical settings may be less engaged, have many competing priorities, and be from a marginalized population, linking them to medical care is a challenge. In addition, programs testing in non-clinical settings are challenged to find new positives. Project Officers are working with agencies and providing technical assistance to assist them in finding new positives and in improving linkage to care.

b. Describe how the overall FY13 EIIHA Plan contributed to the goals of the National HIV/AIDS Strategy.

The EMA's overall FY2013 EIIHA Plan was crafted to meet the jurisdiction's needs and to contribute to the goals of the National HIV/AIDS Strategy (NHAS). The three primary goals for the NHAS are: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. One of the strategies recommended by the NHAS for reducing new HIV infections is to increase the percentage of people living with HIV who know their HIV status. The primary activity of the EMA's F20Y13 EIIHA Plan is to increase the percentage of people who know their HIV status. Once an individual is newly diagnosed, programs are expected to link the individual to clinical care within three months, consistent with the NHAS strategy target for linkage to care. To reduce HIV-related disparities, the EMA targets testing and linkage services to populations and neighborhoods most impacted by HIV.

c. Describe how the FY13 EIIHA Plan incorporated and addressed activities surrounding the Unmet Need population.

Approximately one-third (36%) of persons diagnosed, reported, and presumed to be living with HIV/AIDS in the EMA are not currently in care. Funded testing programs often come in contact with previously diagnosed individuals who have fallen out of care or who have never engaged in medical care. These testing programs have the opportunity to connect these individuals to medical care. In FY2013, funded testing programs (RW and other funding) encountered and linked to medical care 562 previously diagnosed persons who have fallen out of care or who were never engaged in care.

d. If any since the most recent EMA/TGA application, describe any efforts to remove legal barriers, including State/Local laws and regulations, to routine HIV testing.

The NYC DOHMH continues to work with the New York State Department of Health and the New York State Legislature to facilitate routine HIV testing. Prior to 2010, any person to be tested for HIV in New York must sign a form before testing occurs. In 2010, legislation was passed which expanded the options available for providers to obtain consent for testing.

The change in legislation allowed providers using rapid testing technologies to use documented oral consent. In addition, consent for HIV testing may be integrated with the consent for medical care.

e. Provide the following data for January 1, 2012 – December 31, 2012. Discuss any changes in the data collection, analysis, or utilization that have impacted the EIIHA Plan outcomes.

	Ryan White Contracted Testing	***Contracted Testing, Other Funding***	***Total Contracted Testing***
Total # of publicly funded test events	63,457	63,581	127,038
Total # of new HIV positive tests	202	305	507
Total # of previously diagnosed HIV positive individuals	124	166	139
Total # of new HIV positive individuals with results received	193	290	483
Total # of new HIV positive individuals linked to medical care	160	259	419
Total # of previously diagnosed HIV positive individuals linked to medical care*	64	94	158
Total # of new HIV positive individuals who received partner services	191	305	496
Total # of new HIV positive individuals linked and referred to prevention services	193	305	498
Total # of new HIV positive individuals who received CD4 cell count and viral load testing	*The EMA does not currently have the numbers for HIV positive individuals identified by testing programs who received CD4 cell count and viral load testing. We are working on mechanisms to obtain this information.*		
Total # of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing			

* Testing programs frequently come in contact with previously diagnosed persons. Persons with a known diagnosis are not tested again for HIV. For persons who have been out of care for more than 9 months or who have never been in care, programs will attempt to link these persons to care. In CY2012, funded programs combined linked 421 previously diagnosed persons to care.

f. Select three target populations from the FY13 EIIHA Plan and provide an explanatory narrative about the EIIHA Plan activities deemed successful or unsuccessful by the Grantee.

The three primary target populations in the EIIHA Plan are populations that the National HIV/AIDS Strategy recommended for more attention and resources: Black men and women, Latinos and Latinas, and gay and bisexual men.

Target Population: Black Men and Women

a. For the EIIHA Plan activities that were successfully implemented:

Blacks and Latinos combined accounted for 78% of all persons tested by funded programs. Black men and women received 45,860 HIV tests by funded programs, 37% of all tests conducted in FY2013. Clinical facilities linked 92% of new positives to medical care within 90 days of diagnosis.

i. Describe what was done to achieve the successful outcomes

To better target testing services to Black men and women, DOHMH funded clinical facilities that provide medical services in neighborhoods with high percentages of Blacks. DOHMH also funded community-based organizations with strong ties with the Black community. For *The Bronx Knows* and *Brooklyn Knows,* DOHMH developed and fostered working relationships with providers that serve the Black community.

ii. Describe the resources and partnerships used (both internal and external to the program)

To better outreach to the Black community, DOHMH leveraged and coordinated internal and external resources. Various divisions and bureaus of the DOHMH contributed to the success of the plan – the Bureaus of HIV, STD, and TB control, the Office of Correctional Health, Office of Minority Health, and the District Public Health Offices that serve Central Brooklyn and South Bronx. For *The Bronx Knows* and *Brooklyn Knows,* DOHMH developed working relationships with community providers, community leaders, and elected officials. Steering committees and sub-committees focusing on planning/promotion, linkage to care, and outreach to the faith community.

iii. *Describe any barriers and/or challenges faced in achieving the specific successful outcomes*
Success in a routine testing strategy is highly dependent on both placing programs in communities were people unaware of their status are seeking care as well as increasing provider comfort with implementing routine testing with people who may not perceive themselves at risk, or who are not readily reporting their risk. Both these issues present as challenges that must be overcome, hence the rebidding of the entire HIV testing portfolio to find provider situated in these communities and intense technical assistance.

b. *For the EIIHA Plan activities that were unsuccessfully implemented:*

i. *Describe any barriers and/or challenges faced*
While the Plan was successful in providing HIV tests to Black men and women, 253 new positives were identified. In addition, 66% of persons newly diagnosed in non-clinical settings are linked to care in 90 days.

ii. *Describe what could have been done differently to produce more favorable outcomes*
Project officers are now working with agencies to review the risk factors of those tested through targeted testing, and to use this information to better inform targeting of higher risk groups among Black men and women, such as men who have sex with men, sex workers, injection drug users. Project officers are providing technical assistance on Anti-Retroviral Treatment and Access to Services (ARTAS) to assist agencies in improving linkage rate.

iii. *Describe the resources and partnerships that might have been used (both internal and external to the program) to produce a more favorable outcome*
DOHMH is working on creating forums to allow agencies to share best practices in targeting and finding positives, and in linking positives to care. DOHMH has requested assistance with CDC to provide booster trainings on social network strategy and on ARTAS.

Target Population: Latinos and Latinas

a. <u>For the EIIHA Plan activities that were successfully implemented:</u>

Blacks and Latinos combined accounted for 78% of all persons tested by funded programs. Latinos and Latinas received 49,838 HIV tests by funded programs, 41% of all tests conducted in FY13. Funded programs (clinical and non-clinical) linked 86% of new positives to medical care within 90 days of diagnosis.

i. *Describe what was done to achieve the successful outcomes:*
To better target testing services to Latinos and Latinas, DOHMH funded clinical facilities that provide medical services in neighborhoods with high percentages of Latinos. DOHMH also funded community-based organizations with strong ties with the Latino community. For *The Bronx Knows* and *Brooklyn Knows,* DOHMH developed and fostered working relationships with providers that serve the Latino community.

ii. *Describe the resources and partnerships used (both internal and external to the program)*
To better outreach to the Latino community, DOHMH leveraged and coordinated internal and external resources. Various divisions and bureaus of the DOHMH contributed to the success of the Plan – the bureaus of HIV, STD, and TB control, the Office of Correctional Health, Office of Minority Health, and the District Public Health Offices that serve Central Brooklyn and South Bronx. For *The Bronx Knows* and *Brooklyn Knows,* DOHMH developed working relationships with community providers, community leaders, and elected officials. Steering committees and sub-committees focusing on planning/promotion, linkage to care, and outreach to the faith community.

iii. *Describe any barriers and/or challenges faced in achieving the specific successful outcomes*
Success in a routine testing strategy is highly dependent on both placing programs in communities were people unaware of their status are seeking care as well as increasing provider comfort with implementing routine testing with people who may not perceive themselves at risk, or who are not readily reporting their risk. Both these issues present as challenges that must be overcome, hence the rebidding of the entire HIV testing portfolio to find provider situated in these communities and intense technical assistance.

b. For the EIIHA Plan activities that were unsuccessfully implemented
   i. *Describe any barriers and/or challenges faced*
   While the Plan was successful in providing HIV tests to Latinos and Latinas, 184 new positives were identified. In addition, 73% of persons newly diagnosed in non-clinical settings are linked to care in 90 days.

   ii. *Describe what could have been done differently to produce more favorable outcomes*
   Project officers are now working with agencies to review the risk factors of those tested through targeted testing, and to use this information to better inform targeting of higher risk groups among Latinos and Latinas, such as men who have sex with men, sex workers, injection drug users. Project officers are providing technical assistance on Anti-Retroviral Treatment and Access to Services (ARTAS) to assist agencies in improving linkage rate.

   iii. *Describe the resources and partnerships that might have been used (both internal and external to the program) to produce a more favorable outcome*
   DOHMH is working on creating forums to allow agencies to share best practices in targeting and finding positives, and in linking positives to care. DOHMH has requested assistance with CDC to provide booster trainings on social network strategy and on ARTAS

Target Population: Gay and Bisexual Men

Clinical facilities offer HIV testing to clients, regardless of risk. As such, clinical agencies do not collect risk factor for those who test negative for HIV. Therefore, we are unable to determine the number of gay and bisexual men who were tested for HIV in clinical settings. We do have risk factors for those who test positive.

a. For the EIIHA Plan activities that were successfully implemented:
   Screening for acute HIV infections (AHI) among high-risk groups presenting to DOHMH STD clinics (mainly men who have sex with men) has enabled DOHMH to identify and notify individuals of their infection when they are very infectious.
   i. *Describe what was done to achieve the successful outcomes*
   AHI screening required changing of clinic flow and procedures to ensure that high-risk individuals are

identified and that specimens are tracked and sent for AHI screening. The clinics worked with the Public Health Laboratory to streamline processes so that patients can receive their results as soon as possible.

ii. *Describe the resources and partnerships used (both internal and external to the program)*
AHI screening is a collaboration between the Bureau of STD Control, the Bureau HIV/AIDS Prevention and Control, and the Public Health Laboratory.

iii. *Describe any barriers and/or challenges faced in achieving the specific successful outcomes*
The cost of screening all clients seen at DOHMH STD clinics was costly. The Bureau of STD Control reviewed clinic data to create selection criteria for AHI screening. The end result is that the number of acute infections identified at the STD clinics stayed about the same, while costs were reduced.

b. For the EIIHA Plan activities that were unsuccessfully implemented:

i. *Describe any barriers and/or challenges faced*
Community programs conducting targeted testing reported testing 123 MSMs and identifying 70 newly diagnosed positives. Programs are not completely capturing and reporting risk data of those tested.

ii. *Describe what could have been done differently to produce more favorable outcomes*
During the monthly calls and quarterly visits with contracted agencies, project officers are beginning to review risk data of tested clients with the agencies. They will review the process of data collection and reporting to identify possible causes for incomplete data. In addition, project officers will work with agencies to brainstorm ways to increase the number of MSMs tested.

iii. *Describe the resources and partnerships that might have been used (both internal and external to the program) to produce a more favorable outcome*
To produce a more favorable outcome, some contracted agencies will need support to build up quality improvement capacity. A good working partnership is needed between program staff and DOHMH project officers providing technical assistance.

g. Describe any presentations or dissemination of the EIIHA Plan and results e.g. poster presentations, journal articles, presentations to planning bodies.

Staff from the EMA/TGA has made several presentations of the EIIHA Plan to the Planning Council.

IV. Administration Final Expenditures – Attachment 2

Ten percent (10%) of the FY2013 award was allocated to administration. At the end of the year, $29,986 remained unobligated.

Object Class Category budget and expenditure report attached.

V. Technical Assistance

a. Technical Assistance Received

The Grantee received a comprehensive programmatic and fiscal site visit in March of 2013. The EMA was visited by HRSA/HAB Project Officer Michael Amoh and two HRSA Consultants, Jeananne Cappetta and Julia (Lolita) Cervera.

Over the course of four days the site visit team received presentations from the Grantee and our two master contractors – Public Health Solutions and the Westchester County Department of Health, reviewed programmatic and fiscal monitoring documentation, and visited two contracted service provider sites.

On June 07, 2013, Grantee and Planning Council staff received the Comprehensive Site Visit Report. Overall, the report found our administration, programs, and Planning Council to be in compliance with the standards and regulations governing the Ryan White Program.

- "The Grantee's fiscal unit, headed by the assistant director for financial administration, employs excellent fiscal controls, internal systems, procedures, and analytical tools to ensure the sound financial performance of the Part A Grant."
- "The master contractors' monitoring procedures have all the elements required by HRSA/HAB for compliance with the monitoring standards."
- "Council members are engaged in the process of providing the best services possible to persons living with HIV/AIDS; and Council staff and members work diligently to ensure that they are in federal compliance."

There were only four (4) Findings and six (6) Improvement Opportunities identified in the report. The Grantee and Planning Council staff had already resolved, or were in the process of resolving, the issues related to findings and have implemented the improvement opportunities as appropriate. The CAP document completed and submitted to our HRSA Project Officer is below:

CRITICAL FINDING	RESPONSIBLE PARTY	INTERVENTION/ ACTION	PROGRESS TO DATE	DATE RESOLVED
Legislative Requirement- Advance of Federal funds	Grantee	No action required. All advances to contracts are made with local, non-federal funds.	Complete	6/07/2013
Legislative Requirement - Payment Methodology and adherence to Cost Principles	Grantee	In addition to activities already being conducted, the EMA will be implementing end of year close out as recommended by Fiscal Consultant, L. Cervera.	Complete	6/07/2013
Programmatic - FFR and the Payment Management System	Grantee	The FFR is submitted by the due date with the most accurate information available. BHIV Fiscal continues to work with its partners to ensure that the FFR is accurate and completed on time, but if disallowances are discovered the FFR may need to be re-open (up to 15 months as allowed by HRSA).	Complete	6/07/2013
Legislative Requirement - Assessment of the Administrative Mechanism	Grantee and Planning Council	The Planning Council has designated their Finance Committee, with the elected Finance Officer as chair, as the independent third party who assesses the Administrative Mechanism.	Complete	6/07/2013

b. Technical Assistance Needed

The Grantee has not identified any technical assistance needs to address challenges at this time.

The Planning Council has worked with our Project Officer to request technical assistance for Planning Council members on roles and responsibilities and strategic planning.

VI. Certification of Aggregate Admin Costs – Attachment 3

First line entities reported aggregated administrative expenditures less than 10% of program funds.

The certification is attached.

VI. FY2013 WICY Expenditures Report

The WICY report will be submitted separately as a component of the New York State Ryan White Part B Progress Report.