Meeting Minutes
NEEDS ASSESSMENT COMMITTEE
Lee Hildebrand, DSW, Chair

January 6, 2012
Federation of Protestant Welfare Agencies
281 Park Avenue South, Conference Room A
10:00 am – 12:00 pm

Members Present: Angela Aidala, PhD, Randall Bruce, Terri Faulkner, Guillermo Garcia-Goldwyn, Graham Harriman, Lee Hildebrand, DSW, Rosemary Lopez, Frank Machlica, Ariel Negron, Jan Carl Park, Glen Phillip, Marcy Thompson

Members Absent: Martin Bruner, Carlos Manuel Gonzalez, Sabina Hirshfield, PhD, Natalie Humphrey, PhD, Jennifer Irwin, Rebecca Kim, Julie Lehane, PhD, Leslie Mack, Tamella McCowen, Don McVinney, Freddy Molano, MD, Ricardo Vanegas-Plata, DDS

NYC DOHMH Staff Present: Stephanie Chamberlin, Mary Irvine, DrPH, Rafael Molina, Nina Rothschild, DrPH, Benjamin Tsoi, MD

Public Health Solutions Staff Present: Lauren Feldman Hay, Wilson Joseph

Others Present: K. Adolphs, Felicia Carroll, Alissa Wassung

Material Distributed:

- Agenda
- Minutes from the December 2, 2011 Meeting
- Presentation on Comprehensive Strategic Plan for HIV/AIDS Services in the NY EMA 2012-2015
- Data Sources for Comprehensive Plan
- Comparison of 2009-2012 and 2012-2015 Goals in Comprehensive Plans
- Glossary of Terms for Comp Plan
- Paragraphs Describing ECHPP/Twelve Cities and EIIHA
- Planning Council Calendar for January 2012

Welcome/Introductions/Moment of Silence: Committee Chair Lee Hildebrand welcomed meeting participants. Committee members introduced themselves. Everyone observed a moment of silence.

Review of the Meeting Packet/Review of the Minutes: Nina Rothschild reviewed the contents of the meeting packet. The minutes from the December NA Committee meeting were accepted and will be posted on the Planning Council website at nyhiv.org.

Comprehensive Plan for HIV/AIDS Services in the New York EMA: Jan Carl Park stated that a number of questions had been raised at the December Needs Assessment (NA) Committee meeting and were brought back to the Grantee's office for clarification. If the revised presentation as delivered today is approved, it will go to the Executive Committee and then to the full Planning Council. Submitting a comp plan is a requirement from our federal funder, the Health Resources and Services Administration (HRSA). A copy of the presentation is posted on the Planning Council website at nyhiv.org.

A few guidelines when examining the presentation:

- Graphs show both the current plan and target and the proposed plan and target.
- Arrows show the percentage increase

The following are examples of how to read some of the slides:

<u>Slide #8</u>

- The baseline of number of HIV tests done in 2008 was 247,290.
- Remaining on target with what was predicted for 2011 would have brought us to 346,206 tests.
- We know, however, that we are closer to 275,000 tests in 2010 and are unlikely to reach the goal of 346,206.
- We are, therefore, revising our proposed plan to 300,000 tests in 2013.

<u>Slide #14</u>

- According to Goal #2, for both the EMA as a whole and for Ryan White clients more specifically, we are looking to increase to 80% the proportion of people who enter into care within three months of receiving an HIV diagnosis.
- In 2008, 70% of clients were linked to care within three months of receiving their diagnosis.
- The graph projects out that 80% of clients may be linked within three months by 2013 but also notes that although we come close to the

National HIV/AIDS Strategy (NHAS) of 85%, we are not realistically going to achieve it.

Slide #17

- In the current (2009-2012) plan, we are looking for a 20% decrease in the proportion of PLWHA who show a gap in primary care of four months or longer at any time in the most recent 12-month period.
- In the new plan, we are looking to increase to 80% the proportion of PLWHA with evidence of regular care.

Slide #18

- In 2008, 56% of Ryan White clients had evidence of retention in care.
- The target is to reach 75% by the end of 2013 – a bit below the NHAS goal of 80%.

Slide #20

- The target in the proposed plan is that 75% of clients on ARVs will achieve 95% or greater medication adherence. According to data from the CHAIN study, we have already exceeded our target regarding adherence: in 2010, 85% of clients on ARVs were adherent.

Slide #29

- This slide presents data on hospitalization.
- The number of hospitalizations is relatively small, so a change in the numerator or denominator could be due to the small number of people.
- The target is a decrease in the proportion of PLWHA who have more than one hospitalization within a 12-month period, to 3% or less.

Discussion: Dr. Hildebrand asked about the variance between the goals for Ryan White clients and for all clients in the EMA. In some cases, we have higher expectations for Ryan White clients than for the City as a whole, but we don't necessarily have the data. Dr. Irvine noted that we could argue that all targets for Ryan White clients should be the same as the targets in the NHAS. Marcy Thompson asked whether lower goals for our clients might have an impact on our grant award from HRSA. The HIV Prevention Program always uses NHAS targets.

Terri Faulkner noted that she worked at a Ryan White agency and is doubtful about the accuracy of Ryan White data. She also expressed concern that with the likely inaccuracies in Ryan White data, we might not be able to meet the EMA standards. Randall Bruce asked about the meaning of the term "unique

individuals" in slide #7 and was informed that the term refers to the number of people who were tested and that an individual who tested more than one time is only counted once. Mr. Bruce also raised a question about slide #28, asking whether PLWHA might go more frequently to the Emergency Department (ED) with increasing age and comorbidities. How are hospitalizations for HIV and for non-HIV causes differentiated? The EMA's logic is that anyone may go to the ED one time per year – e.g., for a broken arm – but that individuals who go more frequently than once per year may be seeking treatment for HIV-related problems. A meeting participant asked whether New York State health homes will have an impact on our projections about hospitalizations. The success of health homes will in part be measured by the ability to decrease hospitalizations.

Asked about the definition of linkage to care, Dr. Irvine responded that linkage is indicated by viral load and CD4 count as evidence of a primary care visit. Dr. Irvine noted that linkage to care, as shown in slide #15, is not necessarily through Ryan White efforts and, therefore, not definitively attributable to Ryan White but is likely to have been accomplished through RW efforts. Changes in contractual payment points will likely lead to higher numbers of clients linked to care.

Regarding slides 23 and following, Marcy Thompson asked whether the new guidelines on test-and-treat would have an impact on viral load suppression. Ms. Chamberlin responded that we would need to wait and see whether the recommendations affect trends.

Dr. Aidala recommended consistency between EMA goals and Ryan White goals and noted that consistency with NHAS goals would be a good idea. She also recommended that, regarding viral load, rather than expecting people to be suppressed to x level for y period of time, we should just look at suppression.

Randall Bruce made a motion recommending consistency between Ryan White and EMA targets, where appropriate. All Committee members present voted in favor of this motion. Committee members also discussed whether the targets should be consistent with the targets in the NHAS, but Jan Carl Park stated that consistency with the NHAS is not important vis-à-vis our award. No one in Washington, DC, is checking whether we arrive at a target of 83% vs. 85%. In fact, no one is certain how the NHAS goals were determined.

The Committee voted to accept the goals, indicators, and objectives and forward them to the Planning Council's Executive Committee.

Public Comment: Alissa Wassung of God's Love We Deliver noted that her organization delivers over 300,000 meals each year and that an advisory

group is examining the connection between food and nutrition and health outcomes. She asked about the meaning of reducing disparities. We want to reduce gaps between groups to non-significance and then keep them non-significant.

Adjournment: The meeting was adjourned.