HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting Minutes
NEEDS ASSESSMENT COMMITTEE
Lee Hildebrand, DSW and Mimi Pinon, NP, Co-Chairs

Thursday, April 7, 2011
Cicatelli Associates, 505 Eighth Avenue
20th Floor, Lavender Room
2:00 pm – 5:00 pm

Members Present: Angela Aidala, PhD, Randall Bruce, Martin Bruner, Lee Hildebrand, DSW, Sabina Hirshfield, PhD, Jennifer Irwin, Rosemary Lopez, Tamella McCowen, Freddy Molano, MD, Ariel Negron, Jr., Jan Carl Park, Glen Phillip, Mimi Pinon, NP, Kate Sapadin, PhD, Marcy Thompson

Members Absent: Terri Faulkner, Guillermo Garcia-Goldwyn, Carlos Manuel Gonzalez, Jose Gonzalez, Rebecca Kim, Barbara Kobrin, Fabienne Laraque, MD, MPH, Julie Lehane, PhD, Frank Machlica, Donald McVinney, Ricardo Vanegas-Plata, DDS

NYC DOHMH Staff Present: Carol Davin, Yoran Grant, PhD, Taiwanna Messam, Rafael Molina, Nina Rothschild, DrPH, Ellenie Tuazon

Public Health Solutions Staff Present: Lauren Feldman Hay

Others Present: Felicia Carroll, Ron Joyner, Mallory Marcus

Material Distributed:

- Agenda
- Minutes from the March 3, 2011 Meeting
- Data, Data, Data Presentation by Carol Davin
- Timeline and Process for Needs Assessment
- 2009 Comprehensive Strategic Plan Analyses
- 2011 Planning Council Membership Application
- April 2011 – Planning Council Month at a Glance
- April 2011 Planning Council Calendar

Welcome/Introductions/Moment of Silence/Next Steps: Dr. Lee Hildebrand welcomed meeting participants. Members introduced themselves. Randall Bruce led the moment of silence. Dr. Hildebrand stated that the Committee would devote its next full meeting to a robust discussion of all the presentations we've had to date. Nina Rothschild will present a summary of all the presentations.

Review of the Meeting Packet: Nina Rothschild reviewed the contents of the meeting packet.

Update on HRSA Site Visit: Jan Carl Park summarized the visit from the Health Resources and Services Administration (HRSA), our federal funder, noting that the genesis of the site visit was a lack of clarity regarding roles, responsibilities, and boundaries between the Planning Council and the Grantee. In the wake of the site visit, a set of sweeping reforms is being enacted, including:

- Extending terms of PC members from 2 years to 3 years to strengthen the institutional memory and take advantage of member expertise developed over time. Staff is working on a change in the Executive Order that would enable this recommendation to be implemented.
- Eliminating alternates (alternates are not vetted by the Mayor's Office; the practice of having alternates dates from the earlier days of the epidemic when consumers were very sick and could not always attend meetings)
- Relocating the Planning Council Support Unit within the Health Department in order to establish a firewall between the PC and the Grantee
- Establishing a direct line of communication between Jan Carl Park and HRSA
- Establishing ownership by the PC and the Committee members of the PC process and products, including the questioning of authority when appropriate.
- Future awards to the NY EMA are conditional on successful implementation of HRSA's suggestions.

Data, Data, Data: Carol Davin of the Research and Evaluation Unit in the Bureau of HIV/AIDS Prevention and Control previously delivered a general overview of data sources to the Needs Assessment Committee membership. This time, her presentation focused on epidemiology terminology and the different types of data sources available:

- surveillance data on prevalence and incidence
- administrative data
- program data

- survey data
    - CHAIN
    - Medical Monitoring Project (MMP)
    - Return to Care Survey
    - National HIV Behavioral Surveillance (NHBS) data using venue-based and respondent driven sampling
- needs assessment data
- STD and TB data
- SPARCS data on hospital discharges
- Medicaid data
- HOPWA data on housing (using eCOMPAS)
- Some HASA data

Ms. Davin noted the following:

- The distinction between prevalence and incidence
- The definition and examples of surveillance data
- How HIV/AIDS surveillance data is collected in NYC
- Events that are reportable by NYC laboratories
- More details about information in HARS, as well as limitations to HARS data
- Sources of administrative data
- Features of Medicaid data
- Features of SPARCS data on hospital discharges (hospital discharge data for pregnancy can be examined as a proxy for high risk sexual behavior. Researchers can also look at discharge data for males and females with HIV-related hospitalizations.)
- Examples of program data (RW data, RW QM data, HOPWA data)
- Survey data (CHAIN, MMP, Return to Care, NHBS) and its limitations (we need to bear in mind the limitations of survey data that are based on self-report: stigmatized behaviors may be underreported)
- Qualitative data (e.g., focus groups)

HRSA is not altogether happy with our quality management data. The NA Committee needs to have a better understanding of the QM data, according to HRSA. Members discussed having the AIDS Institute come and present to the Needs Assessment Committee regarding their work on quality management.

2009 Comprehensive Strategic Plan Analyses: Jan Carl Park introduced Dr. Yoran Grant of the Research and Evaluation Unit in the Care, Treatment, and Housing Program. Dr. Grant presented on the 2009 Comprehensive Strategic Plan Analyses. HRSA requires the Planning Councils in EMAs to develop comprehensive strategic plans incorporating a very clear and direct set of reasonable milestones. We have compared our goals with the goals set out in the National HIV/AIDS Strategy, and we match or exceed the NHAS goals. Dr.

Grant noted that she would focus on 2009 data but that the 2009 data can be compared with 2008 data.

Dr. Grant stated that the analysis of the extent to which we are meeting the goals articulated in the Comprehensive Strategic Plan uses data from several sources including:

- contractually required material from contractors (AIRS and electronic medical record data)
- HARS data from NYC DOHMH
- rapid testing data from HIV prevention programs
- CHAIN
- The Medical Monitoring Project (a collaboration between DOHMH and CDC).

Dr. Grant provided the following descriptive statistics about the demographics of Ryan White clients:

- In 2009, 26,578 HIV+ Ryan White clients were served.
- 63% were male
- 47% were Black
- 38% were Hispanic
- 9% were white, non-Hispanic (a smaller proportion than the percentage of HIV-infected white, non-Hispanic MSM in the City as a whole because Ryan White tends to draw on a lower socioeconomic status demographic)
- A higher concentration of Ryan White clients lives in the Bronx compared with the percentage of Citywide HIV-infected individuals living in the Bronx
- 50% of the sample is between 30-49 years of age

Dr. Grant also addressed several of the goals and objectives articulated in the comprehensive plan for HIV/AIDS services:

- Goal 1 called for increasing the number of individuals who are aware of their HIV status. Objective #1A calls for increasing the number of individuals who receive rapid tests. Using RW funds, a total of 60,132 individuals were tested. Citywide, a total of 291,804 rapid tests were administered, but the Citywide numbers are not de-duplicated, whereas the RW numbers are de-duplicated. Of the 60,132 individuals tested with RW funds, 1.2% had a preliminary positive result.
- Objective #1B called for reducing the number of concurrent HIV/AIDS diagnoses (i.e., the number of AIDS diagnoses within 90 days of an HIV test). In 2008, 24% of Ryan White individuals had a concurrent

HIV/AIDS diagnosis. In 2009, only 17% had a concurrent diagnosis – but this different is not statistically significant.

- Objective #4A called for reducing the disparities in the number of individuals with delayed HIV diagnosis. 17% of Ryan White clients had a delayed diagnosis, and 19% of female RW clients had a delayed diagnosis. This delay may occur because women may not consider themselves to be at risk for HIV infection and may not seek out testing.
- Goal 2 called for promoting early entry into and retention in care. Objective #2A focuses on prompt linkage to care. The focus here is on the newly diagnosed – looking at what proportion is linked to care within 90 days but removing concurrent diagnoses because we don't know whether their linkage was because of Ryan White-funded linkage efforts or because these patients were really sick. In 2008, 31% of Ryan White clients were linked within 90 days, and in 2009, 43% of RW clients were linked within 90 days. This increase is significant. The new data system known as e-SHARE, initially rolled out to medical case management providers and ultimately to be extended to all RW-funded providers and to providers funded through the HIV Prevention Program, will allow us to match our data with Citywide data.
- Objective #4B called for reducing disparities in linkage to care. The data show that persons under 30 years of age are doing well, possibly because they are more energetic and mobile, have fewer co-morbidities, and may be better able to navigate the health care system -- but we have a ways to go for the larger pool of RW clients.
- Objective #2B concerns retention in care. In 2008, 66% of our clients had a gap greater than 4 months in their care, but we are getting better at capturing these clients before they go for 6 months without care. Persons under age 30 are, again, less likely to have a gap in care.
- Objective #2C called for reducing emergency room visits. Unfortunately, we cannot currently track whether ER visits and hospitalizations were or were not HIV-related, but we will be able to track emergency department visits when e-SHARE is fully rolled out.
- Goal #3 calls for promoting optimal management of HIV infection, including adherence to anti-retroviral therapy. CHAIN clients were significantly more adherent in 2009 than in 2008.
- Objective #3B calls for improving viral suppression. We are interested in determining the proportion of clients who can either start and remain undetectable or improve from detectable to undetectable. Among Ryan White clients, there was no significant change in the proportion with viral suppression from 2008 to 2009, although the increase for Citywide clients was significant. Reducing community viral load is an overall goal for HIV prevention, but there is no set threshold at which transmission is expected to drop.

- Objective #3C relates to immunological health. From 2008 to 2009, we saw a significant increase from 70% to 75% in the percentage of individuals with improved immunologic function.
- Objective #3D calls for reducing the number of hospitalizations. The changes from 2008 to 2009 were not statistically significant.
- Goal #5 calls for an evaluation of the cost effectiveness of Ryan White services. The plan was developed by a team from Downstate and may be implemented with CHAIN data or eSHARE data.

Dr. Grant also noted a few caveats about the data. For example, we only track linkage within our programs. If a client is tested using RW funds but is linked to care by a non-RW Part A provider, we wouldn't know about it. With performance-based contracting, however, contractors will not be paid if they do not document linkage – so they will have more of an incentive to ensure linkage. Even with the flaws within our system, however, we did see improvement in linkage. Overall, Dr. Grant noted, while there is room for improvement, we are doing better than we were previously.

Review of the Minutes: Review of the minutes from the previous NA meeting was deferred until the May meeting.

Next Steps: Committee members agreed to engage in an in-depth discussion next session about where we are going as a Committee. Dr. Rothschild agreed to put together bullet points summarizing the major points of discussion in advance.

Adjournment: The meeting was adjourned.