Meeting Minutes
NEEDS ASSESSMENT COMMITTEE
Lee Hildebrand, DSW, Chair

May 23, 2012
Federation of Protestant Welfare Agencies
281 Park Avenue South, Conference Room A
3:00 pm – 5:00 pm

Members Present: Randall Bruce, Guillermo Garcia-Goldwyn, Lee Hildebrand, DSW, Sabina Hirshfield, PhD, Rebecca Kim, Rosemary Lopez, Jan Carl Park, Marcy Thompson

Members Absent: Angela Aidala, PhD, Terri Faulkner, Graham Harriman, Natalie Humphrey, PhD, Jennifer Irwin, Julie Lehane, PhD, Frank Machlica, Tamella McCowen, Freddy Molano, Ariel Negron, Glen Phillip, Ricardo Vanegas-Plata, DDS

NYC DOHMH Staff Present: Stephanie Chamberlin, Marybec Griffin-Tomas, Mary Irvine, DrPH, Rafael Molina, Nina Rothschild, DrPH, Jacinthe Thomas

Public Health Solutions Staff Present: Julie Cohen, Lauren Feldman Hay

Others Present: Billy Fields

Material Distributed:

- Agenda
- Minutes from the April 25, 2012 Meeting
- New York EMA 2009-2012 Comprehensive Strategic Plan Annual Update
- Planning Council Calendar for June 2012

Welcome/Introductions/Moment of Silence/Review of the Meeting Packet/Review of the Minutes: Dr. Lee Hildebrand welcomed meeting participants. Committee members introduced themselves and observed a moment of silence. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the May meeting of the Needs Assessment

Committee were accepted for posting on the Planning Council website at nyhiv.org.

Conclusion of Work on the New Comprehensive Plan: Lee Hildebrand thanked everyone for their work on the new Comprehensive Plan for HIV/AIDS Services in the NY EMA for 2012-2015.

Update on Third Year of Implementation of the "Old" Comprehensive Plan for HIV/AIDS Services in the NY EMA for 2009-2012: Stephanie Chamberlin and Dr. Mary Irvine of the Research and Evaluation Unit in the Bureau of HIV/AIDS Prevention and Control stated that the presentation would examine progress against the targets for the 2009-2012 plan. The presentation is posted on the Planning Council website at nyhiv.org. This presentation is reflective, as opposed to creating new goals, objectives, and indicators. Ms. Chamberlin and Dr. Irvine provided background, data sources, a summary of demographics, information on objectives, indicators, and progress toward targets for Goals 1-4 of the old Comp Plan, and an update on Goal 5 of the old Comp Plan.

The Ryan White legislation requires the Eligible Metropolitan Area (EMA) to develop a Comprehensive Plan. Today's presentation focuses on data from implementation of the Comp Plan for 2008-2010. Sources on which the presentation draws include:

- Required client-level Ryan White data reported by contractors via AIRS and eShare, allowing analysis by Ryan White service category but limited by the completeness of providers' data reporting
- Data from the surveillance registry (limited by a lengthy reporting lag between when the particular reportable event -- e.g., measurement of viral load -- took place and when the data is available to epidemiologists, and representative only of the NYC population, not the EMA as a whole, and not reflective of actual services or treatment received, but very complete)
- Rapid testing data from the DOHMH prevention program, submitted by all agencies with DOHMH funding for testing
- CHAIN, a longitudinal cohort study commissioned by the HIV Planning Council, drawing on interviews with persons recruited from agencies providing social and/or medical services
- MMP – the Medical Monitoring Project, a CDC-initiated, serial cross-sectional study covering people recruited from HIV medical facilities (including private doctors' offices), offering several strengths including comprehensiveness in topics but limited to NYC participants.

For different indicators, the Research and Evaluation Unit uses different sources. A few differences between the RW data and the EMA data re as follows:

- Data for Ryan White (RW) programs are broken down by self-identified gender, whereas data for the EMA are broken down by sex. A higher proportion of females are served under RW programs.
- Fifty-one percent of the Ryan White population is Black, whereas 45% of the EMA population is Black.
- RW serves a slightly younger population.
- A higher proportion of RW clients identify as living in the Bronx.
- Goal 1 of the old Comp Plan was to increase the number of individuals who are aware of their HIV status. Objective 1A was to increase the number of individuals receiving voluntary rapid testing. According to Ryan White data, the number of clients receiving rapid testing climbed from 2008 to 2010 (with most of the climbing occurring from 2008 to 2009, with the start of new programs). For the EMA, the analysis indicates a slight reduction in HIV testing from 2009 to 2010, but still an overall increase since 2008.
- Objective 1B of the old Comp Plan was to decrease delayed diagnosis of HIV by the end of 2012. For RW Part A, the estimates show reduced concurrency for 2009-2010, but in 2010 concurrency remained higher than in 2008. In NYC, female Part A clients had lower rates of concurrency, but there was no gender disparity for NYC overall. Generally, older age groups have worse levels of concurrency.
- Objective 2A is to increase the number of newly diagnosed individuals who enter primary care within three months of diagnosis. Among RW clients, we see increased prompt linkage from 2009-2010. In the EMA, we see that NYC estimates for linkage are gradually moving in the right direction. Female Part A clients and females in NYC overall do better on linkage. Among males, linkage increased from 2008-2009 and held steady from 2009-2010. No clear patterns emerge by age. NYC data overall shows that prompt linkage most often occurred among White and Other racial/ethnic groups.
- Objective 2B is to increase retention in HIV care and treatment by 2011. Primary care retention increased from 2008-2009 for the EMA and for Part A, but then the numbers leveled for the EMA as a whole and decreased slightly in Part A. Overall, we see some retention disparities. In NYC overall, female PLWHA had slightly higher retention in care in 2008-2010. Part A data shows better retention among females in 2010, along with lowest rates of retention among transgender clients. Poor health drives retention in care. Generally, women do better in retention, and the DPHO areas are doing better. These groups may be retained in care because they are generally in worse health and are more likely to have AIDS.

- Goal #3 refers to optimal management of HIV infection, and Objective 3A is to improve medication adherence. The CHAIN cohort may do better on adherence because they are a self-selected sample who choose to go through an annual interview.
- Objective 3B is to increase viral suppression by 2011. Ryan White clients had an increase in viral suppression in 2008-2009 but a decrease in 2010. For Part A, overall results (65% suppressed) exceeded results for Part A medical case management (MCM) clients, 55% of whom were suppressed for 2010. In the EMA as a whole, a sustained viral suppression has been achieved by a higher percentage of PLWHA each year since 2008 and reached 70% in 2010.
- Objective 3C refers to immunological health. For RW, this clinical indicator showed an increase from 2008-09 and a drop in 2010. EMA-wide, the percentage of PLWHA with stable/improving CD4 counts steadily increased each year.
- Objective 3D refers to a decrease in HIV-related hospitalizations of PLWHA, and Objective 2C is to decrease visits to emergency departments. Part A acute care utilization did not show a clear trend (if anything, a slight increase in hospitalizations but a decrease in ED visits), but the source changed in 2010 (from filtered CHAIN interviews to eShare reporting). For the EMA, a slight downward trend in acute care utilization appears for MMP, alongside a stable or slight downward trend for CHAIN, depending on the measure (% with more than 1 event, vs. mean #).
- Goal 5 concerns an economic evaluation of Part A services. A plan has been developed for a cost and outcome analysis for the next three years that will inform the community planning discussions.

Dr. Hildebrand asked whether the analysis looks at transmission risk factors. Ms. Chamberlin responded that it does not but that the Research and Evaluation Unit has the capability to look at transmission risk factors.

Dr. Hildebrand also asked whether we can drill down to find out what the best practices are for linkage to care. Dr. Ben Tsoi, who heads the Bureau of HIV/AIDS Prevention and Control's testing program, believes that changes in payment point – i.e., a shift in the program model – make the difference. In the past, when payment for linkage was not a separate point, less incentive existed for providers to connect people who tested positive to care.

Marcy Thompson noted that staff at her agency are seeing new strains which are resistant to many medications and asked whether that finding relates to the numbers for viral suppression. Dr. Irvine stated that the EMA numbers for viral load suppression are across all breakdowns.

Needs Assessment Update: Nina Rothschild provided a brief update on the needs assessment in which the NA Committee was engaged prior to being swept full-time into vetting the Comp Plan for 2012-2015. A Gantt chart outlining presentations will be updated to reflect more realistic dates for delivery of presentations of the various components. In addition, the NA Committee may want to revisit the special populations: these populations were not selected using systematic epidemiologic guidance but, rather, were based on the impressions of Committee members about groups in particular need of attention. We may want to reach out to the HIV Epidemiology Program and craft a more methodical way of establishing special populations.

Guillermo Garcia-Goldwyn underscored the importance of knowing more about the needs of the over 50 population. Lee Hildebrand mentioned her interest in concurrency, noting that this has been a big issue in Brooklyn. Jan Park asked about the factors driving these numbers. How can we improve the system of care that we've created? Dr. Irvine noted that a recent CHAIN report on mortality may be of interest to the NAC. It provides data on rates, subgroup differences, causes of death, and helps to identify the most worrisome comorbidities – information which may help us to intensify our focus.

Dr. Irvine mentioned the PCSI project, which is working on a way to merge DOHMH's registries for HIV, STD, hepatitis C, and TB. Conceivably, this project may yield new information for the NAC. We should also think about the kind of anecdotal, qualitative information that would be useful.

Planning Council Update: Jan Carl Park noted that the Planning Council will apply to HRSA for a waiver from the 75%/25% core/non-core allocation of funding. The Council's attention now shifts to the setting of priorities and allocation of resources. The PSRA Committee will ask questions of the NAC – e.g., concerning missing data – and we can begin to commission some of that work.

Public Comment: No members of the public commented.

Adjournment: The meeting was adjourned.