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 of the
PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, February 12, 2014
AIDS Service Center of NYC, 41 E. 11th Street, 5th Floor
10:10am – 1:00 pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney, Randall Bruce, Joan Edwards, Graham Harriman, Jan Hudis, Peter Laqueur, Jan Carl Park, Tom Petro

Other Council Members Present: Billy Fields, David Martin

Members Absent: Nancy Cataldi, Felicia Carroll, Robert Cordero, Amanda Lugg, L. Freddy Molano, M.D., Deb Marcano, Daniel Pichinson, Sam Rivera, Allan Vergara, Leonardo Vicente III

Staff Present: David Klotz, Darryl Wong, Anna Thomas, Benjamin Tsoi, MD (DOHMH); Rachel Miller, Gucci Kaloo, Bettina Carroll (Public Health Solutions)

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Ms. Duke opened the meeting followed by introductions. *Mr. Klotz* reviewed the meeting packet. The draft minutes of the January 13, 2014 meeting were approved with no changes.

Agenda Item #2: Public Comment

J. Payne: Home and Community-based Services programs provide an essential service for some PLWHA, particularly those without Medicaid. It ensures care delivered at home, which for some is the only contact with the care system.

M. Gold: I get over 60 hours of home-delivered services per week, which are essential to keeping me connected to care.

J. Lopez: The Outreach to Homeless Youth component of EIS services is effective at finding young people who are hard to engage, and successfully tested many and linked them to care.

D. Martin: we should not eliminate testing programs solely based on their positivity rates. It is important to look at models that effectively link people to care.

Agenda Item #3: FY 2014 Spending Scenario Planning

Ms. Duke prefaced the discussion by saying that in a time of shrinking resources, the PSRA and Council must make tough choices, based on data, that provide for the best possible outcomes for PLWHA.

Early Intervention Services (EIS)

Dr. Tsoi presented on Ryan White-funded EIS programs. He began by reviewing the treatment cascade, which shows the drop-off of people with HIV to those not tested to those not in care to those not virally suppressed. EIS programs address the first part of the cascade. He reviewed the NYC DOHM HIV testing strategy and how RW-funded programs fit into the whole. HIV testing in NYC is done through DOHMH with funds from: CDC, Ryan White, City Tax Levy (including jails and school-based programs), and SAMHSA (expiring this year). Additional Resources include RW Part C, State programs and insurance (Medicaid, Medicare, private). For context, the grant application must describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care, and 33% of the score is based on this. Part A funds for testing under EIS are used for: HIV testing and targeted counseling; Referral services; linkage to care; and health education and literacy training that enable clients to navigate the HIV system of care.

In February 2011, DOHMH rebid its portfolio of Prevention- and Ryan White-funded HIV testing contracts. This allowed DOHMH to implement comprehensive testing strategy for NYC while ensuring priority populations are covered. Testing Models included:

1. **Routine HIV screening in clinical settings**: Healthcare facilities routinely offer testing to clients who present for medical services. This approach yields a high volume of tests, with expected lower testing positivity, yet yielding a high number of positive tests.
2. **HIV testing using Priority Populations model**: Agencies outreach to at-risk priority populations in community settings. This approach yields a high volume of tests, with expected lower testing positivity, yet yielding a high number of positive tests.
3. **HIV testing using Social Network Strategy**: Agencies recruit community members with high risk networks and encourage network associates to test for HIV. Testing positivity is higher, but with much lower testing volume.

For all testing models, contracts are reimbursed for out-of-care positives who are identified and re-engaged in care. 75 contracts were awarded to 68 agencies:

- Prevention: 24 contracts
  - 13 contracts for routine HIV screening in clinical settings
  - 6 contracts using priority populations model
  - 5 contracts using social network strategy
- Ryan White: 51 contracts
  - 11 contracts for routine HIV screening in clinical settings
  - 33 contracts using priority populations models (Priority Populations, Social Networking, Harm Reduction Testing, and Outreach to Homeless Youth)
  - 7 contracts using social network strategy

For RW Part A EIS programs, service models focus on HIV Testing, Linkage to Care, and/or Re-engagement in Care:

- Routine HIV Screening (hospitals and community health centers): $2,693,574*
- Priority Populations: $1,913,457
- Outreach to Homeless Youth: $1,249,147 (formerly funded by HOPWA)
- Harm Reduction Testing: $1,354,322
- Social Network Strategy: $583,281
- Re-engagement in Care: $606,047

*NYS law requires that testing is offered in clinical settings. RW funds were meant to help implement a system that should be in place now. As with all RW programs, funds are payer of last resort and will not reimburse for tests for those with other forms of payment.

Six data points that measure success with linkage to care and identifying PLWHA were used to assess performance of EIS programs. A point is given for each measure for which a program did not reach the goal level of performance for Linkage and Testing Positivity Rate. Dr. Tsoi reviewed graphs that showed total points of performance under expected levels. For example, overall in FY 2012, 14 contracts (worth $1.9M) met their targets (.75% or greater), 29 contracts (worth $4.6M) were below the target, and 8 contracts ($894K) had zero positives found. For routine testing contracts, 3 (1.2M) met the goal of 0.4% and 8 ($1.4M) did not. For targeted testing, 13 contracts ($1.5M) met the goal of 0.75%, and 27 contracts ($3.2M) did not. Dr. Tsoi also provided data on linkage goals met. In addition, DOHMH receives surveillance data indicating PLWHA in NYC who have fallen out of HIV care (no visit, no labs reported in 6 months). Staff follow up with individuals to offer assistance with re-engagement in care and to offer HIV testing to partner(s).

In Year 22: 289 people were confirmed HIV Positive, with 206 (71%) Linked to Care. An additional 256 previously diagnosed PLWHA were re-engaged in care. Some contracts have very high positivity and linkage rates (9 Contracts had positivity rates greater than 1% with nearly 90% linked to care). Most of the contracts were in the Targeted testing portfolio, but one was a Routine testing contract. Of these 9 contracts, 4 had positivity rates greater than 2% with 89% linked to care.

Dr. Tsoi described the Field Services Unit (FSU), a component of the EIS funds. The program receives surveillance data indicating PLWHA in NYC who have fallen out of HIV care (no visit, no labs reported in 6 months). Staff follow up with individuals to offer assistance with re-engagement in care and to offer HIV testing to partner(s). Through the program, 71 PLWHA were linked to care in FY12, 110 PLWHA linked to care in FY13 (to date).

Overall in EIS, opportunities for continued success include: 1) Routine Testing, which has lower positivity rates, but a high number of PLWHA identified, due to volume of tests completed. This strategy can help identify people who do not identify themselves as at-risk. Linkage rates are a very high 87%, which surpasses the National HIV Strategy goal of 85% linkage by 2015. and 2) Targeted Testing, which sees most of the very high positivity rates and identifies more than half of the PLWHA identified by RW-funded programs, including those who may be most difficult to reach.

The ensuing discussion is summarized below:

- PSRA should consider raising the goal for positivity and linkage as a marker for allocations.
- With diminishing resources, RW funds should be used as much as possible for PLWHA, rather than “worried well”.
- Hospitals and community health centers offer the most routine screening due to the law mandating that tests be offered, but testing numbers are still relatively low. Ryan White funds promote the implementation of systems for routine testing.
- These programs are performance-based, and so are only reimbursed for tests done.
- EIS should be reduced by a total of $5M (including the original $3M recommended in the application spending plan), based on the number of programs that are significantly below target.
- There is a pending request to HRSA to use EIS funds for hepatitis C screening. Also, there are some over-performing contracts, and so consideration should be made for keeping some EIS funds available to account for these contingencies.

- The program should set quantifiable standards, as other funding streams do (e.g., CDC).

A motion was made and seconded to reduce the EIS allocation by $5M. A friendly amendment was accepted to make the cut $3M up to a maximum of $5M to allow for the grantee to account for the value of over-performing contracts. A vote was taken and the motion defeated, but as there was not a quorum, the vote was invalid.

A recommendation was made to keep the reduction at $3M and PSRA will continue discussion on further possible reductions at the next meeting.

Home and Community-based Services (HOM)

Ms. Thomas presented on HOM, as requested by PSRA. She gave a summary of the HRSA and local EMA program definitions, a history of HOM allocations and ranking, and client eligibility. The program was last re-bid in 1998. An overview of the demographics of the 325 clients served was given, along with insurance status (92% are insured, mostly Medicaid).

Services provided in this category are: Mental Health Counseling (includes Individual, Group, Family Counseling-MH, and Individual Counseling-AOD); Supportive Counseling; Nutritional Counseling; Custodial Visits (homemaker/ chore services to provide support to the family, including childcare); Pantry Bag Distribution; and Psychiatric Evaluation and Visits. A breakdown of how services are provided by the four contractors was given. Units of service are not distributed evenly across the clients in each service grouping. You can't divide the number of clients by unit, as the reality is that in most cases, many clients receive a small amount of service units over a short amount of time, while a small number of clients are receiving a large amount of services over a longer amount of time. Custodial visits are the only service that are not provided under another Part A service category. The number of clients receiving this service increased from 2011 to 2012, while the others decreased or stayed stable.

The ensuing discussion is summarized below:

- If this category were no longer funded, clients would have to be transitioned to another agency to receive similar services.
- There are no waiting lists for these programs.
- These programs have a high cost per client, mostly because services are delivered in the client's home. These are cost-based contracts, and so it is not possible to tease out actual spending per client.
- All clients were enrolled pre-Medicaid expansion or ACA implementation.
- The environment has changed significantly since these were first funded. The Council should not let another year or two go by without making serious changes to this category.
- There was discussion on whether PSRA's funding decision should come before IOC even considers restructuring the category definition, or should be process be reversed. There was discussion at IOC that PSRA should decide on funding first, and if the category is not funded, there is no need for a new service directive.

While there was no quorum, the PSRA recommended that the allocation should be lowered to reduce duplication of services. An analysis is needed with dollar estimates.

There being no further business, the meeting was adjourned.