Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, April 17, 2017
ASCNYC, 64 W. 35th Street, 3rd Floor
3:10 – 5:00pm

M I N U T E S

Members Present: Matthew Baney (Co-chair), Sharen Duke (Co-chair), Joan Edwards (by phone), Graham Harriman, Steve Hemraj (by phone), Jan Hudis, L. Freddy Molano, M.D. Claire Simon (by phone)

Members Absent: Victor Ayala, Randall Bruce, Daphne Hazel, Matthew Lesieur, Amanda Lugg, Jesus Maldonado, Jan Carl Park, Kimberleigh Smith

Other Council Members Present: Paul Carr, Billy Fields (by phone)

Staff Present: David Klotz, Nasra Aidarus, X. Pamela Farquhar, Ashley Azor *(NYC DOHMH)*; Christine Nollen, Bettina Carroll (by phone) *(Public Health Solutions)*; Julie Lehane, PhD *(Westchester Department of Health)*

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Baney and *Ms. Duke* opened the meeting, followed by introductions and a moment of silence. The minutes of the March 20, 2017 meeting were approved with no changes.

Agenda Item #2: FY 2017 Scenario Planning

Mr. Klotz reviewed the discussion from the previous meeting on the FY 2017 Spending Scenario. The EMA does not expect our full grant award until June or July. If approved by the EC and full Planning Council this month, the spending scenario will allow the Grantee to implement the final award immediately upon its receipt. Given the appropriations process in Congress, we expect level funding nationally for the current fiscal year through a continuing resolution. Given changes in formula funding over the last few years, we anticipate that this would result in a reduction to the award between 1% and 2%.

The draft scenario accounts for up to a possible 1.9% cut to the award. There are savings to the carrying cost of programs from the previous year. Some is from the elimination of Home and Community-based Services (HOM) in FY 2016, some from some small savings in several other service categories after contract negotiations.

The NYS DOH AIDS Institute has agreed to take a 5% upfront reduction to the allocation for ADAP for FY 2017 (to be restored as much as possible through reprogramming). This amount will cover the rest of

a reduction to the total award up to 1.9%, without having to cut any other service categories. If the cut to the award is less than 1.9%, the upfront reduction to ADAP will be smaller. All reductions are taken out of the Base portion of the award for simplicity's sake. The allocation to ADAP (which gets both Base and MAI funds) can be used to balance the Base and MAI portfolio. The PSRA is grateful to the AIDS Institute and ADAP Director Christine Rivera for their continuing partnership with us, and allowing us the flexibility to avoid cuts to the rest of the portfolio.

There was a consensus to forward the FY 2017 spending scenario as presented to the Executive Committee for approval.

Agenda Item #3: Long-term Scenario Planning

Mr. Klotz reviewed proposed Congressional appropriations for HIV programs for FY 2017 and 2018. There is a strong likelihood of a continuing resolution for the current year. For FY 2018, the president has released a budget blueprint that calls for draconian cuts to domestic spending, including all HIV programs. The blueprint includes a 22% cut to all Ryan White programs, as well as similar cuts to CDC prevention and NIH research budgets. There is significant resistance to these cuts from members of both parties, and there will be a long period of negotiation, but it is important for the PSRA to be informed about what is being proposed in Washington. There is also no information yet on whether the State or City will be able to step in and restore federal funding cuts. Also, similar cuts are proposed for HUD/HOPWA programs.

Ms. Duke and *Mr. Baney* noted that, when planning for a severe cut in FY 2018, doing across-the-board proportionate reductions to all categories is no longer tenable. In discussions with DOHMH staff, it was decided to ask the Grantee to propose potential elimination of entire service categories in the event of an extreme cut. The idea was to use data to be strategic in cutting services in the least disruptive way, as was done with the elimination of HOM, based on evidence that there was reduced need and that services are covered in other parts of the portfolio. In planning for a severe cut, everything should be on the table.

Mr. Harriman presented ideas for eliminating two service categories in the event of a severe cut, should PSRA have to take such action: Transitional Care Coordination (TCC) and Health Education/Risk Reduction (HER). TCC provides stabilizing case management for homeless and unstably housed individuals and is a separate sub-category under Medical Case Management (MCM), different from the MCM's Care Coordination Program (CCP). Ranked the fifth highest priority, there are five contracts funded at $1.4M, last re-bid in 2011.

TCC's goal is to improve care for people with HIV who are homeless or unstably housed (e.g., in SROs) by: ensuring entry into and continuity of HIV primary medical care; providing linkage to housing services and other social support services; and decreasing unnecessary emergency room visits and hospitalization. It is an adaptation of Critical Time Intervention (CTI): case management services and care coordination services to reduce homelessness among people living with severe mental health disorders; short-term program with phases (transition, try-out, and transfer of care); successful in its support and stabilization of persons with mental health disorders and homelessness. Services provided in this category include: targeted case finding and outreach; screening and referral for social service needs such as housing, Medicaid, HIV/AIDS Services Administration (HASA); health education and coaching; linkage to an HIV primary medical care provider; and transition to a case management program.

TCC was developed to address housing needs, however since its inception there have been other mechanisms developed to address the need for housing: HOPWA, HASA, Health Homes. When TCC was first developed, Health Homes and Ryan White Non-Medical Case Management (n-MCM) did not

exist. Similar to TCC, CCP and n-MCM provide similar services (navigation and linkage, case Management, health Promotion).

There was some discussion about clarifying the difference between TCC, CCP and nMCM. Also, as the IOC is currently revising the CCP service model, there was a suggestion that the IOC look at TCC in conjunction with that. PSRA should also at least know what the new CCP model will look like before making any decisions about TCC. There is also a need to identify additional data points (e.g., unduplicated client counts, caseloads, target populations, program graduation).

HER is a peer-delivered, evidence-based, self-management heath education curriculum, that engages PLWH in self-management in order to: increase engagement in healthcare, improve treatment adherence, reduce risk behavior, address life issues (co-factors), and improve overall health. HER is ranked low on the PC's priority list and is recognized as assisting in accessing other services. The target population is PLWH who are newly diagnosed (<2 years), lacking/low self-efficacy with HIV management, and motivated to engage in self-management. Based on the community implementation of the Positive Life Workshop, PLWH enrolled in the model were more likely to respond well to the HIV peer-led workshops and change their HIV risk-behavior. Peer support is a popular aspect of the workshop and peer leaders desire to "practice what they preached", which led to changes in health behavior. However, participants enrolled in the model were not representative of the target population. They were mostly already ART adherent and virally suppressed with an HIV diagnosis >10 years. Only 8% of participants were diagnosed within the last two years and only 20% were not virally suppressed.

The following is a summary of the ensuing discussion on HER:

- Most newly diagnosed PLWH are not interested in a multi-day workshop, but are in crisis mode.
- The longer-term diagnosed do get some benefit from the program, especially in terms of social support, but this may not be the best use of limited Ryan White funds.
- There are places where people can get the kind of health education that HER provides, including nMCM programs.
- The Positive Life Workshop is an excellent curriculum and should be promoted in other places, even if HER is not funded with Part A dollars.
- HER has had a big impact on non-HIV related health behaviors, such as smoking cessation.
- Continuing education (beyond viral load suppression) is important.

The PSRA will continue this discussion over the course of the next few months and into the fall/winter. The Committee also needs to consider an application spending request before the July Council meeting, and so may consider a revised spending plan that incorporates these changes, with funds redirected to areas of high need.

Agenda Item #4: Housing Update

Ms. Farquhar presented on the funding picture for Housing services, particularly those funded by HOPWA. In the past four years, the HOPWA NY Eligible Metropolitan Statistical Area (EMSA) experienced a cumulative $9.7M cut from the U.S. Department of Housing and Urban Development. In addition, the EMSA expanded in 2014 to include three counties in New Jersey with no additional funding. The Housing Opportunity through Modernization Act, signed into law July 29, 2016, includes modernization of the formula to distribute formula funding more equitably by counting confirmed living HIV/AIDS cases rather than cumulative AIDS cases. The allocation formula also considers housing costs and local poverty rates as formula factors. Implementation of the formula would take place gradually over five years and include a stop-loss provision to cap gains and losses by 10% and 5%. By adjusting the

formula funding to living with HIV/AIDS cases, HOPWA will align with the Ryan White Care Act. HOPWA provides permanent housing to low-income individuals living with HIV. The RW housing portfolio complements HOPWA by providing short-term housing services. The HOPWA program is currently also engaged in scenario planning for additional reductions.

Historically, Housing Placement Assistance (HPA) contracts have underperformed in both HOPWA and RW due to lack of affordable units and the 2% vacancy rate across NYC. In 2015, an agency opted not to renew its RW HPA contract due to difficulties it was experiencing identifying apartments in the community that were within the Fair Market Rent. NYC RW and HOPWA agencies continue to access the HIV/AIDS Service Administration (HASA) on behalf of their clients. HASA provides housing and case management services to low-income individuals living with AIDS in NYC. Effective August 29, 2016 HASA expanded its eligibility requirements wherein all low-income persons living with HIV and not just individuals diagnosed with CDC-defined AIDS would be eligible for rental assistance and other benefits. 3,747 clients (not unduplicated) were served through HOPWA in 2016. RW Housing services reached 5,787 clients (not unduplicated) in 2015. RW rental assistance is only for the non-HASA eligible (e.g., undocumented immigrants). There was discussion on proposals, opposed by DOHMH, to transfer the bulk of HOPWA funds to HASA (much HOPWA funding already goes to HASA).

PSRA should keep this data in mind when developing a spending request for the FY 2018 grant application.

The next meeting is set for May 8th. There being no further business, the meeting was adjourned.