Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, May 11, 2015
AIDS Service Center of NYC, 64 W. 35th St., 3rd Floor
2:15 – 5:05 pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney (Co-Chair), Victor Ayala, Randall Bruce, Amber Casey (for Graham Harriman), Steve Hemraj (by phone), Jan Hudis, Amanda Lugg, L. Freddy Molano, M.D., Jan Carl Park, Tom Petro

Other Planning Council Members Present: Billy Fields

Members Absent: Joan Edwards, Matthew Lesieur, Jesus Maldonado, Lazara Paz-Gonzalez, Sam Rivera, Lyndel Urbano

Staff Present: David Klotz, Nina Rothschild, DrPH, Wilbur Yen (DOHMH); Bettina Carroll, Gucci Kaloo (Public Health Solutions); Peter Messeri, PhD *(CHAIN)*

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

Ms. Duke and *Mr. Baney* opened the meeting, followed by introductions. Mr. Park led a moment of silence in honor of late activist Eddie Rivera. The draft minutes of the March 9, 2015 meeting were approved with no changes.

Agenda Item #2: Impact of FY 2013 Cuts

Mr. Yen presented on the results of a survey of providers on the effect of the FY 2013 cut in the grant award (clients are surveyed separately on client satisfaction measures). The survey was done to obtain information from contractors and inform the annual Part A grant application, as well as to conduct a preliminary analysis on the impact of the Affordable Care Act (ACA) on Part A clients. Surveys were sent out to Agency Heads, Senior Administrators, and Program Directors, via SurveyMonkey in mid-July to all NYC and Tri-County agencies. Information was requested on the lasting effects of the FY 2013 mid-year 14.75% reductions; a separate survey response was requested for each service category from agencies with multiple contracts. Response rates in NYC were 90/131 programs (68.7%), and 64/79 agencies (81%). Response rates by unique program per service category ranged from 2.2% (Home and Community-based Services) to 24.4% (Medical Case Management). 72% of responding agencies were CBOs, 26% hospitals. If there were more than one response from a single agency, answers were averaged.

89% of programs responding to the survey received a funding reduction in FY 2013. Of those 80 programs, at least 65% indicated reducing RW-funded staffing, resulting in at least a 58.8 Full Time Equivalent (FTE) staff reduction across the RW portfolio. 53% reduced the number of clients they were

able to serve through their RW-funded program. 36% of the 80 programs indicated they would be setting caps for client enrollments. 23% would be dis-enrolling the least needy clients this year; 38% percent indicated a reduction in RW program services. Cost containment measures included alternate staffing plans (64%), waiting lists (30%), and service frequency caps (20%). There was a reported decrease in staff morale, leading to problems with staff retention, and a diminished capacity to fund non-personnel items such as equipment and transportation. Examples of the reduction in services were: 1,000 fewer mental health services; 1,900 fewer hours of legal counsel; 5,300 fewer harm reduction encounters; 2,100 fewer supportive counseling services; and 6,000 fewer meals.

Points raised in the discussion included:

- The data is a good first step in understanding the impact of the cuts, and justifies a request for additional funds in the application.
- While there was a small restoration in funding with the $1M increase in the FY 2014 grant award, this may be the "new normal" for Part A funding, which the EMA has to work with.
- Some cost cutting measures are not easy to quantify (e.g., service intensity).
- It would be interesting to get deeper analysis on the reduction of staff morale.

Agenda Item #3: Early Intervention Services (EIS) Directive and Cost

Dr. Rothschild presented the revised EIS service directive approved by the Integration of Care (IOC) Committee on May 6th, developed over five months of intensive meetings. The principal change in the service model is more emphasis on linkage to care for positive people (rather than testing, which is mostly done with the "worried well"), due to the large amount of resources available for testing. The other changes to the model are: use of social networking strategy; testing only in non-clinical settings (CBOs, jails); referral to PEP and PrEP; no laundry list of target populations (all HIV+ people out of care are targeted); access to facilitated enrolment in NYS insurance exchanges; primary care status measures; ensuring access to people with physical, behavioral, psychosocial and sensory impairments (incorporated into all new directives). Finally, no EIS contracts will go to programs with Part A Care Coordination contracts due to the extensive overlap or services. With CDC funding for EIS mostly used for testing, and the low positivity rates, Part A will mostly target linkage to care for both newly diagnosed and for those who have fallen out of care.

The PSRA chairs commended IOC for aligning the directive with the PSRA's vision, as reflected in the changes to the service category allocation last year. There was some concern expressed that some CBOs with higher positivity rates in their testing programs may not be eligible for funding.

Mr. Yen explained the cost analysis for the new directive's services, which are based on the current reimbursement rates. This is the first time that a cost analysis has been done for a new service directive. PSRA will have to decide, based on the unit costs and need, how much of the service it wants to purchase (i.e., the service category allocation). While there are some unknown factors, the cost analysis gives us a more realistic depiction of the scale of need and the resources required to meet it. The approximate cost for providing navigation, service checks and linkage to a primary care provider is $1,760 per client. Using the treatment cascade and the numbers of newly diagnosed, there are an estimated 376 people who will need EIS services (for a total of $661,760). Positives identified in clinical programs not linked to care through the existing system brings accounts for 298 people ($524,480). Re-engagement in care would be provided for a person who has been previously diagnosed that shows up at the clinical site for another test, someone who is seeking clinical or emergency room care, or the Field Services Unit. Accounting for disengaged and transient populations (e.g. inaccurate addresses and/or contact information), inability to access everyone who is out of care, and people who may be re-engaged in other programs (e.g. Care Coordination), the new model would serve an estimated 300 out of 599 eligible people for a total of $528,000. There was some

discussion about this estimate, and it was concluded that finding about half of this disengaged population is a reasonable start. The estimated total annual cost to link and re-engage 974 persons ($1760/person) with linkage services is $1,714,240.

For testing and linkage services (navigation, linkage, and service checks) in non-clinical settings, potential clients include: persons with unknown HIV status; persons newly diagnosed with HIV and not linked to care; and persons with HIV who have fallen out of care. In 2014, 19,050 rapid tests were provided by Ryan White. The approximate value of these services (based on a 1% positivity rate and 85% confirmed positive linkage rate) is $2,621,926. This brings the total estimated cost for all the whole new EIS package to $4,336,166 (Testing and linkage to care services in non-clinical settings, 39% Linkage to care services in clinical settings). This is $59,985 less than the current FY 2014 EIS allocation. There was some concern that the 1% positivity rate does not reflect all testing programs, especially community-based ones that target high risk populations.

The service directive applies only to NYC. Mr. Petro noted that the Tri-county Steering Committee may add TC-specific elements (e.g., allowing for testing in clinical settings) that would only apply to that region. **A motion was made, seconded and approved unanimously to accept the IOC's service directive. There was a consensus to accept the methodology of the cost analysis and to defer the final allocation when considering the full FY 2016 spending plan for the application in July.**

Agenda Item #4: CHAIN Report: Service Needs and Utilization

Dr. Messeri presented an update on service needs and utilization in the CHAIN cohort, as of the 2013 interviews. He noted that the CHAIN cohort is now predominantly middle aged, and that the next wave of recruitment will focus on people in their 20s-30s. The study looked at a number of domains, measuring who needs the service and how many who need the service received it. For example, 93% of respondents (up from 91% in 2011) reported a need for food services (defined as: not enough money in the household for food once in a while to very often in the last six months; a period without anything to eat in the last 30 days; receipt of food stamps; limited or no access to a kitchen; participation in a meal delivery program). Of the 93% who needed food services, 20% (up from 18% in 2011) had adequate utilization of the service (defined as: meals provided in a group setting; prepared meals delivered to home; food voucher or food from a food pantry).

The following is a summary of the findings:

- Need for rental assistance and long-term rental assistance increased
- Need for permanent housing placement and housing stability maintenance declined
- Permanent housing placement and nutrition counseling service showed the largest gains in service utilization
- Home care showed the only substantial decline in service utilization
- HIV standard of care, nutrition counseling, and food services stand out as service areas with high need but low levels of utilization
- White and Puerto Rico-born participants stand out as subgroups with above average need and below average utilization across multiple service areas

There being no further business, the meeting was adjourned.