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, May 13, 2013
Cicatelli Assoc., 505 Eighth Avenue, 20th Floor
3:10– 5:00 pm

MINUTES

Members Present: Marya Gilborn (Co-Chair), Victor Benadava, Randall Bruce, Sharen Duke, Joan Edwards, Graham Harriman, Peter Laqueur, Amanda Lugg, Hilda Mateo, Tracy Douglas Neil, Tom Petro, Dena Rakower, Allan Vergara, Leonardo Vicente III, Dorella Walters

Members Absent: Felicia Carroll, Nancy Cataldi, Robert Cordero, Deb Marcano, Jan Carl Park, Sam Rivera

Staff Present: David Klotz, Darryl Wong, Anna Thomas (DOHMH); Rachel Miller, Bettina Carroll, Gucci Kaloo, Lauren Feldman-Hay, Rozzano Trotman (Public Health Solutions); Peter Messeri, Ph.D. (CHAIN)

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

Ms. Gilborn opened the meeting followed by introductions. *Mr. Neil* led the moment of silence. The draft minutes of the April 8, 2013 meeting were approved with one typo corrected.

Agenda Item #2: FY 2013 PSRA Planning Timeline

Mr. Klotz reviewed the PSRA work timeline for the rest of the planning cycle. The work extends into summer due to the IOC's timeline of developing new service directives, which PSRA will have to rank. Data needed for rankings and allocations will be delivered through June, including today's presentations, a revised Payer of Last Resort Tool, and data from the Consumer Listening Sessions. At the June meeting, PSRA will also approve final FY 2013 spending and reprogramming plans. The July 15, July 29 and August 12 meetings will be 3 hours in order to complete the ranking and allocations for the FY 2014 application. In response to a question from Ms. Gilborn, *Mr. Harriman* stated that consultant Jessica Wahlstrom will again coordinate the application, with various DOHMH staff contributing appropriate sections.

Agenda Item #3: CHAIN

Dr. Messeri presented on service needs and utilization, which is key to assessing the consumer priority criterion in the PSRA ranking tool, beginning with a brief overview of the prospective CHAIN cohort. The study looked at two constructs: does a respondent need a service (based on objective criteria for each service category), and is a respondent receiving that service (based on minimum criteria). Data was

compiled from 1,229 CHAIN interviews completed with 724 New York City residents, and an additional 400 surveys have been done with no basic change in trends.

Dr. Messeri presented findings for each of 19 service areas, such as ambulatory outpatient care, alcohol and drug use services, mental health services, etc. New areas in this version of the study included: Standard of HIV Medical Care; Nutrition Counseling; Permanent Housing Placement; Housing Stability; Rental Assistance; and Long-Term Rental Assistance.

Key finding include: 1) rental Assistance and long-term housing stability are service areas with increased needs; 2) permanent housing placement needs significantly decreased; 3) adequate utilization decreased for standard of HIV medical care; 4) adequate utilization increased for ARV treatment support and permanent housing placement; and 5) persons not stably housed reported above average levels of needs and below average levels of adequate service utilization for multiple service areas. Two areas with notably high needs but low utilization are Nutrition Counseling and Food Services.

A summary of the discussion follows:

- The definition of who needs Non-Medical Case Management and AOD Services does not include users of crystal meth, although CHAIN does ask about this.
- Data is needed from a younger cohort, including crystal meth users, to get information on emerging needs and populations.
- The definition of need for ARV treatment support should look at viral load, not just CD4 count. Also, with "test and treat" becoming the standard of care, this expands the pool of potential users of this service.
- Definition of adequate utilization of AOD services does not include counseling and other harm reduction modalities, only outpatient treatment such as methadone maintenance.
- The decrease in the need for permanent housing placement is not necessarily related to the cohort's age, as many people report moving in and out of housing.
- CHAIN does ask questions on housing quality, but the responses are not built into the measures on this report.
- There are women-specific issues that CHAIN asks about, but there is usually not a statistical difference in gender for these measures. The population that has the highest need and lowest utilization in general is active substance users.
- The two populations most under-represented in the CHAIN cohort are the affluent and the under 30. The cohort has added some more recently diagnosed.

Agenda Item #4: Service Category Scorecards

Ms. Feldman-Hay presented the 2009-11 service category scorecards, which summarize spending, units of service, and client demographics over three years. Highlights of the data include:

- Overall there were 49,285 Part A clients and 50,720 rapid tests in FY 2011 (of which 0.8% tested positive). A slight decrease in reported number of clients from FY 2010 is due to adoption of a unique identifier for reporting.
- The high number of HIV-negative clients is due to clients who test negative for HIV and/or who receive short-term low-threshold Harm Reduction services for service categories that target individuals of unknown HIV status. Effective March 2012, HIV status unknowns/negatives are only eligible for testing and no other Ryan White services.
- The percentage of unspent funds from the modified spending plan remains at record low levels (0.9% in FY 2011).

- Overall, as of FY 2011, 41.5% of Part A clients are female (virtually all women of color). Forty-eight percent are African-American/black, 36.6% Latino/Hispanic, 24% in their 20s, 19% in their 30s, 25% in their 40s and 27% over 50. About 5% are immigrants (although documentation status is not recorded).
- Some special populations may be under-represented because programs were not required to report them in eShare or AIRS.
- The testing data from the Harm Reduction category is reported under Early Intervention and accounts for the high number of HIV-negative/unknowns.
- The service units reported for Food and Nutrition might be artificially low due to deliverables-based payment and the client-level database transition in newly re-bid contracts.
- In FY 2011 a new category, Transitional Care Coordination, began, and programs are included with MCM. Units of service are not included for Care Coordination (MCM) contracts because they were not required to enter services in AIRS during FY 2009 and 2010. Beginning in FY 2011 they entered services in eSHARE, but they do not project units of services. Therefore, actual enrollments against projected enrollments are shown.

An error on the amount of under-spending in the Mental Health scorecard will be corrected. Next year's scorecards will have new special populations (transgender, young MSM, homeless/unstably housed) as well as primary care status measures.

There being no further business, the meeting was adjourned.