



Meeting of the
PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

May 4, 2011
Cicatelli Associates, 505 Eighth Ave.
3:05 – 5:00 pm

MINUTES

Members Present: Marya Gilborn (Co-chair), Allan Vergara (Co-chair), Victor Benadava, Sean Cahill, Felicia Carroll, Nancy Cataldi, Sharen Duke, Joan Edwards, Linda Fraser, Judy Juster, Fabienne Laraque, MD, MPH, Kali Lindsey, Matthew Lesieur, Amanda Lugg, Sharon Mannheimer, MD, Hilda Mateo, Jan Carl Park, Tom Petro, Dena Rakower

Members Absent: Steve Hemraj, Deb Marcano, Leonardo Vicente, Susan Wayne

Staff Present: David Klotz, Graham Harriman, JoAnn Hilger, Mary Irvine, Yoran Grant, Beau Mitts, Rafael Molina, John Rojas (DOHMH); Rachel Miller, Gucci Kaloo, Bettina Carroll (Public Health Solutions)

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

Ms. Gilborn and Mr. Vergara opened the meeting followed by introductions. Ms. Mateo introduced the moment of silence. Mr. Klotz reviewed the meeting packet. The minutes of the March 2, 2011 meeting were approved with no changes.

Agenda Item #2: Care Coordination Update

Mr. Harriman introduced a report on the implementation of the Care Coordination (CC) program. The 28 CC programs were allocated \$22,445,575 in FY2011-12 base and MAI funds, with 16 contracts at hospitals and 12 contracts with community based organizations (including community health clinics). As of February 2011 3276 (77.9%) of 4,206 projected 2010-11 clients were enrolled in Care Coordination. Primary challenges with enrollment included hospital and community staff hiring difficulties, medical provider buy-in, and that enrollment increased significantly at end of year.

Dr. Grant presented data on performance measures for FY 2010, the first year of the program, in four key areas: Enrollment and Demographics; Primary Care Status Measures (PCSM); Key Medical Case Management indicators; and Cross-service Category Outcome Measures. Dr. Grant reviewed the program goals: 1) Ensure that patients maintain a stable health status; 2)

Ensure that PLWHA are linked to care in an efficient manner; 3) Maintain patients in care via medical care/social service navigation; 4) Teach and support treatment (medication) adherence; 5) Support and coach patients to achieve self-sufficiency.

CC has the largest percentage (99.3%) of active clients among all enrolled clients of all service categories. This includes clients in all tracks of the program. Dr. Laraque explained that there are five tracks, based on need, ranging from client who do not need anti-retroviral (ARV) drugs to those who need daily directly observed therapy (DOT).

CC clients are similar to the other Ryan White Part A clients with regard gender, age, race/ethnicity and borough of residence. A larger proportion of Care Coordination clients compared to the portfolio overall have detectable viral load (45.8% vs. 21.5%) and/or have CD4 counts under 200 (31.1% vs. 14.9%) at baseline. This shows that CC is reaching clients who are in greater need of this service and are more difficult to keep in care than the general pool of Part A clients.

The four main PCSMs are: primary care provider provider (PCP) visit frequency; antiretroviral therapy treatment status (on or off ARVs); viral load (test dates and values); and CD4 (test dates and values). Measures were done by breaking the year into equal trimesters. CC showed some improvement on PCP visit reporting in trimester 3, despite known lags in documentation. CC providers documented ARV status somewhat less regularly than they did PCP visits, but this difference in performance between these two indicators is common in AIRS reporting (reporting should improve with the switch to the eSHARE system). CC displayed the highest rates of viral load documentation in the 2010 grant year, having viral load and CD4 data entered for 50%-79% of their clients throughout the year.

There are two main outcome measures: antiretroviral adherence, and engagement in care. For all Care Coordination key outcome indicators, eligible clients have to have been continuously enrolled in MCM for the entire trimester (i.e. have a CC enrollment date before the start of the period and NO program closure date prior to the end of the period). In the first year of program implementation, CC programs continuously increased the proportion of clients with greater than or equal to 95% adherence to antiretroviral therapy. In the first year of program implementation, CC programs did a fair job of documenting engagement in care. Limitations for this indicator include incomplete data and reporting lags in AIRS. Other measures examined were ARV need met, viral suppression, and immunologic health (CD4 counts). There is no data yet on ARV resistance.

In summary, CC showed relatively high reporting on lab tests; overall ARV adherence among CC clients increased by trimester 3 with approximately 75% of clients with adherence \geq 95%; CC programs were relatively successful in engaging clients in care (average of 79% in trimester 1 and 2); 90% of CC clients with documented need for ARVs were reported to be on ARVs in trimester 3; 22.1% of CC clients with CD4 below 200 improved to at or above 200, while 87.2% maintained CD4 at or above 200; and 37% of CC clients starting out detectable achieved viral suppression during this year, while 84% maintained already suppressed viral load. A limitation of the data is that results on outcomes reflect data on PCSM that are not complete for individual clients over time or across the population. It is in part due to this concern about

representativeness of the evaluation data that DOHMH is transitioning Ryan White and Prevention programs to a new data system (eSHARE).

Mr. Kaloo reported that of the \$22.4M committed to CC in base and MAI in FY 2010, \$20.9M was spent, leaving \$1.46 (7%) unspent. The unspent funds were reprogrammed according to the Council's plan. In the first year, the contracts were mostly deliverable-based (e.g., staff hiring). In FY 2011, the programs will have a fee-for-service and milestones-based payment structure based on the client's track. The goal is to move clients towards self-sufficiency and to pay for milestones towards reaching their goals.

Mr. Mitts reported that \$500,000 had been spent on training approximately 350 staff in fourteen 10-day trainings. As this was the first year, all staff had to be trained. In FY 2011 training costs will be far less, with some refresher trainings and "train-the-trainer" trainings to build capacity in the agencies to train their own staff.

In response to a question from Dr. Cahill, Dr. Laraque and Ms. Hilger explained that it is not possible to compare the performance of the CC programs with the former Case Management, Maintenance in Care and Treatment Adherence programs as CC is a different, more intensive and comprehensive model. Ms. Rakower stated that it will be more important to examine improvement over time from baseline measures.

Mr. Lesieur urged the grantee to provide materials in advance of meetings. Mr. Park responded that this is the intent, when possible, but that DOHMH's recent move has caused some difficulties.

Agenda Item #3: FY 2011 Reprogramming Plan

Ms. Gilborn presented the draft FY 2011 reprogramming plan, based on the FY 2010 plan with the following ranked items: 1) Restore \$1M reduction to ADAP; 2) Grantee flexibility to move funds between categories; 3) Purchase of rapid test kits; 4) ADAP/ADAP+.

Ms. Hilger explained that current contracts where testing is performed (Early Intervention and Harm Reduction) separate out the cost of purchasing test kits. After these contracts end (Sept. 2011 for EIS, Feb. 2012 for HR), the new costs will be included in the reimbursement rate and any enhancement would be covered under reprogramming item number two.

There was consensus that the 15% cap on moving funds between contracts applies only to enhancements and the description in the reprogramming plan will be adjusted to make this clearer. In response to questions from the Committee, it was clarified that the grantee reports regularly on modifications to the spending plan to the Finance Committee, which in turn reports to the full Council. Ms. Miller said that it is possible to give a report to the full Council on reprogramming.

The reprogramming plan will be formally approved after the announcement of the full FY 2011 Part A grant award. Mr. Park reported that HRSA is expected to release the full award in June.

Agenda Item #4: Other Business

Mr. Klotz reported that at its recent TA visit, HRSA strongly recommended that PSRA membership be restricted to Council members. The rationale is that priority setting and resource allocation are the core functions of the Council and should only be conducted by mayorally-vetted members. The Council is expected to vote later this month to amend its bylaws accordingly. Current PSRA members may continue through the remainder of the term as non-voting members. Those who are appointed to the Council will have the opportunity to be assigned to another committee (e.g., Integration of Care).

There being no further business, the meeting was adjourned.