Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, June 12, 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), Victor Ayala, Randall Bruce, Broni Cockrell (by phone), Graham Harriman, Steve Hemraj (by phone), Jan Hudis (by phone), Matthew Lesieur, Jesus Maldonado, L. Freddy Molano, M.D., Jan Carl Park, Kimberleigh Smith

Members Absent: Joan Edwards, Amanda Lugg, Claire Simon

Other Council Members Present: Paul Carr, Tim Frasca

Staff Present: David Klotz, Darryl Wong, Melanie Lawrence, Ashley Azor, Scarlett Macias, Tran Trang, Tabitha Julien, Jennifer Carmona, X. Pamela Farquhar, Christina Rodriguez-Hart *(NYC DOHMH)*; Bettina Carroll, Gucci Kaloo *(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 May 8, 2017 meeting were approved with one minor change.

Agenda Item #2: Public Comment

M. Brown: The advances in HIV prevention and care in NYC should be applauded, especially compared to places such as Jamaica and Cuba, where rates are rising quickly.

Agenda Item #3: FY 2018 Application Spending Plan

Ms. Duke and *Mr. Baney* explained that the PSRA and Council need to approve a draft spending plan for the FY 2018 application. The amount the EMA will be able to ask for may be issued in the application guidance (due in August). The final award for the current year (FY 2017) is still not known, but it expected before the next PSRA meeting and would be used as the baseline for planning for the application spending plan. One idea is to ask for an increase (up to the allowable cap) earmarked for Housing Services, given the extensive data that can be cited in the grant application on additional need for this service from the Community Briefing and from data presented to PSRA by Ms. Farquhar on the declining HOPWA award. Given that people are living longer with HIV, continued new infections, the greater cost of doing business for providers and the increasing need for Housing, the EMA can make a strong case in the grant application for the severe need in the EMA, which can help increase the

supplemental award and partially offset the expected continuing reductions in formula funding. The EMA is not bound by the application spending plan, and will have all autumn and winter to plan for the actual spending plan. A motion was made, seconded and rejected to table the discussion to the next meeting.

Points raise in the ensuing discussion include:

- Other ideas for an increase should be considered, including targeted increases to other service categories, and an across-the-board increase to cover the rising cost of providing services for all providers.
- Over- and under-performance in service categories should be considered when recommending increases to any service categories.
- One approach could be a hybrid of targeted increases (e.g., to Housing), with an across-the-board increase based on service category rank.
- The Council should register their displeasure with HRSA on the cap (which is also in place in grant programs throughout the federal government under the new administration).

Spreadsheets with the final FY 2017 award and various increase scenarios for the application will be presented at the July PSRA meeting for further discussion.

Agenda Item #4: Long-term Scenario Planning: Transitional Care Coordination (TCC)

Mr. Baney and Ms. Duke introduced the presentations on TCC as a reminder that the PSRA is seeking to learn more about this service category in the context of the entire Part A portfolio.

Ms. Macias and *Ms. Tran* presented on TCC Quality Indicators and Provider Feedback. Quality indicators are data on enrollments, individual services and referrals & appointment tracking from Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE). Provider feedback is from FY 2016 and a May 2017 provider meeting.

Quality indicators are process or outcome measures used for quality improvement and is a tool to measure a specific aspect of care and services that is optimally linked to better health outcomes. The purpose of quality indicators is to help us understand program performance and challenges around core client services to ensure the highest quality of care. Other service categories have similar quality indicators that are also used for quality management. For TCC, the following program activities have the attached indicators (note: "linkage" is defined as referral and ensuring that the client received the service through follow up):

1. Discussion of housing options with clients – percentage of clients who received a housing linkage
2. Identifying an appropriate case management program for client – percentage of clients who received a case management program linkage
3. Follow up with medical provider and patient regarding medical appointment – percentage of clients who received primary care linkage
4. Health promotion – percentage of clients who received 3 health promotion services within the first three months of enrollment

Housing program linkage has varied from a high of 49.4% in FY 2014 to a low of 28.3% in FY 2016. Linkage was verified in eSHARE, but the ultimate outcome of who was successfully housed is not known. By far the primary concern of RWPA-funded TCC agencies is linking clients to housing.

Case management program linkage ranged from 15.1% in FY 2012 to 28.5% in FY 2015. TCC is meant to be short-term to stabilize the client and connect them to longer-term case management (e.g,. Care Coordination, Health Homes). Case management linkage is often the most challenging for agencies. Many clients no not need or want it. Health Homes count as linkage to case management and some are already enrolled, but some are not aware of their enrollment or uncertain of how to connect with or receive services from case managers.

Primary care linkage ranged from 37% in FY 2012 to 61.5% in FY 2015. For client with the most needs, primary care is often secondary. Health promotion was a high of 82.3% in FY 2013 and 71.1% in FY 2016.

Clients come into the program with a wide range of issues, often out of care or newly diagnosed with limited knowledge about HIV. A summary of the indicator results are: 1) decrease in proportion of clients completing primary care linkage and case management program linkage for the first time since Y22; 2) continued decrease for the housing program linkage since Y24 with the largest drop occurring this contract year; 3) continued decrease for the health promotion indicator since Y23.

Provider comments were presented about the TCC mode. *Short-term Intervention:* "We need to address clients only being in the program for one year. [There's] not a full understanding of all the issues that clients have…Other service categories are not equivalent." *Health Promotion:* "Many clients are new and didn't have this level of care before and love learning. It's like the blue print to their independence." *Outreach:* "Clients coming to us with lots of needs, we try to help them get on their feet. We look for them when they're lost to follow up. It's about connecting the people out of the system to the system."

The following is a summary of the ensuing discussion:

- TCC, unlike Medical Case Management/Care Coordination (MCM/CCP), does not require a medical referral.
- TCC is more of a low-threshold bridge to care with the goal of connection to key longer-term services (housing, case management, medical care).
- TCC providers do not have the manpower to go to every SRO and shelter, especially in the Bronx where many are clustered.
- TCC is touching a lot of people, but the issue in not accomplishing its goals may be related to the program design.

Ms. Julien presented on TCC, non-Medical Case Management (NMG) and MCM/CCP Linkage to Housing Placement. Background was provided on the three different Part A-funded models. NMG = Provide advice and assistance to individuals living with HIV in obtaining medical, social, legal, and financial counseling, and other needed services to improve their physical and mental health status. CCP = Provide comprehensive medical and care coordination services to individuals living with HIV. Model ensures clients maintain a stable health status, are linked to care, retain clients in care through medical and social service navigation, teach and support HIV self-management, and provide health promotion. TCC = To improve the care of HIV + individuals who are homeless and/or unstably housed by ensuring entry into and continuity of primary medical care and providing linkage to housing services and other social support services.

Background was also provided on HOPWA, which serves about 2000 people and targets low-income PLWH who are homeless or unstably housed. The HOPWA service portfolio includes: rental assistance, housing placement assistance, and supportive housing. The NYC HIV/AIDS Services Administration (HASA) also provides public assistance, housing assistance (including emergency housing, transitional

housing, permanent supportive housing, and rental assistance) and case management to about 36,000 people annually. The Ryan White Part A Housing Program serves about 1200 clients with short-term rental assistance, short-term supportive housing (~ 24 months), and housing placement assistance.

An analysis of the population showed that newly enrolled TCC, NMG or MCM clients with a completed Intake Assessment between 3/1/2014 –9/30/2015 were clients who were unstably housed or homeless at enrollment and who were not in transitional or permanent housing at enrollment. One outcome measured was improved housing (from unhoused/unstably housed to Non-emergency temporary/ permanent housing) at first placement within 12 months (i.e., is there an improvement in housing status at first placement within 12 months post- TCC, NMG, and MCM enrollment? Is there any difference between TCC and MCM/NMG?). Another outcome measured was improved housing anytime within 12 months (i.e., after 12 months of enrollment, what proportion of unstably housed TCC, NMG, and MCM clients are placed in improved housing? Is there any difference between TCC and MCM/NMG?). It was noted that the program that did the linkage got the credit for the eventual placement. There are also non-emergency Housing Placement Types: HOPWA housing placement, RW housing placement, and HASA stable housing placement (independent living, permanent supportive housing only).

A summary of the results are: Housing improvement at first placement – 31.9% of TCC, and 27.7% of MCM/NMG programs. Housing improvement at any time within 12 months post-enrollment – 50.8% of TCC, and 42.4% of MCM/NMG. Conclusions were: There was a 30% improvement in housing status among all TCC & NMG/MCM clients at first placement within 12 months after enrollment. More TCC clients had an improvement in housing status at first placement, compared to MCM/NMG (32.9% vs. 27.7%, respectively. Among all TCC, NMG/MCM clients, about 47% were ever placed in permanent or temporary housing within the 12 months after enrollment. More TCC clients were ever placed in temporary or permanent housing, compared to MCM/NMG (50.8% vs. 42.4%, respectively).

There was a comment that these seems to be good indicators for TCC, but a fuller picture is needed.

The next meeting will be held on July 10th. There being no further business, the meeting was adjourned.