Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Wednesday, June 13, 2012
LGBT Center, 208 W. 13th Street, Room 301
2:10 – 5:05 pm

M I N U T E S

Members Present: Marya Gilborn (Co-chair), Victor Benadava, Nancy Cataldi, Sharen Duke, JoAnn Hilger (for Graham Harriman), Amanda Lugg, Deb Marcano, Hilda Mateo, Tracy Douglas Neil, Jan Carl Park, Tom Petro, Dena Rakower, Leonardo Vicente III

Members Absent: Felicia Carroll, Robert Cordero, Joan Edwards, Peter Laqueur, Allan Vergara, Dorella Walters

Staff Present: David Klotz, Darryl Wong, Nina Rothschild, Rafael Molina (DOHMH); Rachel Miller, Lauren Feldman-Hay, Bettina Carroll, Rozzano Trotman (Public Health Solutions)

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

Ms. Gilborn opened the meeting followed by introductions and a moment of silence. The minutes of the May 9, 2012 meeting were approved with no change.

Agenda Item #2: Revised Priority Setting Tool

Mr. Klotz presented the revised ranking tool based on the changes made at the previous meeting. The scores for previously existing categories are from FY 2012 and will be re-ranked in the coming sessions, but have been recalculated with the new criteria weights. The 2 new categories (Non-medical Case Management, Health Education) have been left at 0 value and will be ranked by the committee. They have been temporarily placed underneath the categories they were pulled out of (Medical Case Management and Early Intervention respectively).

Agenda Item #3: Service Category Report Cards

Ms. Feldman-Hay presented the Service Category Report Cards, which have data from FY 2008-10. Data on the report cards includes (by service category): number of contracts, spending plan allocation, modified allocation, percentage expended, frequency of contractor issues, projected and actual units of service, client breakdown by HIV status, special population, gender, race/ethnicity and age. The data is from the old AIRS reporting system; future data will be more eShare and be more extensive. Highlights of the data and discussion follows:

- Providers are not required to report special populations (which are determined by the Needs Assessment Committee) and may be under-reported.
- Data on these populations should be required if we are trying to evaluate service delivery to them, but NAC needs to assess the populations they want to focus on.
- For Base programs overall, 57.9% of clients were male and 41.4% female; 44.8% black, 39.4% Hispanic, 9.3% white and 1.4% Asian/PI; the clients tend to be older (54.3% over the age of 40).
- Legal Services contractors have consistently provided more than the projected units of service. Over-performance does not necessarily mean that the providers did not get paid for providing the extra service. Agencies may have been able to provide services for less per client or donated in-kind.
- The scorecards will be more useful for the allocation portion of planning than ranking. Over-performance does not necessarily indicate greater value of a category.
- The Early Intervention category has a high number of HIV-negative and unknowns due to the testing programs. The number of clients has dramatically increased each year in this category due to the ramping up of testing programs.
- The increase in the amount of unexpended funds in FY 2010 for Food & Nutrition programs is probably due to programs winding down in the last year of their contracts.
- The high percentage of immigrants served in Emergency Rental Assistance programs is likely due to the fact that the service is for non-HASA eligible people, and that the sole provider in this category targets this population.
- Women of color are disproportionately represented among Home Care clients.
- The high number of HIV-negative and unknown clients in Harm Reduction programs is due to clients receiving low threshold services under the old service model.
- Medical Case Management programs have an average cost of about $6,000-7,000 per client, which is close to what was expected for this high intensity service. The outcomes of the programs (treatment adherence and other primary care status measures) have been positive.
- The decrease in the number of Mental Health contracts and allocation represents a "right-sizing" of the category as providers limit the number of eligible clients. The percentage of unexpended funds has gone down concurrently. IOC may want to look at a new model similar to State-funded programs that provide MH readiness.
- The big decrease in number of contracts (and clients) in Outpatient Medical Care represents the fact that this category is now limited to bridge care programs linked to MCM.
- Supportive Counseling programs have consistently exceeded the projected units of service.
- For MAI programs overall, 52.*% were male, 46.9% female; 92.5% are people of color. Data on units of service for MAI MCM programs are not available.
- There are no scorecards for the Tri-county portion of the grant due to lack of staff resources.
- A pattern of over-performing can indicate an emerging need or gap in service, but not necessarily. Trends must be examined, rather than individual years so as not to take an idiosyncratic year as an indicator.

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

Dr. Messeri presented data on service needs and utilization in the NYC CHAIN cohort from 2009-11. He noted that the CHAIN cohort is comparable to Ryan White clients. A subpopulation analysis was done with the CHAIN cohort subdivided by gender, race/ethnicity, age, borough of residence, mental health, housing status, illicit drug use, type of medical care provider, country of birth. Subpopulations with "Unusually High Need" were identified (i.e., 10% or more above need for the entire cohort), and with "Unusually Low Adequate Utilization" (i.e., 10% below adequate use for the entire cohort. Each category had its own definition of who needs the service (e.g., MCM = no primary care in past 6 months, missed one or more appointments, etc.), and adequate utilization (MCM = a case manager helped connect client to care in past 6 months). The following is a summary of the data and ensuing discussion:

- 40% of CHAIN clients needed MCM, and of those, only 20% adequately utilized the service.
- Groups with unusually high need include those with poor mental health, current drug users, unstably housed and those born in Puerto Rico.
- Puerto Ricans are broken out of the larger group of those born outside the continental US because of their large numbers and distinctness of the group as US citizens. Also, Puerto Ricans are counted in the larger group of Latinos.
- 37% of the CHAIN cohort needs treatment adherence support and 58% adequately use the service. Blacks, drug users and homeless have poorer than average utilization.
- 51% of the CHAIN cohort needs mental health services and 71% adequately use the service.
- Substance abuse services measured in CHAIN are mostly traditional drug treatment and not low threshold harm reduction, and thus are not necessarily comparable to Ryan White services.
- 91% of CHAIN participants have some food insecurity, but only 46% adequately meet their need for food services. Numbers are similar for nutrition counseling. Food insecurity is correlated with poor connection to medical care.
- The number of people who need housing placement has dropped and the number adequately utilizing the service has increased. This could be related to the fact that this service often takes over a year to come to fruition.
- Rental assistance, however, is a huge need (86%), but is highly adequately used (83%).
- The service area with the biggest gap between need and adequate utilization is food and nutrition. It is not clear if this is because of an access issue, or capacity issues with providers.

The above data, along with the Medicaid and Health Homes data presented at the previous Council meeting will be the data set used for the upcoming ranking and allocation exercise.

There being no further business, the meeting was adjourned.

The next meeting will take place on Wed., June 27, 9:30am-12:30pm at Cicatelli Associates.