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

Wednesday, June 27, 2012
Cicatelli Assoc., 505 Eighth Avenue, 20th floor
9:40 am – 12:35 pm

M I N U T E S

Members Present: Marya Gilborn (Co-chair), Allan Vergara (Co-chair), Victor Benadava, Nancy Cataldi, Sharen Duke, Graham Harriman, Peter Laqueur, Deb Marcano, Hilda Mateo, Jan Carl Park, Tom Petro, Dorella Walters

Other Council Members Present: Randall Bruce

Members Absent: Felicia Carroll, Robert Cordero, Joan Edwards, Amanda Lugg, Tracy Douglas Neil, Dena Rakower, Leonardo Vicente III

Staff Present: David Klotz, JoAnn Hilger, Rafael Molina (DOHMH); Bettina Carroll, Gucci Kaloo (Public Health Solutions)

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

Ms. Gilborn and Mr. Vergara opened the meeting followed by introductions. The minutes of the June 13, 2012 meeting were approved with no change.

Agenda Item #2: Public Comment

Mr. Klotz read a letter to the PSRA from clients of various food and nutrition programs (FNS), including God's Love We Deliver, La Nueva Esperanza, Harlem United and Project Hospitality. Approximately 300 letters were received, some personalized, all stating the importance of food and nutrition services (FNS) to the health and quality of life of PLWHA and asking the PSRA to give a high priority to this service category.

A. Wassung (God's Love We Deliver): FNS is vital to the management of HIV and is linked to improved health outcomes in the CHAIN study. Food insecurity (reported by 42% of CHAIN participants) is linked to missed medical appointments, detectable viral loads and higher CD4 counts. Malnutrition can lead to hospitalization, which is far more expensive than providing FNS. FNS will still be mostly not covered by Medicaid (only in long-term care plans).

J. Shields (GLWD): FNS is used at all stages of HIV disease, includes a wide range of services, from pantry bags to home-delivered meals, and serves people in all five boroughs. 90% of FNS

clients live below the poverty line, and without the service, they would face possible institutionalization or hospitalization. FNS program meals are specially designed for PLWHA and to cope with co-morbidities.

S. Robertson (GMHC): FNS enhances health, maximizing the benefits of medications. They also help break clients' isolation and link them to primary care, mental health, and other services. With recent fiscal difficulties and growing need, there is a 0ne-year waiting list for pantry services at GMHC, showing the continuing high priority for this service.

S. Grant (Heritage Health and Housing): Enrolment in our FNS program has grown ten-fold this year. The program allows clients to take their medications and serves clients in SROs where they usually have no access to kitchen facilities to cook their own food. Meals provided are calorie- and protein-rich and full of fresh ingredients.

A. Garcia (ACQC): Funding for food vouchers, particularly for undocumented immigrants, has been reduced, putting an extra strain on Part A-funded FNS.

In response to a question from Mr. Park, it was noted that recent AIDS Institute FNS programs have been cut, particularly to home-delivered meals.

Agenda Item #3: FY 2013 Priority Setting Tool

Mr. Klotz reviewed the revised ranking tool, including the definitions of each criterion and the changes made at previous meetings. The scores for previously existing categories are from FY 2012, 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. *Ms. Gilborn* reviewed the process for ranking the priorities in order with any changes to be based on the date presented at the previous meeting and at the Council.

There was a brief discussion about whether the entire Council should be involved in the priority setting process. It was noted that half the Council members are voting members of PSRA, and that all PSRA decisions are reviewed and approved by the Executive Committee and full Council. The Rules & Membership Committee can consider for next year whether or not to expand PSRA's membership. The Committee then began its review by service category:

ADAP/ADAP+: Christine Rivera will be asked to provide information concerning ADAP's needs for FY 2013 for the allocation portion of the planning.

The Committee voted to maintain the current rankings for ADAP and ADAP+.

Outpatient Medical Care (OMC/Bridge Care): *Ms. Carroll* provided a definition of the service (non-reimbursable primary care provided in non-clinical settings, such as SROs). Points made in the discussion of this category were: reimbursement has declined, the service is linked to MCM programs; the grantee is looking at why some providers did not renew their contract; patient navigation was added to the service model; the number of clients is small but the service is vital for that population; HRSA does not allow this service to be defined as MCM and so it can not be rolled into that category; it is difficult to get consumer priority data for this due to the small and

disconnected group of eligible clients – CHAIN or the Needs Assessment Committee should address this.

It was pointed out that, even when new data is not available (e.g., no consumer focus groups or CAB survey since 2009), providers can give anecdotal evidence as they serve the population. In general, PSRA needs to note what data is needed or needs to be updated for the next year's process, but that the Committee must use the available data for this year.

The Committee voted to maintain the current rankings for OMC.

Medical Case Management (MCM): Points made in the discussion of this category were: the state will be implementing Health Homes regardless of the outcome of the Supreme Court decision on the Affordable Care Act (ACA); Health Homes are distinct from MCM in that they are not paying for treatment adherence support, the State is only enrolling those in Medicaid Managed Care plans, and payment rates for services are much lower than MCM meaning that services are less intensive; Health Homes contracts will not be fully operational until the end of the Ryan White 2013 fiscal year; the State has not resolved how they are going to coordinate with Part A MCM programs.

The Committee voted to maintain the current rankings for MCM.

Non-Medical Case Management (Transitional Care Coordination for Prison Releasees/PRS): *Ms. Carroll* provided a definition of the service (connecting released prisoners post-discharge to primary care, with follow-up; no actual primary care; the drop-in center was rolled up into this category). Points made in the discussion of this category were: unlike NYC Depts. of Corrections or Probation programs, this service focuses on the HIV population; Part A funds the DOC HIV-specific program and is thus the only payer; the program has connections with providers to ensure connection to care within 30 days; in the absence of specific consumer data on this category, the score for that criterion should be the same as MCM, the category that PRS was extracted from; a presentation on this service model is needed in the future.

The Committee voted to rank PRS as 8 (POLR), 8 (ATC/MIC), 8 (Consumer Priority), 5 (Gaps/Needs).

Housing: Points made in the discussion of this category were: the only substantive change in the service model under the new guidance is a consolidation of target populations; Medicaid will provide $60M in new services, but they are not HIV-specific; there is an increase in homelessness and a decrease in the amount of affordable housing; data is needed on HOPWA allocations and how they are similar to or different from Part A services; data is needed on waiting lists for these services.

The Committee decided to defer ranking this category until the above referenced additional data is obtained.

Mental Health (MH): Points made in the discussion of this category were: the reduction in the amount of contracts has "right sized" the category so that under-spending has declined; while

50% of the CHAIN cohort reports need for MH services, this is lower than other categories and the percent of those who need the service who adequately utilize it is high; the implementation of the HRSA monitoring standards has not changed the amount of clients the providers report they can serve.

The Committee voted to maintain the current rankings for MH.

Health Education (Positive Life): Before ranking this category, the Committee asked that data be presented on: the number clients served in 2011, the percentage of PL clients served who were newly diagnosed, and any available evaluation information (such as pre and post-test results).

The ranking process will continue at the next meeting, which will take place on Wed., July 11, 2-5pm at Cicatelli Associates. One additional meeting is scheduled for Wed., July 18 to complete the allocation process and develop a preliminary spending plan for the FY 2013 application.

There being no further business, the meeting was adjourned.