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, July 18, 2012
Cicatelli Assoc., 505 Eighth Avenue, 20th floor
2:20– 5:00 pm

M I N U T E S

Members Present: Victor Benadava, Sharen Duke, Graham Harriman, Peter Laqueur, Deb Marcano, Hilda Mateo, Tracy Douglas Neil, Jan Carl Park, Tom Petro, Dena Rakower, Leonardo Vicente III, Dorella Walters

Other Council Member Present: Randall Bruce

Members Absent: Felicia Carroll, Nancy Cataldi, Robert Cordero, Joan Edwards, Marya Gilborn, Amanda Lugg, Allan Vergara

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

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

Mr. Park and Ms. Walters, acting as co-chairs, opened the meeting followed by introductions and a moment of silence. *Mr. Benadava* expressed disappointment that there was not better attendance from the PSRA members and recommended that in the next planning cycle the number of committee members be increased. The minutes of the July 11, 2012 meeting were approved with no change.

Agenda Item #2: FY 2013 Priority Setting Tool

The Committee continued its review of the ranking tool by service category with Health Education and Risk Reduction (The Positive Life Workshop - TPLW), a peer-led health education workshop series that engages participants learn to take actions to treat or prevent illness and promote their own health. *Mr. Harriman* presented the following information on TPLW:

- From September 2011 through July 2012, 310 participants completed intake, 172 completed the introduction, and 96 completed the intensive workshop.
- 92% were African-American of Latino; 39% were female; 9% were recently diagnosed.
- Pre- and post-test evaluations were done with 64 participants, showing significant increases in self-reported attitudes about: beliefs about HIV (i.e., that it is a manageable

illness), mental health, treatment adherence, risky sex and drug use, self-management, and patient-provider relationships.

- Pre-test knowledge levels were high, but behavior and attitudes improved. Qualitative data suggest demonstrate that the workshop facilitates peer support and social connections.
- 60% of the TPLW funds were spent in FY 2011-12.
- Program accomplishments included: needs assessment and curriculum development, peer facilitator training, workshop pilot, recruitment and retention, and marketing and outreach.
- Plans for the remainder of FY 2012 and for FY 2013 include: outreach and recruitment strategies and engagement of Spanish-speaking participants (including translation of materials).
- Though CBOs and hospitals incorporate self-management strategies for PLWHA in case management and interventions focused on mental health, substance use or harm reduction, these programs tend to address clients' needs via individual counseling. The PWA LTI delivers a self-management program in New York City, the number of participants it serves is low (approximately 30 PLWHA annually).
- The Manatt presentation to the Council reported that coverage for referral services, linkage to care, health education and literacy training that enables clients to navigate the HIV system of care are not separately billable (although some of these services may be provided in the course of a billable medical visit).
- The NYSDOH AIDS Institute reports that Part B funding is not being utilized to fund Health Education.
- The goals of The Positive Life Workshop are for PLWHA to increase engagement in healthcare, improve treatment adherence, and reduce sex and drug-using behaviors that may transmit HIV. Preliminary health outcome survey evaluation found a significant favorable change in participants' attitudes among these three primary goal behaviors for those who completed workshops from March to June 2012.
- In late 2010, HIV-positive peer leaders from agencies in all five boroughs provided guidance to NYC DOHMH regarding the need for and design of a structured HIV self-management program with an articulated curriculum and evaluation component that would allow many aspects of health and wellness to be addressed at once. Focus groups of PLWHA identified the need for a program to facilitate trusted support, especially from peers who have shared similar experiences related to HIV, substance use, or both. Program design reflects these priorities, and analysis of participant performance evaluations suggests that the workshop facilitates peer support and social connections.
- The Positive Life Workshop targets three PLWHA populations who would most benefit from the program – PLWHA with a recent HIV diagnosis, out-of-care, and/or PLWHA who struggle with treatment adherence and/or healthcare engagement. Specific service gaps for HIV health promotion exist for Spanish-speaking Hispanic / Latino PLWHA. The FY2012 allocation funds English-to-Spanish translation of materials supporting the program (Resource Manual and Health Journal), and the workshop plans to offer peer experience groups conducted in Spanish in FY2013.

Highlights of the ensuing discussion included:

- The intent of the program was to enroll 1/3 of all newly diagnosed people. All Part A and prevention testing contracts are required to make referrals to TPLW. It is not known why participation from this group is low – perhaps because newly diagnosed people are not ready for an intensive workshop. New strategies, including co-hosting with providers will hopefully increase participation.
- The development stage focused on reviewing best practices, but the model is open to improvement based on input from the Council and IOC.
- A similar program at Shanti in San Francisco was very helpful and was one of the models for TPLW.
- The TPLW curriculum can be scary and overwhelming for a newly diagnosed person.
- Three-month follow-up outcomes measurements will include self-reported maintenance in care and treatment adherence.
- The CDC has expressed enthusiasm for TPLW and sees value in replicating it. It complements prevention with positives programs.
- CDC funds pay for some similar work, and some elements are provided within clinical contexts or MCM programs, but TPLW is unique, including in its focus on social support.
- TPLW is a cost-based program with three full time staff, 2 interns and about 20 peers who receive a stipend.
- The reasons for TPLW to be a stand-alone service category, rather than part of EIS, were reiterated (HRSA service category definitions, monitoring standards).
- TPLW has a one-time impact, and so its affect on access to/maintenance in care is not strong.
- Other media (e.g., online) should be explored to deliver the trainings.

The Committee voted to rank Health Education and Risk Reduction (TPLW) as follows: 5 (POLR), 3 (ATC/MIC), 5 (Consumer Priority) and 5 (Emerging Gaps).

Agenda Item #3: FY 2013 Preliminary Spending Plan

Mr. Kaloo described the following modifications to the FY 2012 approved Base and MAI spending plans:

Base: ADAP restored by $2,768,244 in order to fund at its full amount; a small reduction of $46 to Food and Nutrition due to contract negotiations; Care Coordination reduction of $34,792 resulted from removing TCC Training ($21,635) and one CC contract was negotiated for less ($13,157); Harm Reduction allocation reduced by $598,771 as a result of an overall reduction of $179,200 to the training allocation within this category for 2013 and an additional reduction of $419,571 from reductions to subcontracts stemming from removal of Low Threshold services to negative clients as well as shifts/increases to the Testing (EIS) portion of several contracts; Outpatient Medical Care reduced by $338,628 due to contract terminations; very small reductions to Legal ($1) and Home Care ($4) from contract negotiations.

Tri-county has approved a spending plan with a fixed dollar amount which is a reduction of $55,555 compared with year 2012. The Tri-County percent allocation comes down to 4.580%

from 4.71%, but Tri-county is entitled to receive 4.71% of the final grant award, based on its share of the HIV cases in the EMA.

In MAI, there is a very small reduction to Early Intervention (EIS) of $323 from contract negotiations. With a fixed dollar amount for Tri-County which is a reduction of $9,259 compared with year 2012. There is $8,656 in uncommitted MAI funds to reallocate. The combined Base and MAI plans without further modification is now 70.89% Core and 29.11% Non-core.

A summary of the ensuing discussion follows:

- The allocation for ADAP should be restored to its full amount. These additional funds are typically where reductions would take place in the case of a cut to the grant award, with the promise of restoration through reprogramming.
- CHAIN data and trends in over-performing from the Scorecards indicates that there is a need to request additional resources for Food & Nutrition (FNS), Housing and Supportive Counseling.
- The issuance of an RFP for Housing will allow for the most practical way to spend additional funds in a service category.
- The PSRA could consider reallocating the uncommitted funds freed up to over-performing categories, then asking for the ADAP restoration on top of that.
- The average of over-spending in the over-performing contracts over recent years is FNS – 7%; Supportive Counseling (SCF) – 15%, Housing – 2%.
- The national budget picture is not promising and there is a likelihood that the national appropriation for Ryan White will decrease, meaning that an increase in the grant award will be difficult to attain.
- There was some discussion about the wisdom of requesting new funds for non-core services, with a consensus that there should be a reasonable request based on needs that can be justified in the grant application narrative.
- A waiver of the core services requirement allows for any percentage of non-core services above 25%, not a specific percentage.
- The overall increase in the spending request should be aligned with similar requests made in past applications.

A motion was made, seconded and approved to reallocate the Base uncommitted funds as follows: FNS - $413,000; SCF – $324,000; Housing – $235,000. The ADAP allocation will be increased by $2,768,244 to restore it to its original allocation. The $8,656 in uncommitted MAI funds will be allocated to ADAP Plus. The overall plan is now 70.25% core services.

Agenda Item #4: FY 2011 Carry-over Plan

The total carry-over from FY 2011, as reported to the Finance Committee, was $1,065,760 (<1% of the grant award). The Tri-county Steering Committee voted to request the use of $60,000 for Oral Health Care to be used to serve 75 patients, providing 50 preventive, 50 restorative, and 5 palliative oral health care services. The balance of Tri-county carry-over, along with the entire

NYC portion of the carry-over will be used for ADAP, as requested in the carry-over waiver request submitted to HRSA in December 2011. $1,005,760 will be used to reimburse for approximately 2,523 prescriptions at an average cost of $398.50 per prescription, which represents about 30 days' supply of drugs for 897 participants, for the period ending February 28, 2013.

A motion was made, seconded and approved unanimously to approve the carry-over plan as presented.

Members were thanked for their commitment through the planning process.

There being no further business, the meeting was adjourned.