Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, July 9, 2014
AIDS Service Center of NYC, 85 University Pl., 5th Floor
2:30 – 4:50 pm

MINUTES

Members Present: Sharen Duke (Co-Chair), Graham Harriman, Jan Hudis, Amanda Lugg, Peter Laqueur, Deb Marcano, Jan Carl Park, Tom Petro, Allan Vergara, Leonardo Vicente III

Members Absent: Matthew Baney, Randall Bruce, Felicia Carroll, Nancy Cataldi, Robert Cordero, Joan Edwards, L. Freddy Molano, M.D., Daniel Pichinson, Sam Rivera

Staff Present: David Klotz, Nina Rothschild, Rafael Molina, Anna Thomas, (DOHMH); Rachel Miller, Bettina Carroll (Public Health Solutions)

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

Ms. Duke opened the meeting. *Mr. Park* led a moment of silence. The draft minutes of the June 23, 2014 meeting were approved with one change to reflect the correct allocation amount for counseling services in syringe exchange programs (see below). Mr. Klotz reviewed the meeting packet.

Agenda Item #2: Reclassification of Services from Mental Health to Supportive Counseling

Mr. Klotz read a letter from the chairs of the Integration of Care Committee (IOC) supporting the reclassification to the Supportive Counseling and Family Stabilization (SCF) category of a portion of the currently funded mental health services (not included in the new MH directive) to provide wrap-around counseling services in State-funded syringe exchange programs. The services are currently funded at $812,733. The reclassification will allow small agencies that can not get Medicaid certification to provide these services.

There was general support of the reclassification in the Committee, and the ensuing discussion focused on how to "memorialize" it in the SCF RFP that is about to be issued. With the reclassification, the current targeted allocation comprises 29% of the total SCF allocation. It was agreed that the amount should not be fixed given the possibilities of a change in the funding for the overall category and the vagaries of who will apply for the funding. There was a consensus that the PSRA should recommend to the Executive Committee and full Council that the reclassification be made with the amount for the targeted allocation (to be noted in a footnote in the spending plan) set at "approximately" 29% of the total service category allocation. **Later in**

the meeting when a quorum was achieved, a motion was made and a vote taken to unanimously accept the recommendation.

Agenda Item #3: Care Coordination Update

Mr. Harriman provided an update on the Care Coordination (Medical Case Management) program. There are 28 agencies (16 hospital-based, 12 community-based) providing CC with caseloads ranging from 52 to 230 clients. There is an active caseload of about 3,300 PLWHA at any time, with 4,986 unique clients served in FY 2012-13. Service sites are concentrated in areas of highest prevalence and serve people at highest risk for sub-optimal health outcomes. Mr. Harriman provided an overview of client demographics and the service model, with its various tracks from lowest to highest intensity and client-centered service components (treatment adherence, navigation, etc.). CC offers services that wrap around services provided by Health Homes (e.g., treatment adherence support, DOT). All contracting agencies were given guidance on how to enroll and serve clients who are also enrolled in HHs.

While enrollment never reached the expected target of 4,500, from FY11 to the present, CC enrollment has remained relatively stable. This is due to the fact that it is a rigorous program with defined medical criteria and not suitable for everyone. The allocation and expenditures have been reduced over the years to match the need.

Recent outcomes analysis by DOHMH matching eShare and NYC HIV registry data shows significant increases in engagement in care and viral load suppression. For example, with CC clients who had been previously diagnosed, VL suppression increased from 32% to 51%. Significant improvements were seen in all sub-groups, with the exception of those of other/unknown race (which may include white people or immigrants who do not identify with established racial categories, such as African immigrants). The greatest improvements were seen among men, people over age 45, the uninsured, and those with CD4 counts <200. Newly diagnosed clients also fared well. These short-term outcomes data will be supplemented by more long-term data in the next stage of the evaluation. Committee members expressed satisfaction with the data. In response to questions from the Committee, Mr. Harriman stated that it is too difficult to measure effectiveness by intensity track, as clients move from track to track depending on need. Also, this kind of research is being done on other categories and being shared with the Council (e.g., Food & Nutrition data was reported at the last Council meeting). This data can be posted on the Council website.

Agenda Item #4: Mental Health Costs and Service Category Ranking Scores

Ms. Duke described her analysis, using the data from the service category scorecards, of costs for MH services, which have remained reasonable. Given that the new service directive does not differ much from the existing services, the costs will likely not need to change.

Mr. Klotz reviewed the rationales for changes in service category ranking scores last year. Given the time constraints and the fact that the Committee did an intensive re-review in the previous planning process, the Committee will re-rank only MH, SCF and Home and Community-based Services (HOM), which will have a new directive approved by IOC before the next meeting.

There was an initial discussion on the scores for these categories. There was some sentiment among the Committee members that, given more explicit language in the new guidance, the MH score in the Access to Care/Maintenance in Care criterion could be raised from 5 to 8. In a poll of the Committee, a majority supported maintaining the current score. There was a consensus to maintain the MH scores in the other criteria as is.

There was discussion on the rationale for increasing the Payer of Last Resort score for SCF from 5 to 8, given that there is no Medicaid funding for these services (including the newly reclassified services in syringe exchange programs). Also, *Mr. Laqueur* reported that the AIDS Institute is reducing funding for these services in NYC. Raising this score to an 8 would give SCF the same score as MH but it would not move in its place in the rankings. A poll of members showed an even split on this criterion score. There was general agreement on keeping the SCF scores in the other criteria, with some members expressing the need to revise them (e.g., Consumer Priority, as *Mr. Petro* reported that Tri-county consumers have expressed a strong need for peer group support).

The final PSRA meeting of the session will take place on Mon., July 21, 2-5pm. The agenda will include ranking three priority categories (MH, SCF, HOM) and developing an application spending plan. The spending plan will be partially informed by information from ADAP director Christine Rivera. Also, John Rojas will be asked to provide information on the impact of the recent $5M cut to HOPWA. The Committee will also consider whether or not to request partial restoration of the severe cut from FY 2013 (which would be weighted based on new ranking scores).

There being no further business, the meeting was adjourned.