Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, September 21, 2015
AIDS Service Center of NYC, 64 W. 35th St., 3rd Floor
3:10 – 4:45 pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney (Co-chair), Victor Ayala (by phone), Randall Bruce, Amber Casey (for Graham Harriman), Julie Lehane, PhD., Amanda Lugg (by phone), Jesus Maldonado (by phone), Claire Simon, Jan Carl Park

Other Planning Council Members Present: Billy Fields

Members Absent: Joan Edwards, Steve Hemraj, Matthew Lesieur, L. Freddy Molano, M.D.

Staff Present: David Klotz, Nina Rothschild, Nasra Aidarus, M. Bari Khan (DOHMH); Bettina Carroll, Gucci Kaloo (Public Health Solutions)

Agenda Item #1: Welcome/Introductions/Re-thinking the PSRA Methodology

Ms. Duke and *Mr. Baney* opened the meeting, followed by introductions and a moment of silence. The minutes of the August 10th meeting were approved with no changes.

Ms. Duke provided the context for the discussion, explaining that Medicaid redesign, DSRIP, Ending the Epidemic and a convergence of metrics to improve quality of care and increase rates of viral suppression will affect the care system. PSRA had asked to review recommendations from the Council's Needs Assessment that might inform our discussion.

Dr. Rothschild presented a summary of the salient points from the Needs Assessment, which was approved by the Council in 2014. The Needs Assessment has four main sections: 1) Major attributes of PLWHA population in NY EMA; 2) Current panorama of policy and funding; 3) Service needs and utilization: discusses trends in involvement in HIV primary care and explains need for and engagement in supportive services that improve connectedness to HIV primary care; and 4) Accessibility and quality of care: focuses on Ryan White clients' encounters with services and opinions about quality of care, as well as emphasizing obstacles to and enhancers of engagement in care. The last two have the most relevance for PSRA's planning.

In section three (Service Needs and Utilization), highlights were: 1) Homelessness and drug use enhance likelihood of later entry into care; 2) More intense involvement in HIV primary care does not always mean better clinical outcomes; 3) Possible explanation for disconnect between engagement and VL suppression: problems staying on treatment because of unaddressed medical and social support needs; 4) Young gay,

bisexual, and other MSM, and homeless and unstably housed individuals may not take sufficient advantage of care options for several reasons, e.g., convenience, other priorities, stigma.

Recommendations include: Investigate connection between engagement in HIV primary care and clinical results to improve grasp of issues possibly interfering with attaining a reduced VL for PLWHA who are intensively involved in care; 2) Study places where PLWHA go for help and the degree of care-seeking at numerous locations; 3) Examine connection between engagement in an individual service category and major consequences, e.g., linkage to and maintenance in care. 4) Investigate connection between engagement in HIV primary care and clinical results to improve grasp of issues possibly interfering with attaining a reduced VL for PLWHA who are intensively involved in care; 5) Study places where PLWHA go for help and the degree of care-seeking at numerous locations; 6) Examine connection between engagement in an individual service category and major consequences, e.g., linkage to and maintenance in care.

In section four (Accessibility and Quality), highlights were: 1) Ryan White clients utilizing supportive services are content with their care; 2) Services with greatest impact on boosting access to and retention in care are among the services with which clients are happiest; 3) Needs pinpointed by clients to diminish barriers: reduced waits to see providers and more easily accessible service sites; 4) Major features of good care: open communication with providers and enhanced guarantees of confidentiality; holistic treatment of clients; a simplified, restructured system with enhanced communication among providers; and additional social support.

Recommendations include: 1) Maintain and enlarge the Client Satisfaction Survey; 2) Restart and completely fund the Tri-County component of the CHAIN study and support ongoing use of DOHMH's Return to Care Survey and additional qualitative and quantitative information to incorporate the opinions of individuals who are not enrolled in the care system or who were disconnected from care for a length of time; 3) Examine information from NYS's Quality of Care Program, CHAIN's Standard of HIV Medical Care Index, and the Part A QM Program and examine approaches for accurately assessing quality of services; 4) Integrate peer navigators into possible service models; 5) Aggregate best practices in service delivery concerning successful organizational arrangements and methods for outreach to clients in order to shape possible service models; 6) Explore provider needs for resources and additional training to enhance quality of care.

For PSRA purposes, the formal needs assessment is primarily a call for more information, not a prescription for action. It does not tell us to increase allocations to specific service categories or add new service categories, and it does not drive the priority setting process. PSRA can address structural issues affecting access and retention (homelessness, unsafe living conditions, lack of food) and consider adjusting service model for clients who are intensively using services but not experiencing reduced viral load (e.g., examine aspects of MCM possibly impeding good outcomes).

The following is a summary of the ensuing discussion:

- The Needs Assessment has few new or concrete recommendations; it is mostly a call for additional data.
- While there are incremental changes in the system (e.g., ending of Section 8 housing), most patterns have been stable for a while (e.g., food insecurity, housing instability). Major changes are still up the road (e.g., DSRIP, Health Homes) that may require new interventions (e.g., cash incentives for VL suppression).
- When thinking about our "target population" there really is none when cut by demographic groups. Rather, the Needs Assessment discusses the need to target services to the populations we already serve.

- There needs to be a focus on people who have trouble getting insured, even under the ACA (e.g., youth).
- PSRA should examine issues with providers and systems that keep people from moving along the treatment cascade.
- The Medical Monitoring Project (MMP) is now doing a random sample through surveillance, which will include people not in care (although data will not be available for a while).
- An examination is needed on the effect of changes on clients (e.g., new more complex Medicaid enrolment forms). Eligibility assistants would be helpful.
- PSRA should focus on eliminating duplicative services in the portfolio and concentrating on those that work best to move people along the continuum, but it is difficult to isolate which services a client receives are funded by Part A (as opposed to other payers). Quality of care makes a big difference in VL suppression.
- Technology changes (e.g., allowing patients to access their electronic medical records on their phones and communicate to their providers) could have an impact on connection to care.
- There is a need to get more providers to accept Medicaid.

Ms. Duke reviewed a spreadsheet derived from the 2012-14 Part A Scorecards and the FY 2015 implementation plan that gives a crude snapshot of costs per client for each service category and its proportionate share of the Part A portfolio. The chart uses the allocation in the modified spending plan (the amount actually spent in each category for the year after reprogramming, etc.) and the unduplicated client count.

It was agreed that the spreadsheet was a good start, with some caveats: the EIS client count is mostly HIV tests and should be discounted. DOHMH should do a more in depth analysis for certain categories to capture nuances, as was done with EIS. Also, there needs to be a way to capture qualitative data and client outcomes data, as exists with MCM. PSRA needs to look at similar service types across categories such as assessment or counseling ("comparing apples to apples"), with the caveat that some categories include collaterals as well as the index client. The most important task for PSRA is to figure out how much we can buy and how to use our limited resources, and to identify costs that do not make sense. *Mr. Kaloo* recommended adding a column to the spreadsheet that would show trends from the previous year.

There was an agreement that DOHMH would work on refining the spreadsheet for the next meeting, after the grant application is submitted.

The next meeting will take place on Monday, November 9, 2015, 3-5pm.

There being no further business, the meeting was adjourned.