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

June 11, 2010
The Family Center, 315 West 36th Street
9:30 – 11:30 am

M I N U T E S

Members Present: Marya Gilborn (Chair), Victor Benadava, Lyndell Urbano (for Sean Cahill, PhD), Felicia Carroll, Nancy Cataldi, Sharen Duke, Graham Harriman (for Fabienne Laraque, MD, MPH), Steve Hemraj, Judy Juster, Peter Laqueur, Matthew Lesieur, Amanda Lugg, Sharon Mannheimer, MD, Deb Marcano, Jan Carl Park, Allan Vergara

Members Absent: Joan Edwards, Linda Fraser, Terry Hamilton, Hilda Mateo, Tom Petro, Dena Rakower

Staff Present: David Klotz, Ellen Wiewel (DOHMH); Rachel Miller (Public Health Solutions)

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

Ms. Gilborn opened the meeting followed by introductions. Ms. Cataldi introduced the moment of silence. The minutes of the May 4, 2010 meeting were approved with one change reflecting Mr. Lesieur's comment on legal services.

Agenda Item #2: Regularity of HIV-Related Medical Care Among Persons with HIV/AIDS in NYC, 2006-2009

Ms. Wiewel presented data on regularity of HIV-related medical care in order for to provide the Committee with information that would be useful in assessing the access/ maintenance criterion in the ranking tool.

Regular HIV-related medical care is useful because for regularly monitoring VL and CD4, initiating ART, preventing resistance, monitoring side effects, initiating OI prophylaxis, addressing other health-related issues, and receiving behavioral prevention services. Consequences of Discontinuous Care include: excess morbidity (T-cell depletion and disease progression), opportunistic infections, increased hospitalizations/ ED visits, excess mortality, preventable cost related to acute care and complications, and

epidemic propagation (high population viral load and continued spread). Evaluating patterns of care assists in planning interventions, monitoring outcomes, improving outcomes by giving feedback to providers, and setting priorities for improving access to and maintenance in care.

The DOHMH HIV Bureau's Care, Treatment and Housing Program has investigated population-based need for medical case management since 2008, beginning with looking at gaps in care by patterns of VLs and CD4s, using data from HIV Epidemiology & Field Services Program (surveillance) on over 60,000 PLWHA. The main findings are: >90% in care in one year will return anywhere next year; <50% who do not return in next year will return in next 2 years; providers can expect to lose 17% of their patients in a given year, due to provider switching or being out of care. Limitations include: a generous follow-up period (one year), does not assess regularity of care for persons who return.

Looking at NYC residents living with HIV as of July 1, 2005, and surviving through August 31, 2006, and receiving care at least once during this 14-month run-in period, the data assesses: Regular utilization of care between September 1, 2006, and September 30, 2009, or death (after the 14-month run-in period); Regularity of care as a measure of maintenance in care ("Regular" is every 7 months, allowing wiggle room around federal guidelines of VL and CD4 count every 3-6 months after entry into care, before and during ART); Measure of demographic, clinical and run-in care factors associated with regular care. An alternative outcomes measured is "Regular" care is every 12 months.

Of the 60,606 persons, 58% received care every 7 months and 79% every 12 months between September 1, 2006, and September 30, 2009, or death. Females and persons of color were more likely than males and whites to receive care at least every 7 months, and at least every 12 months. The youngest and oldest persons, and persons with IDU or perinatal risk, were most likely to receive care at least every 7 months, and at least every 12 months. Clinical factors associated with regular care are: first diagnosed with HIV or AIDS before 2001; ever having been diagnosed with AIDS; CD4 < 350 during the run-in period. Persons with more visits during the 14-month run-in period were more likely to receive care at least every 7 months, and at least every 12 months. Persons not seeing a private MD or visiting a hospital during the 14-month run-in period were more likely to receive care at least every 7 months, and at least every 12 months.

Implications of the findings include:

- Preexisting care patterns are among the strongest predictors of subsequent care patterns
- Persons receiving any HIV-related medical care in a hospital during the run-in period were more likely to have regular care than persons who did not attend a hospital
- Room for improvement at hospitals, too, which did see the majority of persons *not* in regular care
- Further research would be required to explain why hospitals did better
- Sicker persons are more likely to receive regular care – how to encourage regular care among healthier persons, too?

Questions raised by the Committee include:

- Is there data on regularity of care for patients of stand-alone (non-hospital) outpatient clinics?
- Does the lack of wrap-around services (e.g., case management) at private doctor's offices contribute to their lower rate of regularity in care?
- How does this data compare to other cities or other chronic diseases (for context)?
- How does customer service (especially at initial visit) impact return to care?
- Why did the study not examine people who were not in compliance?

Agenda Item #3: Review of the FY 2009 Priority Setting Tool

Mr. Park set the context for the rest of the meeting, noting that this Committee needs to decide on a preliminary priority ranking and allocation for submission with the FY 2011 Part A grant application. Ms. Gilborn reviewed the priority setting tool, explaining the scoring of the five ranking criteria (payer of last resort, promoting access/maintenance in care, consumer priority, addressing specific gaps/emerging needs, and core services).

Highlights of the ensuing discussion included:

- There will be no 2009 scorecard data because the fiscal year only ended in February, with close-out just completed in May, which means that data will not be available until the end of summer, except for Harm Reduction, which is being expedited for IOC's consideration of a new service model. Scorecard data will always be one year behind.
- A re-explanation of the scoring system is needed, i.e., why the scale increases from 5 to 8 rather than only in increments of 2.
- Recent changes in state and city budgets might mean that some of the payer of last resort data needs to be updated.
- Last year, the Committee discusses a three-year planning cycle, meaning that re-rankings would not be necessary every year.
- Many of the issues identified through program performance data have been addressed through the increases assigned to the categories in the FY 2010 award.

Mr. Park summarized the previous year's discussions that lead to the current rankings by service category. Questions that arose from that were:

- Outpatient Medical Care – this category is now a different model (bridge care for those not yet enrolled in a Care Coordination program), and thus the original rationale for the ranking is outdated.
- Harm Reduction – NAC and IOC are reviewing the service model, and so the ranking may have to be revisited based on the new recommendations.
- Food & Nutrition Services – as nutritional counseling will be a required part of all programs, as per the new service model (as of March 2011), there is a question of whether or not this service category should now be considered a core service.

- Outreach – there is a question of whether or not this service should be considered part of Early Intervention, and thus a core service.
- Legal Services – the non-Ryan White funding landscape might have changed over the last year due to city and state cutbacks.

These questions will be further explored at the next meeting, followed by a determination of the allocation amounts for each category.

The next meeting will take place on Thursday, June 24th, 3:00-5:00 pm, at Cicatelli Associates, 505 Eighth Avenue, 2nd floor.

There being no further business, the meeting was adjourned.