Meeting of the
PRIORITY SETTING AND RESOURCE ALLOCATION COMMITTEE
Eli Camhi, Chair

May 1, 2008
3:00-5:00
GMHC, 119 West 24th Street, NY, NY

Members Present: Victor Benadava (alt. for Antionettea Etienne), Sean Cahill, PhD, Eli Camhi, Felicia Carroll, Sharen Duke, Joan Edwards, Marya Gilborn, Terry Hamilton, Steve Hemraj, JoAnn Hilger, Jennifer Irwin, Fabienne Laraque, MD, MPH, Hilda Mateo, Jan Carl Park, Tom Petro

DOHMH Staff Present: Rafael Molina, Nina Rothschild, DrPH, Anthony Santella, DrPH, Darryl Wong

Public Health Solutions Staff Present: Bettina Carroll

Material Distributed: Agenda; minutes from previous PSRA Committee meeting on April 3, 2008; draft of proposed FY 2009 PSRA tool; year 2008 Ryan White BASE spending plan as approved by the Planning Council on March 20, 2008; FY 2007 MAI spending plan approved by the Executive Committee on April 10, 2008; HRSA service category definitions; annotated guide to data sources; Ryan White Planning Council schedule for May 2008; old PSRA tool.

Welcome/Introductions: Eli Camhi opened the meeting. Committee members introduced themselves.

Review of the Meeting Packet and the Agenda: Jan Carl Park reviewed the meeting packet and outlined the role of the PSRA Committee. Committee members accepted the agenda without adding additional items.

Moment of Silence: Committee members observed a moment of silence in remembrance of individuals who have died. This work is life-sustaining.

Review of the Minutes: Committee members voted to accept the minutes with 3 abstentions and no votes in opposition.

Priority Setting Tool: Mr. Camhi noted that the Committee's task is to begin reviewing the proposal for a new structure and format for the priority setting tool. He underscored that the percentages across the top of the draft tool are not definite but, rather, are included for experimentation. The service categories on the proposed tool come directly from the current spending plan. In the draft version, core services receive a score of 6 and non-core services receive a score of 0. Mr.Camhi noted that including a score of 6 or 0 for a particular service category (indicating whether that category is core or non-core) signals to HRSA that the EMA is not oblivious to HRSA's priorities. Mr. Petro inquired whether the last column listing the total percentage has a purpose and suggested eliminating or hiding the column to make the document cleaner. After Committee members discussed the column, Mr. Camhi noted that the proposed tool will be less confusing when it is populated with data. Ultimately, the tool should be self-explanatory. Mr. Camhi also noted that the proposed limitation on the number of scores of 6 that could be assigned was intended to allow us to amplify our emphasis on particular categories. The goal is to develop a tool that can be used for the 2009 budget.

Dr. Cahill examined the old tool and computed the percentages occupied by each of the criteria in that version: Payer of Last Report comprised 25.6%, Access to Care/Maintenance in Care comprised 20.5%, Specific Gaps/Needs was 18%, Core/Non-Core Services was 15.4%, and Consumer Priority was 20.5%.

PSRA Committee members were reminded that in past planning cycles, a formula was used to apply percentage cuts for scenario planning, and service categories that scored lowest lost a larger share of funding than those with higher scores. Mr. Camhi underscored that we are looking at what the community needs in terms of services and are not – at the present time – deciding on spending. Committee members engaged in extensive debate about the relative weight of the five criteria. They noted the problems associated with the Payer of Last Resort tool commissioned by the Planning Council from the New York Academy of Medicine and the potential difficulties associated with keeping the tool up to date as federal law changes. For example, under Administration-imposed Medicaid changes, Medicaid may no longer be able to pay for escorts, in which case the Planning Council would become the payer of last resort for this service.

Ms. Duke asked for a definition of consumer priority and an explanation of how consumer priorities are assessed. Tools for assessing consumer priorities include the CHAIN cohort study of PLWHAs in the New York EMA, Community Advisory Board surveys, focus groups, a survey of clients who are participating in Maintenance in Care programs, and opinions voiced at the Ryan White reauthorization forum. Mr. Petro noted that the original task force that participated in the scoring process on the first version of the PSRA tool struggled a great deal with the consumer priority criteria and used information from consumer forums, but the information emerging from those consumer forums may have been influenced by the relative intensity of the participation of various individuals and may not have been completely objective. Dr. Santella noted that information emerging from the focus groups of consumers currently being conducted under the auspices of the Health Department should fit the proposed model well. Dr. Laraque asked whether DOHMH should have focus groups of consumers each year, a

proposal enthusiastically endorsed by the group. Mr. Hemraj noted that consumer needs are constantly changing and that yearly focus groups are an excellent way to remain abreast of those needs.

Committee members voted to assign the following percentages to the five criteria:

- payer of list resort = 15%
- access to care/maintenance in care = 35%
- consumer priority = 25%
- specific gaps/emerging needs = 15%
- core/non-core = 10%

PSRA Committee members also discussed a potential scoring system. Dr. Cahill pointed out that having four possible scores (for example, 0, 1, 3, and 6) is preferable to having three possible scores (for example, 1, 3, and 6) because having four scores precludes the people assigning the scores from gravitating toward the middle option.

Bettina Carroll read out loud the components of two service categories -- medical case management and maintenance in care. Committee members discussed the problems associated with using the payer of last resort tool to assess whether other funding sources cover the major activities associated with maintenance in care, including return and linkage to primary care. For example, COBRA currently pays for escorts (a component of maintenance in care) but may not do so in the future; other payers may also cover this service, but we don't know the total number of other payers and how extensive or restrictive their coverage is. Ms. Duke noted that COBRA, for example, may not pay adequately for a service, given the intensity of effort required.

Dr. Santella agreed to send a revised version of the tool to PSRA Committee members, who will be able to assign scores of 1, 3, 5, and 8. Mr. Camhi noted that once the members agree on the tool and the process for assigning scores, we will be able to proceed very efficiently.

Dr. Cahill suggested adding the Youth Risk Behavioral Survey and the Health Department's community health profiles to the Annotated Guide to Data Sources.

Mr. Camhi motioned to accept the tool. Al present voted yes with one vote in opposition and no abstentions.

After the scores are assigned by PSRA Committee members, the revised tool will have to be approved by the full Planning Council in June. Committee members agreed to meet again on June 5th from 12:00-5:00 to assign scores. Data, descriptions of the components of service categories, and the payer of last resort tool will be provided by DOHMH and Public Health Solutions staff.

Public Comment: Terry Troia stated that efforts to help PLWHAs get off the street and into treatment and care will not be successful without the provision of food.