FY 2017
Priority Setting and Resource Allocations Report

September 2016

Prepared by:

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interSector Partners, L3C

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Denver HIV Resources Planning Council

Executive Summary

Introduction

The Priorities Workgroup of the Denver HIV Resources Planning Council designed and hosted its Fiscal Year 2017 Priority Setting and Resource Allocations Process on August 12 and 18, 2016. The process leading up to priority setting and allocations sessions included Priorities Workgroup meetings, data training meetings, Leadership meetings and community meetings to inform the process.

Caryn Capriccioso, interSector Partners, L3C, facilitated and documented the FY 2017 process.

Key Decisions for FY 2017

FY 2017 Part A Priority Rankings and Resource Allocations

Priority #	Part A Category	Percent Allocated
1	Outpatient/Ambulatory Health Services	26.65%
2	Medical Case Management	24.06%
3	Oral Health Care	14.13%
4	AIDS Drug Assistance Program	0.00%
5	Mental Health Services	4.88%
6	Housing Services	8.21%
7	Emergency Financial Assistance	3.15%
8	Early Intervention Services	3.98%
9	Substance Abuse Services (Outpatient)	5.03%
10	Health Insurance Premium & Cost Sharing Assistance	0.00%
11	Food Bank/Home-Delivered Meals	3.18%
12	Medical Transportation Services	2.69%
13	Psychosocial Support Services	3.69%
14	Home and Community-based Health Services	0.35%
	Total	100.00%

FY 2017 Minority AIDS Initiative Priority Rankings and Allocations

Priority #	MAI Category	Percent Allocated
1	Medical Case Management	32.18%
2	Mental Health Services	19.78%
3	Early Intervention Services	21.09%
4	Substance Abuse Services (Outpatient)	21.72%
5	Psychosocial Support	5.23%
	Total	100.00%

In making Priority Setting decisions, the Planning Council members considered various data including:

Value	Percent	Count
The Data Booklet and data provided to me for this process	95.8%	23
The needs assessment and discussion of unmet need and service gaps	91.7%	22
The opinions, perspectives and priorities of community members and consumers	83.3%	20
Presentations from HIV/AIDS professionals throughout the past year	75.0%	18
The opinions and perspectives of other members of the Planning Council	75.0%	18
My professional expertise/knowledge (e.g. service provider, board member, etc.)	75.0%	18
HIV Care Continuum	75.0%	18
Assessment of services in communities of color	70.8%	17
How Medicaid expansion and the Affordable Care Act impact Part A services	70.8%	17
My personal (not professional) awareness of the needs of people living with HIV	58.3%	14
Changes in trends in HIV epidemiology	45.8%	11
New definitions of the service categories	45.8%	11
Information about other federally funded HIV programs and how they impact use of Part A funds payer-of-last-resort)	37.5%	9
The National HIV/AIDS Strategy	33.3%	8
Peer reviewed literature and articles	29.2%	7
Cost Data were used to make funding allocation decisions	25.0%	6
Other	8.3%	2

Other	Count
Part B funded services	1
Personal compassionate convictions	1
Total	2

The following report shares highlights of the presentations, motions, discussion and results of the FY 2017 Priority Setting and Resource Allocations Process.

Denver HIV Resources Planning Council

FY 2017 Priority Setting Meeting
City and County of Denver Environmental Health Building, Grand Mesa Room, 2nd Floor
200 West 14th Avenue, Denver, CO 80204
Friday, August 12, 2016 • 9:00 a.m.—5:00 p.m.

Planning Council members present
Alexis Abrams, Rabecka Blauvelt, Lili Carrillo, Hayes Colburn, Phillip Doyle (Co-Chair), Roberto Esquivel, Rev. Tammy Garrett-Williams, Robert George, Todd Grove, Khalil Halim, Robyn Harte, Brent Heinze, Marty Johnson, Steve Johnson, Kevin Kamis, Kay Kinzie, Carol Lease (Co-Chair), Russell Muhammad, Robert Powell, Thomas Raczkiewicz, Melanie Reece, Jalene Salazar, James Sampson, Kelly Voorhees, Lisa Wheeler

Staff/DOHR Consultants/Facilitator present
Jean Finn, Planning Council Staff; Suzie Pryor, Planning Council Staff; Anthony Stamper, DOHR; Terra Haseman Swazer, DOHR; Kelly Matthew, DOHR; Bettina Harmon, Coldspring Center for Social & Health Innovation; Melinda Marasch, Diverse Management Solutions; Lynn Dierker, Health Management Associates; Caryn Capriccioso, interSector Partners, L3C (facilitator)

Community members and guests present
JC Goodhart, Sarah Lowenstein and Cinamon Romero, Rocky Mountain CARES; Toni Aguilar and Guadalupe Ruiz, Servicios de La Raza

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Welcome and Setting the Stage for Priority Setting
Carol Lease, Planning Council Co-Chair, welcomed the Planning Council and guests to the meeting and led introductions. She shared an overview of the Planning Council Priority Setting and Resource Allocations process.

Jean Finn provided an overview of updates to the conflict of interest policy and reminded the Planning Council of its obligations to disclose conflicts during the process.

Phillip Doyle, Planning Council Co-Chair, reviewed ground rules and the agenda for the day.

Carol reviewed the Planning Council's mission, vision and values to remind the Planning Council of the reasons for its work. She also shared the Denver Principles and reminded the Council of how and when they were created as a reminder to focus on the best interests of people living with HIV/AIDS.

Jean reviewed the reason that Planning Council sets priorities and gave an overview of the roles of the Planning Council and the grantee—Denver Office of HIV Resources—in this process.

Public Comment

The Planning Council opened the floor for public comment. No members of the public signed up to speak and none volunteered to offer comment when the opportunity was verbally shared. The Planning Council closed the public comment section of the agenda.

Community Meetings Presentation

Jean Finn provided an overview of the community input process leading up to Planning Council's Priority Setting and Resource Allocations process. Community members offered to attend the Priority Setting process and provide highlights of the community input with the Planning Council.

Alliena shared her story with the Planning Council. She was diagnosed with HIV in 1993. She expressed that she is living proof of the benefits of proper medication and healthy living. Alliena shared some of the challenges she's faced as a person living with HIV (PLWHA) as well as what she heard from others at the community meeting:

- Stigma from family, work and attorneys
- Not all medication is covered by Medicaid
- Can't afford to live if medications are too expensive
- Women who are newly diagnosed experience people feeling sorry for them
- Some women are afraid to access care
- Dental care, vision care and transportation are additional challenges

Felipe told the Planning Council that it can be hard to be a young man with a history of substance abuse as well as being a PLWHA. He shared that he receives care at Denver Health where there are "booming, radiant, brilliant people" who are very accessible and easy to work with. Felipe wants to set an example for how PLWHA can access resources. He discussed some of the challenges he's faced:

- Diagnosed in jail and then released to find his own way
- Hard to stay healthy when "homeless, sick and surrounded by bad choices"
- Finding information about the resources that are available

He indicated that the most important thing for success is having one place and one person to support you.

Planning Council members asked questions of the guests and thanked them for taking the time to attend the meeting and share their stories, as well as the experiences of others living with HIV.

Planning Council Data and Needs Assessment Discussion

The Planning Council discussed highlights of the data booklet with a focus on unmet needs and implications of the community survey findings. Jean Finn shared highlights of the epidemiologic data:

- People living with HIV in six country TGA in 2015: **9,997**
- People newly diagnosed with HIV infection in 2015: **268.**
- **Almost 50%** of PLWH in TGA use Part A and MAI services.

Some groups are disproportionately impacted

- Males
- Those aged 45-64
- Hispanics
- Blacks
- Foreign-born

New cases of HIV are more likely to be:

- Female
- Aged 13-24
- Aged 25-44
- Hispanics
- Blacks
- Foreign-born

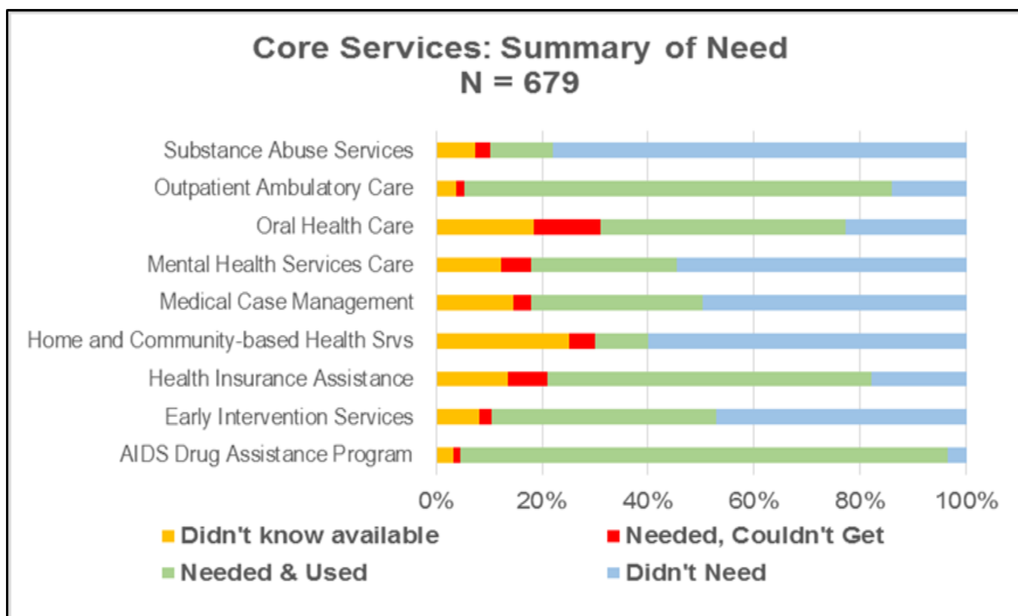
In-Care and Out-of-Care

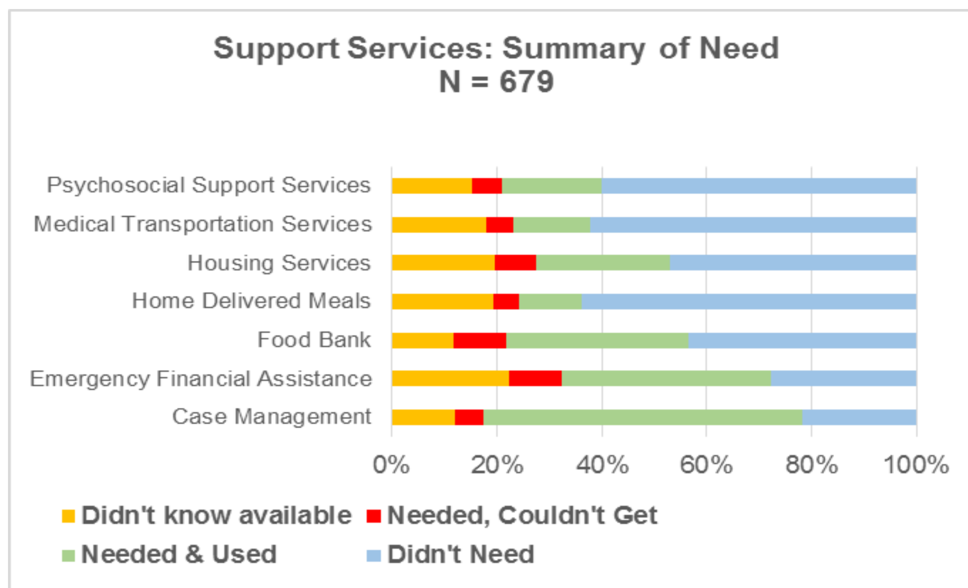
- 57% of those diagnosed with HIV in the TGA have evidence of being in care in 2015 (community-based)
- 72% of those on care continuum are described as engaged in care or virally suppressed (Hx. of med. care)
- 48% of needs assessment respondents report seeing their doctor every 3 months and almost 39.6% report seeing them every 6 months
- 95.9% reported seeing their doc in past 12 months; similar for meds, CD4, VL

Jean shared highlights from the survey about what keeps people in care:

What kind of things help you keep up with your HIV medical care?	Number	Percent
I want to stay healthy and live longer	573	20.8%
My HIV doctor, nurse or clinician	401	14.5%
Seeing the benefits of treatment	375	13.6%
To reduce the risk of transmission to others	336	12.2%
The support of family and friends	234	8.5%
I'm afraid of getting sick	232	8.4%
My HIV case manager or social worker	190	6.9%
My faith, religion, or spirituality	162	5.9%
Staying sober	118	4.3%
An HIV group program	66	2.4%
A mentor at my clinic/agency	54	2.0%
Not applicable- I have never been in HIV medical care	12	0.4%
Other*	5	0.2%
Total	**2758**	**100%**

Jean also presented an overview of service utilization highlights and data showing which core and support services PLWHA didn't know were available, and what they needed and couldn't get.





The Planning Council discussed the data overview and shared some feedback:

- Surprised that people didn't know about services; some agencies give more information than others, there is a lack of consistency of messages to clients
- The DOHR Web site can be a great tool and agencies could do a better job of referring people to the Web site; DOHR staff indicated that they are creating a resource guide that agencies can share with participants
- 41% of new ADAP clients are new to Colorado; it makes sense that people aren't aware of all of the services
- It would be interesting to know how Denver compares to other TGAs

FY 2017 Prioritized Categories and Definitions

Terra Haseman Swazer, DOHR, shared the definitions and changes to definitions of currently prioritized categories. These are changes dictated by Health Resources and Services Administration (HRSA). New service categories were provided to Planning Council in the data booklets (pages 48-58).

The most significant changes are to Early Intervention Services (EIS) and AIDS Pharmaceutical Local which will lead to changes in other categories.

EIS

Previously, EIS included retention in care and linkage to care. These services could now be covered in Outpatient Ambulatory or Medical Case Management categories.

Part A EIS must now include four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to care if found to be HIV-positive
- Referral services to improve HIV care and treatment at key points of entry
- Access and linkage to HIV care and treatment services
- Outreach services and health education/risk reduction related to HIV diagnosis

Planning Council members asked if DOHR could break-out how much of EIS funding was utilized for retention in care and linkage to care in the past. DOHR staff indicated it would attempt to determine this break-down prior to Resource Allocations.

AIDS Pharmaceutical Local

This funding has previously been spent in support of pharmacists at HIV specialty pharmacies. With this category being eliminated, the services could be provided potentially under Outpatient Ambulatory or Medical Case Management. HRSA's new service category definition sets restrictions on the use of this service category. The jurisdiction must have a restricted AIDS Drug Assistance Program formulary, a waiting list, and/or restricted financial eligibility criteria. None of these conditions exist in the transitional grant area.

MDASC Systems Findings

Rabecka Blauvelt and Jean Finn shared the systems review process that the Metro Denver AIDS Service Coalition undertook to recommend service categories for consideration in FY 2017 and explore directives to put forward to the Planning Council. MDASC met four times in July to review service use, needs assessment and health outcome data, review areas of concern, review prioritized services and data on unfunded but needed services, and discuss DOHR's proposal on acuity based medical case management. From this conversation came two proposed directives and suggested service categories.

Recommended Service Categories

MDASC recommended the following Service Categories for FY 2017:

1. AIDS Drug Assistance Program
2. Medical Case Management *(this includes a spectrum of medical and non-medical case management activities)*
3. Early Intervention Services
4. Emergency Financial Assistance
5. Health Insurance Premium and Cost-sharing Assistance
6. Home and Community-based Health Services
7. Food Bank and Home delivered meals
8. Housing services
9. Medical Transportation
10. Mental Health Services
11. Oral Health Care
12. Outpatient Ambulatory Care
13. Psychosocial Support
14. Substance Abuse Treatment – Outpatient

Steve Johnson offered a motion that was seconded by Marty Johnson.

To include all FY 2016 service categories in FY 2017 with the exception of deleting AIDS Pharmaceutical Local and collapsing Case Management (Non-Medical) and Medical Case Management into one category, Medical Case Management.
The motion passed unanimously.

The Planning Council also discussed potential changes to Minority AIDS Initiative (MAI) service categories for the coming fiscal year.

Thomas Raczkiewicz offered a motion that was seconded by Khali Halim:

To maintain the FY 2016 MAI service categories for FY 2017 and change Case Management (Non-Medical) to Medical Case Management. The motion passed unanimously.

Directives
Jean Finn discussed directives with the group including providing a definition:

> Directives are instructions for the grantee to follow in developing requirements for providers for use in procurement and contracting. The guidance usually addresses populations to be served, geographic areas to be targeted, and/or service models or strategies to be used.

Two directives were proposed to the Planning Council by MDASC.

1. **Emergency Financial Assistance and Housing Reporting**
   The Planning Council discussed this directive which was presented by Phillip Doyle and is intended to "oversee service category performance, expenditure of funds, and service use to ensure service category meets needs of PLWH. Discussion of individual contractors' performance or clients will be prohibited, as that is not DHRPC's role. Directive actions include:
   1. Provide quarterly reports to DHRPC (funding and service use)
   2. Develop uniform messaging for clients on eligibility
   3. Train providers and give them uniform messages, tools and handouts
   4. DOHR manage funds to ensure consistent, equitable, and reliable service distribution "

   DOHR reviewed the directive and conducted a feasibility review which was provided to the Planning Council in its packet.

   Planning Council members discussed the proposed directive:
   - The point of this is concern about money being spent down too quickly
   - The process of monitoring will help Planning Council understand and make better decisions

- The reason for this directive was having responsibility as a Council, not to micromanage
- Quarterly review is important; DOHR indicated that it does monitor spending monthly
- Anything we can do to spend wisely and consistently makes sense
- This is new to all of us as its new this year; it would be helpful to get a baseline and then quarterly reports

Robert George also asked the Planning Council to consider the larger issue related to EFA and Housing and how it is utilized to support clients. He expressed that it goes beyond this directive as the Planning Council has yet to decide its goals and values related to housing and EFA.

Lili Carrillo reminded the Planning Council of its values: strength, collaboration, ethics, transparency, client services. Messaging to the community needs to be Planning Council's focus so that transparency is happening.

Thomas Raczkiewicz offered a motion that was seconded by Todd Grove:

To accept the directive with the following changes: change "oversee" to "monitor," delete requirement 1.e. from the reporting and eliminate requirement 3 (training service providers and case workers).

The Planning Council noted a requirement that it vote on the directive as proposed prior to offering a motion with amendments. Given this requirement, the motion was withdrawn to consider the full directive.

Phillip Doyle offered a motion that was seconded by Kelly Voorhees:

To accept the EFA and Housing Reporting directive as submitted to Planning Council.

The motion passed by a vote of 12 to 5 with 6 abstentions.

2. **Expanding Access to Oral Health Services**
   The Planning Council discussed this directive which was presented by Todd Grove and is intended to "expand access to oral health services in the TGA through the following actions: 1. establish funding line in Oral Health Care category to pay for dental services and client cost sharing (deductibles and copays under insurance) at any oral health provider that is selected by the client, whether that provider is directly funded by Ryan White service dollars or not, 2. DOHR would emulate the EFA/Housing single payer system to assure that eligible clients can access assistance regardless of which case management entity that they seek services, and 3. DHRPC will determine the amounts (or percentages) that will be directed to the oral health fund in response to needs assessment data that continues to show oral health as one of the top two unmet needs identified by clients.

DOHR reviewed the directive and conducted a feasibility review which was provided to the Planning Council in its packet.

Planning Council members discussed the proposed directive:

- Is there a limit to the amount of funding to be used toward this directive? DOHR requested that it be included in the directive.
- Would we be giving resources to people who already have insurance like Medicaid?
- Please remove the names of providers from the directive
- Planning Council needs to consider how this will impact undocumented people
- It's hard to understand the numbers since there is no way to compare the cost of Part A funded clinics versus private dental offices
- Appreciate the expanded opportunities this provides for people, but it won't change the need of the currently funded system
- Data says that our oral health care system begs for money; don't want to hurt the agencies
- Have we done analysis of fees for private offices? We should have data to make our allocations decisions
- PLWH, including our community meeting speaker today, mentioned the importance of oral health care

Melanie Reece offered a motion that was seconded by Tammy Garrett-Williams:

To accept the directive as written with the following changes: that a specific percentage of the oral health care category would be identified and a limit per individual would be established.

Caryn Capriccioso reminded the Planning Council of the requirement to vote on the original directive first. <u>The motion was withdrawn</u>.

Tom Raczkiewicz offered a motion that was seconded by Russell Muhammad:

To accept the oral health directive as submitted to Planning Council.

<u>The motion failed</u> by a vote of 3 to 12 with 5 abstentions.

The Planning Council reconsidered the initial motion. Melanie Reece offered a motion that was seconded by Tammy Garrett-Williams:

To accept the directive as written with the following changes: that a specific percentage of the oral health care category would be identified and a limit per individual would be established.

<u>The motion passed</u> by a vote of 15 to 2 with 4 abstentions.

Priorities Process: Q-Sort of Categories for MAI and Part A

Caryn Capriccioso provided an overview of the electronic Q-Sort activity that would be utilized to determine FY 2017 Priorities. She shared that each Planning Council member who is eligible to vote would receive a link to an electronic survey where they would:

- Rank Part A Categories
- Rank MAI Categories
- Share which data or other input they took into consideration when ranking

Individual Planning Council member rankings would then be combined into an overall Part A and MAI recommendation for consideration by the Planning Council during Allocation Setting.

Priorities Q&A and Discussion

The Planning Council held a discussion where they were encouraged to ask one another and the full group questions about Priority Setting. The discussion included the following topics:

- Changes to AIDS Pharmaceutical Local and its impact on Outpatient Ambulatory
- Changes to EIS related to retention and its impact on Outpatient Ambulatory and Medical Case Management
- Clarification around expectations of the oral health care directive and how this might influence priorities and allocations
- Medical Case Management changes
- The impact of ACA on Outpatient Ambulatory
- How to help clients if oral health and EFA directives don't help to meet the need
- Health insurance

Planning Council members were encouraged to utilize the expertise that exists on the council by contacting each other and/or Planning Council staff during their Priorities decision-making process over the next few days.

Adjourn

The meeting was adjourned at 4:50 p.m.

Denver HIV Resources Planning Council
FY 2017 Allocations Meeting
History Colorado Center, 1200 Broadway, Denver, CO
Thursday, August 18, 2016 • 9:00 a.m.—4:30 p.m.

Planning Council members present
Alexis Abrams, Rabecka Blauvelt, Lili Carrillo, Hayes Colburn, Phillip Doyle (Co-Chair), Roberto Esquivel, Rev. Tammy Garrett-Williams, Robert George, Todd Grove, Khalil Halim, Robyn Harte, Brent Heinze, Marty Johnson, Steve Johnson, Kevin Kamis, Kay Kinzie, Carol Lease (Co-Chair), Russell Muhammad, Robert Powell, Rick Proctor, Thomas Raczkiewicz, Melanie Reece, Jalene Salazar, James Sampson, Kelly Voorhees, Lisa Wheeler

Staff/DOHR Consultants/Facilitator present
Jean Finn, Planning Council Staff; Suzie Pryor, Planning Council Staff; Terra Haseman Swazer, DOHR; Kelly Matthew, DOHR; Bettina Harmon, Coldspring Center for Social & Health Innovation; Melinda Marasch, Diverse Management Solutions; Lynn Dierker, Health Management Associates; Caryn Capriccioso, interSector Partners, L3C (facilitator)

Community members and guests present
JC Goodhart, Sarah Lowenstein and Cinamon Romero, Rocky Mountain CARES; Toni Aguilar, Servicios de La Raza

Welcome and introductions
Phillip Doyle, Planning Council Co-Chair, welcomed the Planning Council, members introduced themselves and then Phillip reminded the group of its ground rules and reviewed the day's agenda.

Public Comment
The Planning Council opened the floor for public comment. No members of the public signed up to speak and none volunteered to offer comment when the opportunity was verbally shared. The Planning Council closed the public comment section of the agenda.

FY 2017 Priorities
Melanie Reece reminded the Planning Council of the Priority Setting process and shared the combined Q-Sort results which represent the **recommendations for FY 2017 Part A and MAI Priorities**.

Part A Priorities
The results of the Planning Council Q-Sort to determine FY 2017 Priorities is as follows:

Service Category	FY 2017 Priority
Medical Case Management (Core)	1
Oral Health Care (Core)	2
Outpatient Ambulatory Care (Core)	3
AIDS Drugs Assistance Program (Core)	4
Mental Health Services (Core)	5
Housing Services (*Support*)	6
Emergency Financial Assistance (*Support*)	7
Early Intervention Services (Core)	8
Substance Abuse (Outpatient) (Core)	9
Health Insurance/Cost Sharing (Core)	10
Food Bank/Home-delivered Meals (*Support*)	11
Medical Transportation Services (*Support*)	12
Psychosocial Support (*Support*)	13
Home and Community-based Health (*Core*)	14

The Planning Council discussed the results of the Q-Sort:

- This is the first time that Outpatient Ambulatory has not been the top ranked service category
- It is a significant shift if this Planning Council does not consider direct medical care of PLWH as its top priority
- Understand the changes to support people because of the Affordable Care Act, but when we look at the Ryan White Care Act and National HIV/AIDS Strategy, medical care has to be our priority
- "I selected housing as the top priority," if people are housed, other parts of their care are easier to manage
- "As a PLWH, I appreciate the perspective that's come forth through the Q-Sort, yet as a Planning Council, we need to look at the system as a whole"
- The Planning Council's combined results reflect the needs of the system, "it's not my ranking, but it also seems rational and reflects our process"
- The top two priorities are the two that we discussed the most, that doesn't mean they are the most important; medical care is the most important factor for a full, happy life
- The utilization numbers for Outpatient Ambulatory keep growing, Medicaid had not made the ultimate difference
- "I'm disappointed in the results; I work with people every day who fight for emergency help and transportation; without a way to get to care, it doesn't matter how much care we have available"
- "I was shocked to see that we would change priorities, I think last year was fine. We can change this if we want to."
- To reflect 90-90-90, we need to move up Outpatient Ambulatory
- This has nothing to do with how we allocate money

- We should honor the consensus of the process; the Council has spoken and the voice represents a shift in priorities
- "As a person living with HIV, medical care and medication are my top priorities"

Lili Carrillo offered a motion that was seconded by Khalil Halim:

To move Outpatient Ambulatory to the top priority and shift all others down in the order listed.

The motion passed by a vote of 18 to 2

The final approved FY 2017 Part A Priorities are as follows:

Priority #	Part A Category
1	Outpatient/Ambulatory Health Services
2	Medical Case Management
3	Oral Health Care
4	AIDS Drug Assistance Program
5	Mental Health Services
6	Housing Services
7	Emergency Financial Assistance
8	Early Intervention Services
9	Substance Abuse Services (Outpatient)
10	Health Insurance Premium & Cost Sharing Assistance
11	Food Bank/Home-Delivered Meals
12	Medical Transportation Services
13	Psychosocial Support Services
14	Home and Community-based Health Services

FY 2017 Minority AIDS Initiative Priorities

The results of the Planning Council Q-Sort to determine FY 2017 Minority AIDS Initiative Priorities is as follows:

Service Category	FY 2017 Priority
Medical Case Management (Core)	**1**
Mental Health Services (*Core*)	**2**
Early Intervention Services (*Core*)	**3**
Substance Abuse (Outpatient) (*Core*)	**4**
Psychosocial Support (*Support*)	**5**

Russell Muhammad offered a motion that was seconded by Carol Lease:

To accept the FY 2017 Minority AIDS Initiative as presented.

The motion passed with 19 affirmative votes and one abstention

Overview of Planning Council Role in Resource Allocation

Jean Finn shared the Planning Council's role in making resource allocation decisions. She outlined the Resource Allocation process where Planning Council members determine how much money to allocate to the service categories based on the concept that Ryan White funds are used as the last source of payment for prioritized services. Through Resource Allocation, the Planning Council instructs the Grantee on how to distribute the funds when contracting for different types of services.

She shared that the key decisions for the Planning Council during this process are to: determine whether to fund a service category, and, if a service category is to be funded, determine the level of funding.

Other Sources of Funding for Part A and MAI Categories

The Planning Council reviewed a resource inventory that included all service categories and the various public and private funding sources that support each either fully or partially. See Attachment A for the Resource Inventory.

Changes in 2017: Implications for Resource Allocations

During the Priority Setting process, Planning Council requested additional information about categories that would be changing in FY 2017, as well as data to help consider allocations for the oral health care directive. Jean Finn and the DOHR staff compiled the requested information to support decision-making.

Early Intervention Services
HRSA has clarified is position on EIS given that EIS overlaps with other service categories. In 2017, EIS must include:

- Targeted HIV testing
- Referral services
- Linkage to care services
- Outreach & Health Education/Risk Reduction counseling related to HIV diagnosis

Currently, DOHR-funded EIS programs consist of two critical activities designed to help clients access care and stay in care. These are: Linkage and Re-engagement in Care. Re-engagement is not a part of the new HRSA definition but may be accomplished through other service categories such as, MCM or Outpatient Ambulatory Care.

Current data is insufficient to determine how much money or effort is associated with Linkage or Re-engagement in Care

Medical Case Management
DHRPC voted to collapse case management (CM) and medical case management (MCM) into one category, called MCM. In 2017, MCM will consist of a continuum of case management activities of various intensity, which is determined by the client's need (acuity).

- In 2016, MCM was funded at 11.32%, which equates to $732,164.
- In 2016, CM was funded at 11.32%, which equates to $732,164.

AIDS Pharmaceutical Assistance—Local
AIDS Pharmaceutical Assistance Local is intended to act as a "mini ADAP" when the State has an ADAP waitlist. Since Colorado doesn't have a waitlist, this service category can't be funded in the TGA. In 2016, Part A paid salaries at HIV specialty pharmacies under this service category; one of their activities included treatment adherence.

HRSA's service category definitions now include treatment adherence as a component that could be covered under Outpatient Ambulatory Care or Medical Case Management. In 2016, this category received 5% of service dollars or $323,394.

Oral Health Directive Percentage
In 2016, Oral Health Care received 12.46% of service dollars or $805,898. The directive instructs DOHR to establish a fund in Oral Health to pay for out-of-pocket expenses of clients accessing dental care. Almost 46% of needs assessment respondents reported trouble paying for dental care.

Recommend 5% -7.5% of amount allocated to Oral Health be set aside into the fund. In 2016 dollars, this would be $40,295-$60,443. Unused funds revert to Oral Health Care service category at mid-year point. DOHR will report to DHRPC its plan to implement the directive prior to start of FY 2017.

FY 2017 Minority AIDS Initiative Resource Allocations
The Planning Council discussed FY 2017 MAI Allocations.

Carol Lease offered a motion that was seconded by Khalil Halim:

To maintain the same percentage allocation for FY 2017 as FY 2016, shifting the percentage previously allocated to Case Management (Non-Medical) to Medical Case Management.

The motion passed 20 votes to 1 with 1 abstention

Planning Council Allocations Discussion
The Planning Council held a discussion about a variety of topics related to Resource Allocations. They were encouraged to ask questions, share information and share perspectives / recommendations with the full Planning Council prior to breaking into groups to make formal allocations recommendations. The discussion included topics the following topics:

- Emergency Financial Assistance and Housing
- Medical Case Management (training, resources, etc.)
- Changes to EIS and Pharmacy; impacts and other funding sources
- Oral Health percentage
- Food Bank spending / allocations in FY 2016
- IV drug use and Substance Abuse Category

Part A FY 2017 Resource Allocation Setting

Planning Council, having the benefit of the above discussion topics and recommendations from fellow Council members, divided into three groups to develop and document allocations recommendations. After 1.5 hours, the groups reported out a summary of their recommendations and the full group discussed areas of agreement and differences.

Council held a straw poll to determine early consensus on the idea of averaging the three group's recommendations. Based on the positive results of the straw poll, Planning Council entertained a motion.

Lili Carrillo moved and James Sampson seconded a motion to:

Accept the averages of the three groups as FY 2017 Allocations as follows:

Outpatient/Ambulatory Health Services	**26.65%**
Medical Case Management	**24.06%**
Oral Health Care	**14.13%**
AIDS Drug Assistance Program	**0.00%**
Mental Health Services	**4.88%**
Housing Services	**8.21%**
Emergency Financial Assistance	**3.15%**
Early Intervention Services	**3.98%**
Substance Abuse Services (Outpatient)	**5.03%**
Health Insurance Premium & Cost Sharing Assistance	**0.00%**
Food Bank/Home-Delivered Meals	**3.18%**
Medical Transportation Services	**2.69%**
Psychosocial Support Services	**3.69%**
Home and Community-based Health Services	**0.35%**

The motion passed with 22 affirmative votes and 1 abstention

Steve Johnson moved and Melanie Reece seconded:

That 6.49% (or $59,333) of the Oral Health Care category be allocated toward meeting the new oral health directive.

The motion passed by a vote of 19 to 4

Wrap-up

Caryn thanked the Priorities Workgroup for its work over several months to design a meaningful process and thanked the Planning Council for an exceptional process this year. Phillip Doyle offered thanks to the Planning Council, DOHR staff and the DHRPC for all of their work to make a successful planning process.

Planning Council members were asked to complete an evaluation of the process.

Adjourn

Phillip Doyle adjourned the meeting at 3:55 p.m.

Attachments

A. Service Resource Inventory August 2016
B. Planning Council Survey Results

Attachment A: Resource Inventory, August 2016

Services Covered by Other Funds

Category	Medicaid	Medicare	Part A	Part B	Part C	Part D	Part F	HOPWA	Section 8 HUD Supplement	SAMHSA	HIV Prevention	Commercial Insurance
AIDS Drugs Assistance Program (Core)^	Yes	Yes	No	Yes	No	No	No	No	No	No	No	Yes (Limited)
AIDS Pharmaceutical Assistance (local) (Core)	No	No	Yes	No	No	No	No	No	No	No	No	Yes
Case Management (Non-medical) (Support)	No	No	Yes	Yes	No	No	No	Partial	Partial	Partial	CRCS Partial	Partial (Care Coordination)
Early Intervention Services(Core)	Partial (HIV testing only)	Partial (HIV testing only)	Yes	Partial (Linkage/ Retention)	Yes	Yes	No	Partial	No	Partial (HIV testing only)	Yes	Yes (HIV testing only)
Emergency Financial Assistance (Support)	No	No	Yes	Yes	Yes	Yes	Yes	No	Partial	No	No	No
Food Bank/Home Delivered Meals (Support)	No	No	Yes	Yes (Food Bank only)	No	No	No	No	No	No	No	No
Health Insurance Premium & Cost Sharing (Core)^	No	No	No	Yes	No	No	No	No	No	No	No	No
Home and Community-based Health (Core)	Yes (Limited)	Yes	Yes	Yes*	No	No	No	No	No	No	No	Partial
Housing Assistance (Support)	No	No	Yes	Yes	No	Yes	No	Yes	Partial (SHP one type of rental assistance)	No	No	No
Medical Case Management (Core)	Yes (Limited)	No	Yes	Yes	Yes	Yes	Yes	Partial	Partial	Partial	No	Partial (Care Coordination)
Medical Transportation (Support)	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Partial	No	No
Mental Health (Core)	Yes - w BHOs	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	CRCS Partial	Yes
Oral Health Care (Core)	Yes	Yes (Limited to Hospitalizations)	Yes	Yes	Yes	No	Yes	No	No	No	No	Yes
Outpatient Ambulatory Care (Core)	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Partial	No	Yes
Psychosocial Support (Support)	Yes – some services w BHOs (but Limited)	No	Yes	Yes	Yes	Yes	No	No	No	Partial	Yes	No
Substance Abuse Services – Outpatient (Core)	Yes - w BHOs	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes	CRCS Partial	Yes

^ = Not funded by Part A in FY 2016; ADAP and Health Insurance Premium and Cost Sharing are prioritized but not funded.
* = Funded as part of the Part B Critical Events Program with justification

Attachment B: Planning Council Survey Results

Priority Setting and Resource Allocation Meetings Evaluation; N=16																		
Questions	**Rating Submissions**																**Average Rating**	**Comments**
I had an opportunity to express my thoughts on the topics discussed.	4	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	4.9	
My expertise was used to make decisions.	4	2	5	5	5	5	5	5	5	5	5	4	4	5	4	5	4.6	
I feel Listened to at the meeting.	4	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	4.9	
The facilitator was effective in keeping the meeting on task	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5.0	Excellent- been at others without good facilitation & it was chaos. Thanks!; Yes!
The facilitator was effective in giving everyone an opportunity to speak.	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5.0	Excellent!
Planning Council members treat fellow members with respect.	5	5	3	5	5	5	5	5	5	5	5	5	5	5	5	5	4.9	
I had the information I needed to make sound decisions.	5	5	5	4	5	5	5	5	4	5	4	5	5	5	4	5	4.8	
I had the time I needed to make sound decisions.	4	5	5	5	4	5	5	5	4	5	5	4	5	5	5	5	4.8	
The amount of discussion was about right.	4	5	5	5	5	5	5	5	4	5	4	4	5	5	5	5	4.8	
Our decisions were based on the needs of people living with HIV.	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4.9	
The needs of historically underserved populations were considered in our decisions.	4	5	5	5	5	5	5	5	5	5	5	4	5	5	4	5	4.8	Yeah!
People living with HIV were involved in decision making at the meeting.	5	5	5	5	4	4	5	5	5	5	5	4	5	5	5	5	4.8	
I received adequate notice of the meeting time and location.	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4.9	
I had adequate time to review the materials before the meeting.	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4.9	
We achieved our meeting goals.	4	3	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4.8	
How can Planning Council meetings be improved?	N/A; Everyone did great?; Time Maintenance during discussion; It's good.; Continue to have effective communication; This was the best year yet (#4 for me); good job																	
What did you like about the meeting?	Productive; Decisions were consumer focused; Location. Room; Caryn & the butter bombs; I like how any question is ok-others are not intimidated when you have an energy of openness; Excellent content & flow!; Venue and arrangement of tables; Achieving a goal; Cooperation!!; The after lunch discussion before small group																	