DENVER HIV RESOURCES PLANNING COUNCIL
www.dhrpc.org

FY 2019
Priority Setting and Resource Allocations Report

September 2018

Prepared by:

Caryn Capriccioso, MNM

interSector Partners, L3C
What's *your* bottom line?

Executive Summary

Introduction

The Denver HIV Resources Planning Council held its Fiscal Year 2019 Priority Setting and Resource Allocations Process on August 9 and 16, 2018. The process leading up to priority setting and allocations sessions included planning for the process at Leadership meetings, data training meetings, and preparation at standing Planning Council meetings. Caryn Capriccioso, interSector Partners, L3C, facilitated and documented the FY 2019 process.

Key Decisions for FY 2019

FY 2019 Part A Priority Rankings and Resource Allocations

Part A Service Category	FY 2019 Rank	Final FY 2019 Allocation
Outpatient/Ambulatory Health Services	1	27.22%
AIDS Drugs Assistance Program	2	0.00%
Medical Case Management	3	29.08%
Oral Health Care	4	14.59%
Health Insurance Premium & Cost Sharing Assistance	5	0.00%
Mental Health Services	7	5.01%
Early Intervention Services (EIS)	8	3.82%
Outpatient Substance Abuse Services	10	4.51%
Emergency Financial Assistance	6	4.20%
Housing Services	9	0.00%
Psychosocial Support	13	3.92%
Medical Transportation Services	11	2.89%
Food Bank/Home Delivered Meals	12	4.25%
Home and Community-based Health Services	14	0.51%
Other Professional Services	15	0.00%
Linguistic Services	16	0.00%

FY 2019 Minority AIDS Initiative (MAI) Priority Rankings and Allocations

MAI Service Category	FY 2019 Rank	Final FY 2019 Allocation
Medical Case Management	1	32%
Early Intervention Services	2	20%
Mental Health Services	3	19.78%
Outpatient Substance Abuse Services	4	21.72%
Psychosocial Support	5	6.5%

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

Value	Percent	Responses
Needs assessment and discussion of unmet need and service gaps	95.7%	22
Assessment of services in communities of color	52.2%	12
Data Booklet and data provided to me for this process	95.7%	22
Medicaid Expansion and the Affordable Care Act impact on Part A services	56.5%	13
Presentations from HIV professionals throughout the past year	65.2%	15
Peer reviewed literature and articles	39.1%	9
The opinions, perspectives and priorities of community members and people living with HIV (PLHIV)	95.7%	22
The opinions and perspectives of other members of the Planning Council	73.9%	17
My professional expertise/knowledge (e.g. service provider, board member, etc.)	73.9%	17
My personal (not professional) awareness of the needs of PLHIV	52.2%	12
HIV Care Continuum	65.2%	15
Cost Data were used to make funding allocation decisions	47.8%	11
Changes in trends in HIV epidemiology data	69.6%	16
National HIV/AIDS Strategy	26.1%	6
Colorado HIV/AIDS Strategy 2017-2021	47.8%	11
Information about other state and federally funded HIV agencies/programs (e.g. HUD, HOPWA, Medicaid, etc.)	52.2%	12
Current service categories definitions	52.2%	12
Other - Write In (click to view)	13.0%	3
Other - Write In (click to view)	8.7%	2
Other - Write In (click to view)	4.3%	1

Other Write-in Responses: input from DHR at various meetings, materials and data presented at conferences, new directives, allocations, presentations at HIV forums, needs of persons living with HIV.

The following report shares highlights of the presentations, motions, discussions and results of the FY 2019 Priority Setting and Resource Allocations Process.

NOTE: *Opinions expressed in this report are not necessarily fact, but are a representation of people's understanding of the topic to which they were speaking at the time. Individual thoughts and perspectives do not necessarily represent those of the Planning Council.*

Denver HIV Resources Planning Council

FY 2019 Priority Setting Meeting
City and County of Denver Environmental Health Building, Grand Mesa Room, 2nd Floor
200 West 14th Avenue, Denver, CO 80204
Thursday, August 9, 2018 • 9:00 a.m.—5:00 p.m.

Planning Council members present
Will Abercrombie, Lili Carrillo (Co-Chair); Kayde Claunch, Hayes Colburn, Philip Doyle, Kevin Kamis (Co-Chair); Kay Kinzie, Josh Kooman, Colleen McGuinness, Randy Mitchell, Mashawn Moore, Frances Moran, Russell Muhammad, PJ Patterson, Robert Powell, Melanie Reece, Robert Riester, Karin Sabey, Jim Sampson, Sara Scherrer, Jamie Villalobos, Kelly Voorhees (Vice chair); John Williams

Staff/DHR Consultants/Facilitator present
Jean Finn, Department of Public Health and Environment; Carina Stavish, Planning Council Staff; Andrea Duran, Office of Behavioral Health Strategies; Nick Roth, DHR; Molly Weinstein, DHR; Beau Mitts, DHR; Terra Haseman Swazer, DHR; Caryn Capriccioso, interSector Partners, L3C (facilitator)

Community members and guests present
Arlene Pace, Colorado Health Network; Todd Grove, Colorado Department of Public Health and Environment (CDPHE)

Welcome and Setting the Stage for Priority Setting

Kevin Kamis, Planning Council Co-Chair, welcomed the Planning Council and guests to the meeting and led introductions. Lili Carrillo, Planning Council Co-Chair, discussed the conflict of interest policy with the Planning Council and shared options for how to talk about potential conflicts of interest within the Priority Setting and Resource Allocations process.

Caryn Capriccioso, facilitator, led the Planning Council in developing ground rules for the process. She reviewed the agenda for the day.

Kelly Voorhees, Planning Council Vice Chair, reviewed the Planning Council's mission, vision and values, Kevin Kamis shared the history of the Denver Principles, and Melanie Reece discussed why the Planning Council sets priorities, as well as reviewing the roles of the Planning Council and Denver Office of HIV Resources.

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 Member Presentation

Caryn Capriccioso shared that over the last several years, the Planning Council has invited members of the community to speak at the Priority Setting meeting about their experiences of living with HIV and utilizing services in the area.

Maritza shared her story with the Planning Council indicating that since the time she was diagnosed, she's had great care that has been warm and welcoming; she feels that people she works with really care about her. Maritza especially enjoys group sessions about healthy relationships through psychosocial services. She appreciates seeing and hearing from others as a way to help her understand that people living with HIV can live long and healthy lives.

The biggest struggle, Maritza offered, is helping to teach people about what it means to have HIV. Her mom, for instance, thought that Maritza's diagnosis meant that her daughter would die. She also mentioned that transgender services haven't been well integrated with HIV services and that ADAP is difficult to apply for every six months.

Planning Council questions:

Q: Are you aware that you can reapply online for ADAP? A: It's hard to download the data on my phone.

Q: How quickly do you get a response from case managers when you contact them? A: They are on top of everything. I've been trying to get into providers and the appointments are out a month.

Q: How do you see HIV and transgender services being integrated? A: My hormones are about $8,000 and I've requested help, but since my issues are not related to HIV, I can't get help.

Q: Are HIV providers sensitive to transgender issues? A: Yes.

Q: How are the support groups helpful to you? A: They give a sense of community. Older people with more experience talking about HIV helps me to see that I'll be able to talk more about this as time goes on.

Q: How long did it take between your diagnosis and getting on medication? A: About one month. I was diagnosed on September 27th and on October 28th, saw a doctor. Two weeks later I got my prescription.

Q: What is your biggest takeaway from having HIV and using the services in Denver? A: I wish there were more programs for people without HIV. I try to explain it to people and they blow me off.

Planning Council members thanked the Maritza for attending the meeting and sharing her story to inform the Priority Setting and Resource Allocations process.

Planning Council Priority Setting Topics

Underutilized and/or Over-Resourced Categories

Nick Roth, DHR, shared an overview of underutilized service categories.

Early Intervention Services was underutilized due to changes in the standards of care that moved reengagement services to Medical Case Management and caused a drop-in client utilization of this category as a result. Intake and reengagement are relatively stable.

Mental Health, Substance Use and Psychosocial Support are funded so that when people need them, they can come in and get those services.

Emergency Financial Assistance and Housing were under-resourced. Part B supported these categories financially last year and will not be doing so this year.

Planning Council questions:

Q: Why was Psychosocial Services underspent? A: The service unit was changed so that 12 individuals in a group setting for an hour = 24 units. We are trying to set a standard of care for each type of service in this category.

Q: Was Psychosocial Services underutilized because the category is so broad? A: The category allows for 1:1 or group activities giving agencies the chance to build or design their own programs.

Jean Finn reminded the Planning Council that service utilization data and the reasons for underutilization are included in the data booklet in Attachments M & N.

Proposed Additional Service Categories for FY 2019

Jean Finn shared that the Metro Denver HIV Services Coalition (MDHSC) proposed adding Linguistic Services and Other Professional Services to the list of service categories to be prioritized for FY 2019.

Linguistic Services: The need for language interpretation comes up regularly from providers and when talking with community members. As grantees of the City and County of Denver, all providers and agencies are required to comply with Title VI of the 1964 Civil rights act that requires them to take reasonable steps to make programs, services and activities accessible to people with limited English proficiency. Linguistic services can be written into current contracts, but that currently doesn't happen.

Other Professional Services: Proposed due to a concern that Social Security Disability Insurance (SSDI) will review eligibility of HIV as a disabling condition. Although this is currently on hold, if eligibility were to change, it would create need for legal services for people living with HIV to reapply or seek other support. In addition, there used to be HIV-specific services through the Colorado Cross Disability Coalition, but that offering is no longer available. The Needs Assessment indicated that 20% of people accessing the system say that they need but cannot access legal services. Encourage Planning Council to add the category and not necessarily fund it but have it as a place holder.

Planning Council discussion:

- Q: Do other TGAs prioritize and fund Other Professional Services? A: Minnesota uses this category to fund permanency planning, wills and estates and asylum-seeking. New York funds housing discrimination and employment discrimination services through this category.
- Q: We are only allowed so many categories, correct? A: We can add as many as we want. The focus should be on the service categories that best meet the needs of people living with HIV in the transitional grant area (TGA).
- Q: Is it a lot of work to add service categories and can DHR ask for additional funding for these categories?: A: Yes, administering new categories is a lot of work, but DHR cannot ask for additional funding.
- Q: If we add the categories but don't fund them, will DHR still need to create the standards of care? A: No, but staff would probably create them so that they are ready for future years.

Medical Case Management Measurement Plan Update

Molly Weinstein provided an overview of the Medical Case Management Measurement Plan being undertaken by DHR. She reminded the Planning Council that DHR doesn't yet have data available on the use of the additional Medical Case Management (MCM) funds allocated for FY 2018 or the impact on service utilization.

DHR is working to measure the influx of money to the MCM service category including tracking how it improves clinical outcomes, improves client experience of MCM services, improves efficiency of resource utilization and improve MCM staff experience of MCM services. Molly shared the indicators that are being measured.

Planning Council discussion:

- We should look at the number of unique people and the numbers of people who are new to MCM.
- Q: Will you be looking at case load size as well as visits and units? A: Yes, as well as acuity of patients in the case load.
- It's concerning when we look at the service categories where clients didn't know that services are available. If case managers are the gatekeepers of information, they should let clients know what's available.
- Reminder that not all people receiving services in the TGA are receiving case management so "didn't know" might be because they didn't need the services.
- Q: Who sets the standard for case load size? A: Currently there are recommendations it the standard of care.
- Q: When do we adjust the plan? Is this really about the 5-year plan or the directive: A: The influx of money came after the 5-year plan was implemented, but it made sense to look at them together.
- We should look at the response time for MCM services including if the standards of care should set an expectation of response time

FY 2019 Service Categories and Definitions

Jean Finn shared an overview of the FY 2018 prioritized categories and definitions and reminded the Planning Council of the newly recommended service categories for consideration this year: Linguistic Services and Other Professional Services. She reminded the Planning Council members that they are charged with selecting and prioritizing the categories that meet the needs of people living with HIV in the TGA.

The following are the service categories recommended by MDHSC for FY 2019:

1. AIDS Drug Assistance Program
2. Early Intervention Services
3. Emergency Financial Assistance
4. Food Bank and Home delivered meals
5. Health Insurance Premium and Cost-sharing Assistance
6. Home and Community-based Health Services
7. Housing Services
8. Linguistic Services
9. Medical Case Management
10. Medical Transportation
11. Mental Health Services
12. Oral Health Care
13. Other Professional Services
14. Outpatient Ambulatory Care
15. Psychosocial Support
16. Substance Abuse Treatment – Outpatient

Planning Council discussion:

- Who decides what categories are core and which are support? A: HRSA: Health Resources and Services Administration.
- Given that providers and agencies can apply for linguistic services support through their general funding, don't think it's needed
- Appreciate Robert's opinions on the need for prioritizing linguistic services
- If we include linguistic services, we could choose not to fund it and begin to explore the need in more depth
- Q: If we don't add it, how does a smaller agency get funding for this? A: They can include it as a line item, it would come out of their overall award.
- We need to make sure to think outside the box and remember that this is about the whole TGA. Smaller organizations struggle to provide these services, and these are the agencies that generally are specific to serving the communities that need linguistic services.
- People need translators, but they have to have a college degree and are hard to hire. Note: It is recommended that translators have a degree, but not required.
- Q: Do we have to prioritize a category to collect more data about it? A: No, but there is so much data to collect that we have to make choices about what to collect. Note per DHR: We help to collect data even for categories that weren't prioritized to provide data needed to make decisions.

Robert Riester offered a motion that was seconded by Jim Sampson.

To accept the proposed list of FY 2019 service categories including Linguistic Service and Other Professional Services.

Philip Doyle offered an amendment to accept the proposed list of FY 2019 service categories with the exception of Linguistic Services. The amendment was accepted.

The amended motion failed by a vote of 9 to 11 with 1 abstention.

Philip Doyle offered a motion that was seconded by Melanie Reece.

To accept the proposed list of FY 2019 service categories including Linguistic Service and Other Professional Services.

The motion passed by a vote of 19 to 1 with 1 abstention.

Recommended Service Categories MAI
The following services were recommended for FY 2019 MAI:

1. Medical Case Management
2. Mental Health Services
3. Early Intervention Services
4. Outpatient Substance Abuse Services
5. Psychosocial Support Services

Philip Doyle offered a motion that was seconded by Josh Kooman.

To accept the proposed list of MAI service categories for FY 2019.

The motion passed unanimously.

Update on Part B Funding for Part A Service Categories
Todd Grove, CDPHE, walked through the process for how Part B receives rebates and how they are expended throughout Colorado and in the TGA. The way that rebates are being paid to CDPHE is changing.

While CDPHE put $1.2M into Part A Housing Services (Housing) and $300K into Emergency Financial Assistance (EFA) for FY 2018, and it will be able to maintain that funding for Housing in FY 2019, EFA funding is still unknown. Planning Council should plan as if the funding is not available.

Directives
Jean Finn explained how directives work – that they are written, binding guidance from DHRPC to DHR on how to improve service delivery and address the needs of populations being served, geographic areas to be targeted and/or service models or strategies to be used. They are typically developed by individual Planning Council members or MDHSC in advance of Priority Setting and reviewed / put forward by Leadership Committee.

Jean shared that there are currently five directives in place:

- Oral Health Fund (FY 2017)
- EFA and Housing Services (FY 2017)
- Needs Assessment for Medical Case Management (FY 2018)
- Improving Care for Gender Expansive People (FY 2018)
- Behavioral Health Care Initiative (FY 2018)

For FY 2019, Denver Department of Public Health and Environment leadership requested that DHRPC develop no new directives. DHR agreed to provide quarterly updates on the status of current directives. The first update was provided in June and the next will be provided in September. There are no new directives to review today.

Updates on Current Directives

Oral Health Care
This directive has been operationalized by DHR. Planning Council set a percentage of the service category dollars for the oral health care fund. Of $59,333 allocated, all funds were expended by 85 clients at an average cost of $698. The funding lasted through November.

Planning Council questions:

- Q: Can this be time-limited? A: This directive continues until the Planning Council decides to end the oral health fund.
- Q: Does this cover providers who are not part of the Part A network? A: This was allowed in the directive, but it hasn't been operationalized. Last year there were concerns that this would undercut the existing Part A providers.

EFA/Housing Directive
The directive is not in effect when EFA and Housing are not Part A funded. During FY 2018, EFA and Housing were not Part A funded.

MCM Directive
Planning Council received an update in June. DHR will complete the needs assessment of the MCM training program and make updates.

Gender Expansive People Directive
The directive requires that DHR improve outreach to gender expansive people in the TGA to link and/or engage in care, provide cultural responsiveness training to Part A funded service category providers and reconfigure surveillance and CAREWare data systems to collect sex assigned at birth, current gender identity and sexual orientation. This directive is underway.

Behavioral Health Care
DHR will continue to support community-based AIDS service organizations in the provision of behavioral health services and complete a behavioral health assessment. DHR has funded community-based organizations for behavioral healthcare.

Future Directives
DHR and DHRPC each have policies and procedures on directives. These will be reviewed and aligned where feasible.

Priorities Q&A and Discussion
Mock Q-Sort

The Planning Council was asked to share its thoughts on the Mock Q-Sort that was completed by Council members in July 2018.

Planning Council discussion:

- Surprised that substance use was not higher with the big treatment centers shutting down
- Substance use services are currently underutilized and underspent which is not necessarily an indication of decreased need since Ryan White Part A is the payer of last resort
- I struggle with this category. We hear of need for substance use services, but since its covered by Medicaid and stigma is so high, it's hard to know what is happening.
- Substance use services are at a bottleneck, there is now a treatment on demand clinic
- Sense a shift coming with HIV care, there are new paradigms to get people into care and provide care with a focus on what impacts people
- Housing and transportation are complementary. If people are moving out of Denver, then the transportation need goes up.
- In doing street outreach, we see that housing and substance use go hand-in-hand

Priorities Topics for Discussion

The Planning Council offered up topics for discussion to inform their decision-making about Priority Setting. The following are topics and the key discussion points:

ADAP
Q: How does it work? What kind of input does the community have? A: There is a formulary committee that recommends medications and a medical provider group that makes the final decisions.

Transportation
- Bus travel can be up to three hours each way for people who've moved out of Denver
- Utilization has been about the same; allocations have gone up
- I didn't know that transportation was a service and missed a lot of therapy services appointments
- Q: Is it a capacity or training issue that case managers don't know about all services? A: It's complex for case managers and clients to have to know what's available through Medicaid and Ryan White
- Q: Why has transportation always been low on the list? A: There are other sources of funding for transportation and Ryan White is the payer of last resort.
- People who don't access case management don't know about services like transportation

Oral Health

- People with HIV need a lot of oral health care
- It seems like every year the money runs out
- The directive is designed to assist with out of pocket costs
- Part B covers oral health care through EFA and Medicaid covers $1,000 per year
- Q: As of June, $43,000 of the $51,111 allocated to the directive had been spent; do people get in early because they know it runs out? A: This is a good topic for the allocations meeting.

Food Bank

- Based on observation, more and more people are using this service
- We need to take a harder look at increasing this category; data shows increasing need
- We always add money to food bank when we reallocate
- 991 people utilized the service last year, 19% of the population
- We talked at data trainings about other sources of funding for this service; it relies heavily on donations and fundraising

MAI

- MAI exists because people of color (POC) use services at rates consistent with or exceeding the disease burden.
- POC are well-represented in non-MAI services, as well as MAI
- MAI has federal requirements around who can receive the money
- Historically more services were funded under MAI, but they have become more consolidated over time

Psychosocial Support

Psychosocial Support was underutilized and underspent. Why?

- The number of unduplicated clients increased
- Maybe people got what they needed from the groups and moved on
- Needs vary for newly diagnosed and people who have had HIV for the longer-term
- Consider that funding may have been underspent because we spend less money with more clients

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 2019 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.

Adjourn

The meeting was adjourned at 3:50 p.m.

Denver HIV Resources Planning Council
FY 2019 Allocations Meeting
City and County of Denver Environmental Health Building, Grand Mesa Room, 2nd Floor
200 West 14th Avenue, Denver, CO 80204
Thursday, August 16, 2018 • 9:00 a.m.—5:00 p.m.

Planning Council members present
Will Abercrombie, Lili Carrillo (Co-Chair); Kayde Claunch, Hayes Colburn, Philip Doyle, Martez Johnson, Kevin Kamis (Co-Chair); Kay Kinzie, Josh Kooman, Colleen McGinnis, Marshawn Moore, Frances Moran, Russell Muhammad, PJ Patterson, Robert Powell, Melanie Reece, Robert Riester, Karin Sabey, James Sampson, Sara Scherrer, Jamie Villalobos, John Williams

Staff/DHR Consultants/Facilitator present
Jean Finn, Department of Public Health and Environment; Carina Stavish, Planning Council Staff; Andrea Duran, Office of Behavioral Health Strategies; Nick Roth, DHR; Molly Weinstein, DHR; Beau Mitts, DHR; Terra Haseman Swazer, DHR; Caryn Capriccioso, interSector Partners, L3C (facilitator)

Community members and guests present
Alexis Abrams (Planning Council member who attended as a community member for the community input portion of the meeting)

Welcome and introductions
Lili Carrillo, Planning Council Co-Chair, welcomed the Planning Council and led the group in introductions. She reminded the Council of the importance conflict of interest disclosures. Caryn Capriccioso, facilitator, reviewed the ground rules that the Planning Council developed during the Priority Setting meeting and shared an overview of the day's agenda.

Public Comment
The Planning Council opened the floor for public comment.

Alexis Abrams addressed the Planning Council. She stated that the transgender agenda is in full swing, yet nowhere in the data booklet or attachments are the words "trans," "transgender," "trans woman," "trans man," etc., and that as a member of the Planning Council for a few years, it is disheartening. She asked who on the Planning Council advocates for the trans community.

As a person of color and woman, Alexis shared, she has a place, but as a trans woman, she has no place. "It is a blessing to be identified as female, which is not accurate. It is a curse to be identified as MSM, gay or bi. I am just fighting for my own identity as a trans woman. Maybe with my voice, my voice and that of my community can be amplified."

FY 2019 Priority Setting and Resource Allocations

Review and Approval of FY 2019 Priorities

Jean Finn shared the results of the Planning Council's Q-Sort for Part A and MAI and the Planning Council discussed its thoughts on the outcome.

Part A Service Category	FY 2019 Rank
Outpatient/Ambulatory Health Services	1
AIDS Drugs Assistance Program	2
Medical Case Management	3
Oral Health Care	4
Health Insurance Premium & Cost Sharing Assistance	5
Mental Health Services	7
Early Intervention Services (EIS)	8
Outpatient Substance Abuse Services	10
Emergency Financial Assistance	6
Housing Services	9
Psychosocial Support	13
Medical Transportation Services	11
Food Bank/Home Delivered Meals	12
Home and Community-based Health Services	14
Other Professional Services	15
Linguistic Services	16

Planning Council discussion:

- EFA is interesting. We had heightened awareness of EFA funding in our Priority Setting discussions, but should be careful of our prioritization of support services above core services.
- MCM is important, but it's underutilized with money returned and little accountability
- MCM and Oral Health may not be ranked properly, we could still tweak them
- What is the point of doing this process if we're negotiating the rankings?
- The intention of the Q-sort is not to significantly change the rankings that came out of the process
- MCM was underspent because of staffing vacancies
- Food Bank has a lot of use; should consider more money when it's time to allocate
- This ranking reflects the services I need to survive as a person living with HIV
- Remember that significant changes to priority setting and resource allocations take time to evaluate. We haven't had time to evaluate the changes to MCM. It's a very important service and I'd like to see it ranked higher.
- If we reduce MCM, we make access to other services worse
- I wish that MCM was defined differently; we shouldn't project one agency's lack of responsiveness on others. It's not fair to the system.
- MCM was only underspent by 1% or about $14,000 out of $1.5M
- There isn't money for oral health care in Medicare

Kevin Kamis offered a motion that was seconded by Lili Carrillo

To move accept the FY 2019 Part A Priorities as presented.

<u>The motion passed</u> by a vote of 20 to 1 with 1 abstention.

FY 2019 Minority AIDS Initiative Priorities

The results of the Planning Council Q-Sort to determine FY 2019 Minority AIDS Initiative Priorities is as follows:

Priority #	MAI Category
1	Medical Case Management
2	Early Intervention Services
3	Mental Health Services
4	Outpatient Substance Abuse Services
5	Psychosocial Support

Will Abercrombie offered a motion that was seconded by Lili Carrillo:

To accept the FY 2019 Minority AIDS Initiative Priorities as presented.

<u>The motion passed</u> by a vote of 21 to 1.

<u>Overview of Planning Council Role in Resource Allocation</u>

Kevin Kamis shared the Planning Council's role in making resource allocation decisions. He 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.

<u>Other Sources of Funding for Part A and MAI Categories</u>

Jean Finn shared that HRSA requires Ryan White funding to be used as the fund of last resort and that the Planning Council's job is to backfill and understand other funding sources that are available. She led the Planning Council in a review of a resource inventory that included all service categories and the various public and private funding sources that support each either fully or partially.

Planning Council discussion:

- Q: What is Part D funding? A: It is funding for women, children and youth with HIV. Children's Hospital manages the program.
- Q: When we say that commercial insurance covers services, what about people who don't have insurance, or their insurance won't pay for it? A: Each agency has the obligation to bill insurance first, then use Ryan White as wrap-around.
- There are special instances where private insurance acts as a barrier to care and DHR has allowed patients to opt out of insurance and use Ryan White funding in these cases
- Q: Is our MAI Part F MAI? A: No. Our MAI runs throughout the parts and ours is not Part F.

Staff Appreciation

Beau Mitts, Lili Carrillo and Kevin Kamis offered acknowledgement and appreciation for the work of Jean Finn over the previous four years. They thanked her for her support of the Planning Council and its efforts to serve people living with HIV. Jean accepted a gift in acknowledgment of her service and thanked the Planning Council and DHR for their support of her over the years.

Allocations Overview

Melanie Reece provided an overview of the allocations process. She reminded the Planning Council to base decisions on the needs assessment, the most successful and economical ways to provide services, actual cost and utilization data, the priorities of people living with HIV who are likely to use the services, coordinating Part A services with other services like HIV prevention and substance abuse, the amount of funds from other sources, developing capacity for HIV Services and historically underserved communities.

FY 2019 MAI Resource Allocations

The Planning Council discussed FY 2019 MAI Allocations recommendations. MAI allows POC to have access to services especially where access and navigation are challenging, and especially for those with different cultural experiences and who have been discriminated against, etc. MAI funding will be around $339,000 for FY 2019 if all goes well.

Karin Sabey offered a motion that was seconded by Jim Sampson to approve the following allocations for MAI in FY 2019:

Medical Case Management	**32 %**
Early Intervention Services	**21%**
Mental Health Services	**19.78%**
Outpatient Ambulatory Services	**21.72%**
Psychosocial Support	**6.5%**

The motion passed unanimously.

Planning Council discussed how it would like to allocate MAI funding if there is a 3% or greater reduction in funding:

Josh Kooman offered a motion that was seconded by Karin Sabey to approve the following allocations for MAI in FY 2019 in the case that funding is reduced by 3% or greater:

Medical Case Management	**32%**
Early Intervention Services	**21%**
Mental Health Services	**19.78%**
Outpatient Ambulatory Services	**21.72%**
Psychosocial Support	**6.5%**

The motion passed unanimously.

Planning Council Resource Allocations Discussion

Panel: People living with HIV

PJ, Will, Josh, Robert Riester, Hayes and Philip participated on the panel. Caryn Capriccioso moderated the discussion.

From your perspective, what should Planning Council members keep in mind as they move into the small groups to allocate money to the service categories?

- Allocations is about supporting the entire TGA; it's not appropriate to advocate for a specific cause
- Listening is more essential than speaking
- We are data-driven here, and we only had a limited amount of people coming in with a community voice. What we do with people's lives matters; we need to put that in the forefront.
- We've come together as a Council compared to last year
- As a minority of a minority of a minority, we are data-driven. We must look at numbers and the TGA as a whole. And, there are numbers that are not being counted; there are trans women who don't get linkage to care and aren't counted appropriately by CareWARE? It's disheartening to see how high these numbers of trans women of color there are who don't' get HIV meds, don't seek out psychosocial services and don't get outpatient treatment. "I hope and pray that we can reach everyone in our community."
- It's a very important year to be allocating given what's happening in the nation. We have our data. It's easy to breeze over it, but it's also important to look at the reasons, the number of people using the category, cost per unit, etc. Something that looks big may actually be small and vice versa.
- Things are changing, and people will need legal services re: Medicaid and disability
- There are people who know the system well. They know when the fresh money is coming in. That's why you have shortages in certain categories fairly quickly.
- If you are a provider, keep your Planning Council hat on. I've voted against what I'd be in favor of where I work because it wasn't right for people living with HIV.
- My experiences have not been pleasant, not easy. I realize we have to continue the course when we don't have a lot of data, but as a user of services, I am underwhelmed.

What lingering questions do you have about service categories that might impact your ability to make resource allocations decisions?

- Not everybody is heard. Unless you're in case management, you're not part of the data
- As a person receiving services in a timely fashion, most things I have to say are from a personal perspective. I try to remove myself from advocating because my experience doesn't reflect this slate of service categories. I try to allocate based on what I see as I serve people.
- I'm on the high-functioning level, so I don't have any lingering questions
- I don't use most of the EFA services and suggest we keep allocating at $200K. We always want more money everywhere and we don't know if we are getting the extra $300K.

Panel Q&A

- Q: What, specifically is not available to transgender people? A: I think that is where the disconnect is. People don't know and asking questions is good. For example: I know a trans woman seeking services. She is an IV drug user and wasn't taking her HIV meds or hormones. She just fell through the cracks, forgotten and pushed back to the back-burner. Because these

can be hard clients, sometimes people don't want to work with them. There is also bigotry because providers don't know how to meet their needs.
- I'm not ignoring the issue of transgender people living with HIV, I just don't understand the challenges and need to understand to help.
- Transgender people are represented in the needs assessment despite what we heard earlier
- A couple years ago the Denver Health transgender ombudsman came to speak to us. Maybe it's time to have that conversation again
- I appreciate the input and respect the team as a whole. At the same time, the data reflects the lack of linkage to transgender people. Did our prioritization reflect the needs of transgender people?
- I would use more services if access was better. Numbers would go up. Expanded hours could help.
- Q: What can we do here today that would improve services or outcomes in your community? A: We need to remember the transgender community in all decisions.

Planning Council Allocations Discussion Topics

Planning Council members asked to discuss EFA, the oral health fund and the two new categories in more detail.

EFA

- Q: What is included in EFA? There is an issue between the Part A and Part B standards of care if Part B funds EFA? A: In addition to what is funded by Part A EFA, Part B EFA also funds oral health care, identification cards and childcare.
- Part B recommends that Planning Council fund EFA at $300K.
- Q: What do people recommend we do about this? A: Fund it fully and then reallocate the money if Part B comes through. (Note: Would have to spend the entire category before Part B kicks in.) Put in $200K and hope for the backfill. This seems like plenty as it's a support category.

Oral Health

- Suggest boosting the % that we allocate toward the oral health fund; if it's going to be spent down by November, we'll need more money
- We could increase the service category overall and/or just the directive
- Could we stipulate that if there is any oral health care money to reallocate that it would go to the oral health fund?
- The directive is well done and gives us the power to make choices

Other Professional Services & Linguistic Services

- In the current climate, I tend to lean toward funding this category
- Immigration and asylum services are needed by the people we serve
- There are limitations to what can be legal services; for instance, criminal services aren't included
- There aren't other sources of money to support these needs
- Just like linguistic services, other professional services can be paid for through general Part A awards
- Providers are not currently funding linguistic services out of Part A

- DHR has to apply to HRSA in a month and then DHR will develop the RFP; it seems more measured to not fund these categories and allow time for the standards to be written; we could research and learn from other states

Part A FY 2019 Resource Allocation Setting: Flat Funding

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 1.25 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 results of the poll, the Planning Council held further discussions starting with their observations and moving toward a modified version of the recommendations:

- Our group kept 1.5% in Other Professional Services since it can be spent on pro bono lawyers
- This wouldn't be enough to hire one person
- We don't have the data to write in-depth Standards of Care in 30 days
- Discussing how it would look isn't with in our purview here today
- Q: If money is reallocated later, could it go toward an unfunded category? A: Yes. It would take about 3 months to administer an RFP.
- In 2019, we could do a small needs assessment and use this data to inform the development of standards and FY 2020 Allocations
- If we put off funding new categories, we may not have as much money
- I don't want to fund this until we have more information
- I proposed Other Professional Services; it will be needed a year from now and it's needed now

Will Abercrombie offered a motion and Melanie Reece seconded to approve the following allocations for Part A in FY 2019:

Outpatient / Ambulatory Health Services	27.22%
AIDS Drug Assistance Program	0.00%
Medical Case Management	29.08%
Oral Health Care	14.59%
Health Insurance Premium and Cost Sharing Assistance	0.00%
Mental Health Services	5.01%
Early Intervention Services	3.82%
Outpatient Substance Abuse Services	4.51%
Emergency Financial Assistance	4.20%
Housing Services	0.00%
Psychosocial Support Services	3.92%
Medical Transportation Services	2.89%
Food Bank / Home Delivered Meals	4.25%
Home and Community-based Health Services	.51%
Other Professional Services	0.00%
Linguistic Services	0.00%

The motion passed with a vote of 13 to 8

FY 2019 Part A Reduction Scenario: In the case of a 3% up to 9.99% funding reduction

The Planning Council discussed how it would allocate for Part A if there is a significant reduction in funding.

- Even with a reduction of 3%, we'd have slightly more than we have this year because of the additional $300K from HRSA
- Taking money from MCM would prevent forward progress
- We'd only lose one MCM position over the whole TGA if we reduce funding in this category
- Appreciate that we typically work from percentages, but it's helpful to look at dollars, as well. Some categories may not be viable with a reduction.
- If we took away all increases, except EFA, that would give us about $26,000
- Q: How will we translate the vote into percentages since the cut would be a dollar amount? A: DHR will translate

Josh Kooman offered a motion and Will Abercrombie seconded to approve the following allocation in the event of a 3%-9.99% funding reduction:

No service category will receive an increase in funding
Funding offset will go to Mental Health and Substance Abuse Services
Extraneous funding will go to Medical Transportation Services

The motion passed unanimously

Oral Health Directive Fund

The Planning Council discussed funding for the Oral Health Care fund which is a percentage of the overall allocation to Oral Health Care. The group discussed averaging the percentages from each break-out group which were 8%, 8% and 7%.

Melanie Reece offered a motion that was seconded by Jim Sampson to approve an allocation of 7.67% of the Oral Health Care allocation toward the Oral Health fund.

The motion passed with 19 affirmative votes and 2 abstentions

Wrap-up

Several people offered their appreciation for the work of the Planning Council, DHR, the Priorities Committee and the DHRPC staff.

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

Adjourn

Lili Carrillo adjourned the meeting at 4:40 p.m.

Attachments

A. Planning Council Survey Results

Attachment A: Planning Council Survey Results

Rating Scale: 1=Strongly Disagree, 2=Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree			
Questions	**Average Rating**	**Range**	**Comments**
I had an opportunity to express my thoughts on the topics discussed.	4.9	4 to 5	I felt my thoughts heard
My expertise was used to make decisions.	4.6	3 to 5	
I feel listened to at the meeting.	4.8	3 to 5	Extremely effective
The facilitator was effective in keeping the meeting on task	4.9	3 to 5	awesome
The facilitator was effective in giving everyone an opportunity to speak.	4.9	4 to 5	great facilitation; patient in doing so
Planning Council members treat fellow members with respect.	4.8	3 to 5	very respectful; one member was out of line; yes
I had the information I needed to make sound decisions.	4.7	3 to 5	Need more concrete MCM data; send info in an email
I had the time I needed to make sound decisions.	4.7	2 to 5	Could have used a break between presentation and voting on allocations
The amount of discussion was about right.	4.6	3 to 5	
I received adequate notice of the meeting time and location.	4.9	4 to 5	well done
I had adequate time to review the materials before the meeting.	4.8	3 to 5	I think the data trainings could have been slightly earlier.
We achieved our meeting goals.	4.9	4 to5	yes!; satisfied with outcome
The needs of people living with HIV, who are not retained in care, were discussed in the priority setting and resource allocation process	4.0	1 to 5	Did we discuss retention/ are they being reengaged through other areas?

Questions	Average Rating	Range	Comments
The needs of people who are unaware of their HIV status were discussed in the priority setting and resource allocation process.	3.3	1 to 5	was not outwardly, we could do better here; public comment could be marketed more; not discussed; I felt like we could be more responsive to these populations, especially in read to engagement in care and the continuum of care.
The needs of people who are historically underserved were discussed in the priority setting and resource allocation process.	4.5	3 to 5	is it really in our purview?; through MAI
People living with HIV were involved in the priority setting and resource allocation process.	4.9	4 to 5	
The priorities of people living with HIV were discussed in the priority setting and resource allocation process.	4.8	3 to 5	
The community input was discussed in the priority setting and resource allocation process.	4.4	2 to 5	I think community members could be better invited/included and/or these meetings should be advertised more.
Potential increases or decreases in the Ryan White Part A award was discussed in the priority setting and resource allocation process.	4.6	4 to 5	It was odd to focus on 3% cut but ignore the 9.99% cut
MAI funds were discussed during the priority setting and resource allocation process to enhance services to minority populations.	4.7	4 to 5	
Data were used in the priority setting and resource allocation process to optimize access to core medical services.	4.8	3 to 5	
Data were used in the priority setting and resource allocation process to reduce disparities in access to HIV care in the TGA.	4.6	2 to 5	wasn't necessarily discussed
Changes and trends in HIV epidemiology data were used in the priority setting and resource allocation process.	4.2	3 to 5	Age since diagnosis was changed back to 10/20 yr hidden data sets. s/b 5 yr incr.

Questions	Average Rating	Range	Comments
Cost data were used to make resource allocation decisions.	4.4	3 to 5	Need more data.
Data from other federally funded HIV programs were used in the priority setting and resource allocation process.	4.2	4 to 5	Need more data.; I'm not sure - part B?
Anticipated changes in the health care landscape were discussed in the priority setting and resource allocation process.	4.4	3 to 5	wasn't discussed very much
How can Planning Council meetings be improved?	More time and explanation around the reduction scenario; Recruitment of other individuals, next year MDC; Nice facilitation - Thank you!; I would say the HIV member panel needs to be moved before MAI voting; Panel for next year of PLWH should include those outside the PC and representatives of the TGA PLWH; Panel should have taken place before MAI allocation process. Panel should include voice not already at the table; I think a lot of information near the beginning (e.g. Denver Principles, P.S. yearly process) has been presented in multiple meetings and probably could be left out.; No improvement needed; More data.; It's good as it is; Not really understanding how community member piece fits here, would love to see this through the year and reserve PS/RA as such; I thought it was well done.; great work to everyone!; vet new members that will stay and participate.		
What did you like about the meeting?	Really the collaboration; Great discussions; Robust discussion amount council members, people respected each other's opinions; Good discussion with a willingness to present dissenting opinions. Shows trust among Council members.; We stayed on topic and gave all topics appropriate time.; We handled opposing viewpoints and opinions very well! DHR input and participation was very helpful.; This was best priorities meeting I've attended.; We accomplished a lot!; Facilitation, Data booklet; the planning council being so responsive & respectful; People were courteous, we ended early; Well planned and implemented!; Respectfully discussed each topic; Good discussion, well paced, good food, nice to have data people available for questions & information.; my fellow Planning Council members!; calm, well-organized, informative; I left feeling good about what we accomplished. New stress toys, these are dirty and gross.		