FY 2012
Priority Setting and Resource Allocation Report

September 2012

Draft:
September 12, 2011

Revisions:
December 8, 2011, December 16, 2011, December 29, 2011

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Executive Summary

Introduction

The Priorities Workgroup of the Denver HIV Resources Planning Council hosted a two day process for Fiscal Year 2012 Priorities and Allocations which included:

- Continuing with the approach of holding priorities and allocations on two separate days to allow for more discrete processes and the option to spend more time on each part of the FY 2012 decision-making

- Offering a week between the priorities and allocations processes allowing for more time to process, ask questions and allow for thoughtful evidenced-based responses

- Supporting evidence-based decision-making by focusing on a series of five data meetings in advance of the process to help educate Planning Council and community members on needs assessment findings and how to better utilize the data booklets to drive the FY 2012 priority setting and resource allocation process

- Including an interactive group break-out allocations process with computer stations and worksheets to fully engage all Planning Council members

The Priorities Workgroup hired interSector Partners' Caryn Capriccioso, to facilitate and document the FY 2012 process.

Key decisions for FY 2012

Minority AIDS Initiative
The Planning Council voted to **add Early Intervention Services (EIS)** as a priority under the Minority AIDS Initiative (MAI). The five MAI categories prioritized for FY 2011 along with their corresponding allocation percentages are:

1. Medical Case Management—25%
2. Substance Abuse—20%
3. Mental Health—25%
4. Early Intervention Services—30%
5. Capacity Building – 0%

Overall prioritization of categories for FY 2012:

Core	Outpatient Ambulatory Health Services	1
Core	AIDS Drugs Assistance Program (ADAP) Treatment	2
Core	Medical Case Management	3
Core	Oral Health Care	4
Core	AIDS Pharmaceutical Assistance (local)	5
Core	Mental Health Services	6
Core	Early Intervention Services (EIS)	7
Core	Substance Abuse - Outpatient	8
Core	Health Insurance Premium & Cost Sharing Assistance	9
Support	Emergency Financial Assistance	10
Support	Housing Services	11
Support	Medical Transportation Services	12
Support	Food Bank/Home Delivered Meals	13
Core	Home and Community-based Health Services	14

Allocations decisions for FY 2012

The Planning Council approved the following allocations for funding of 95—105% of the FY 2011 level. Allocations at a funding level of less than 95% or more than 105% will require review and potential reallocation by the Planning Council.

FY 2012 Priority Setting and Resource Allocation			Range (95-105%)	
Service Category		Rank	$6,373,423 (Note: Dollar amount is estimated on previous FY Award)	
			$	%
Core	Outpatient Ambulatory Health Services	1	$2,258,741	35.44%
Core	AIDS Drugs Assistance (ADAP)	2	$0	0.00%
Core	Medical Case Management	3	$853,401	13.39%
Core	Oral Health Care	4	$821,534	12.89%
Core	AIDS Pharmaceutical Assistance (local)	5	$569,784	8.94%
Core	Mental Health Services	6	$402,163	6.31%
Core	Early Intervention Services	7	$314,847	4.94%
Core	Substance Abuse - Outpatient	8	$420,009	6.59%
Core	Health Insurance/Cost Sharing	9	$0	0.00%
Support	Emergency Financial Asst.	10	$177,181	2.78%
Support	Housing Services	11	$319,946	5.02%
Support	Medical Transportation Svcs	12	$84,129	1.32%
Support	Food Bank/Home Meals	13	$125,556	1.97%
Core	Home & Comm-Based Health	14	$26,131	0.41%
		TOTAL	$6,373,423	100.00%
	CORE	TOTAL	$5,666,610	88.91%
	SUPPORT	TOTAL	$706,813	11.09%

The following report shares highlights of the presentations, motions, discussion and results of the FY 2012 Priorities and Allocations Process.

Denver HIV Resources Planning Council

Priority Setting Meeting
Mi Casa Resource Center Community Hall, 360 Acoma Street, Denver
Thursday, September 1, 2011
12:00—4:30 p.m.

Planning Council members present
Bob Bongiovanni; Debi Bridge; Penny DeNoble; Ernie Duff; Jessica Forsyth; Edward Gardner, MD; Patrick Gourley; Kari Hartel; Scott Jackson; Steve Johnson, MD; Kate Leos; Leanne Lowenthal; Fabian Ortega; Ruth Pederson; Don Pults; Robert Riester; Darius Smith (attended a portion of the meeting); Richard Weinert

Staff/Facilitator present
Brooke Bender, Estevan Gastelum, Lynn Hough, Maria Lopez, Berenice Ornelas, Michele Shimomura, Anthony Stamper, Caryn Capriccioso (facilitator)

Community members and guests present
Cathy Grimm, Michael Pearl, Steve Pastor, Anne Reilly, Jalene Salazar

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Welcome and introductions

Richard Weinert, presiding Planning Council Co-Chair, welcomed the Planning Council and guests to the meeting. The Planning Council and community members introduced themselves.

Ground rules and agenda review

Facilitator, Caryn Capriccioso, reviewed the Planning Council Ground Rules and shared a reminder that this is Planning Council decision-making meeting and that community participation will occur through the community representatives' presentation and through direct questions to the community by Planning Council members only.

Priority Setting Overview

Richard Weinert provided an overview of the Planning Council's role in priorities and allocations, discussed and collected conflict of interest forms from the Planning Council.

Categories for Prioritization

Maria Lopez provided an overview of currently prioritized categories for Ryan White Part A (Part A) in the Denver Transitional Grant Area (TGA) including core and support services.

Community meeting update

Brooke Bender explained the process that was used during the August 18, 2011 community meeting to share the needs assessment gap findings and gather community input. Twenty-six people attended the meeting representing 13 consumers, seven providers and six others with some people representing multiple categories.

The top five gaps identified in the needs assessment are: emergency financial assistance, transportation, dental care, housing, groceries and prepared meals.

Michael Pearl and Steve Pastor shared their summary of the community meeting where participants were asked to share what they thought the barriers and/or issues were for addressing the service and to brainstorm possible solutions. Below is an outline of the key themes along with questions and discussion points with the Planning Council. (Please see page 21 for an outline of initial steps taken by the Planning Council during the Priority Setting and Resource Allocations process to address these gaps.)

Common themes across all gaps

Barriers/problems:

- Provider/participant knowledge
    - Need for utilization of outside resources
    - Cultural and language challenges
- Consumer expectations
- System limitations

Solutions:

- Education for providers and participants

Emergency Financial Assistance

Barriers/problems:

- Lack of knowledge (where to find information, rules, eligibility, ongoing changes, etc.) both with providers and participants
- Expectations may be too high

Possible solutions:

- Education of both participants and providers
- 211 (Denver, Colorado's Community Information Telephone Number)
- Alternative funding sources

Transportation

Barriers/problems:

- RTD eligibility for discounted disability fares
- The token distribution system
- Lack of understanding of how the system works

Possible solutions:

- Work with RTD to get discounts
- Other options (volunteers, buddy program, provider coordination, etc.)
- Educate participants in the system

Discussion:

- This item generated a lot of interest as people seemed to think there was opportunity to make changes to address barriers to access.
- Co-location of services was discussed as a way to avoid multiple trips.

Dental Care

Barriers/problems:

- Perceived concerns with the system and providers (appointment times, not enough providers, specialists, staff, turnover, knowledge of requirements, limits on care, etc.)
- Participants' knowledge (fees, what's covered, expecting too much, etc.)

Possible solutions:

- Providers address participant concerns (student dentists, turnover, forums, etc.)
- Flexibility and education of participants

Discussion:

- Even in private dental care, things are not perfect. Most people complain about the dentist.
- Knowledge limitations and expectations need to be managed (re: payments, limits on care, working with student dentists, etc.)
- How can we prepare people in advance of their dental care so they have realistic expectations?

Housing

Barriers/problems:

- Expectations too high and some abuse of the funding/service
- Funding takes away from other services (what is the priority?)
- Systemic problems (inability to access, qualifying, etc.)

Possible solutions:

- Level of supervision for short-term transitional housing
- Work more closely with other agencies (both long and short-term housing providers)

Discussion:

- Do people understand what housing means for Part A?

Groceries/prepared meals

Barriers/problems:

- Knowledge of other food assistance programs
- Transportation to and from food banks

Possible solutions:

- Educate providers and participants on alternatives (as to other food banks, pantries, sliding scale cafes)
- Peer Assistance

Both presenters emphasized that while this discussion was focused on barriers and problems related to gaps, the services provided and received through Part A are generally very good and community members expressed appreciation for the services.

General Planning Council input and discussion:

- Great appreciation for Michael and Steve for making the time to prepare for and present the community input in such a thoughtful way.
- Understanding and sharing resources is an ongoing issue, not one that can be addressed through this process, but that must be on the agenda to tackle
- Q: How do we explore and/or implement the suggestions from the community? A: Michael and Maria are already working together on some pieces. Some issues can be handled through systems changes, some through standards of care. All will be looked at.

Minority AIDS Initiative recommendations

Kari Hartel and Jalene Salazar presented the Minority AIDS Initiative (MAI) recommendations as developed by People of Color Leadership/Rebuilt +. They shared that the group spent a considerable amount of time discussing the addition of an outreach or early intervention services category, but ultimately decided to recommend the same priorities as the current year as follows:

FY 2012 Minority AIDS Initiative Priority Setting		
Service Category		Rank
Core	**Medical Case Management**	**1**
Core	**Mental Health Services**	**2**
Core	**Substance Abuse Services (Outpatient)**	**3**
	Capacity Development	**4**

General Discussion and Clarifying Questions

- Q: Does the needs assessment support these recommendations? A: The group used the needs assessment and looked closely at utilization data
- With the pending changes to Medicaid in Colorado, those who have participated in a strong outreach program will fare better than those who haven't
- Concern about perpetuating a passive system; what are we doing to provide outreach to communities of color?
- Questions regarding duplication between medical case management and early intervention services and between Minority AIDS Initiative and Part A are a consistent theme in the POCL/Rebuilt + group
- How is this recommendation tied to the National HIV/AIDS Strategy?

➢ **Motion** to investigate what outreach would look like including how to target and distribute funds.

Discussion of the motion

- We should investigate both outreach and EIS as potential additional categories
- We can add EIS because it's currently prioritized, outreach would be more complicated
- Q: If we add EIS or outreach, can the Grant Application Review Committee (GARC) handle the change, A: Yes, if this decision is made immediately
- Medical case management can provide EIS or outreach-like activities. Response: Not exactly according to the standards
- Why do we always compartmentalize? If EIS and outreach are important, why not start making shifts internally to include them in medical case management without creating a new grant application process?

- Suggestion to only look at EIS, not outreach since EIS is currently prioritized.

Motion withdrawn.

- **Motion** to accept MAI recommended categories with the addition of EIS and outreach (Forsyth, Hartel)

Friendly amendment to withdraw outreach as a potential funded category, it is not currently prioritized thus no existing standards. Planning Council prefers to investigate how to best utilize EIS and outreach in the system, with strong consideration to align with National AIDS Strategy and prove how these funds are positively impacting health disparities in communities of color and avoid duplication with Part A funded services:

1. Medical Case Management
2. Mental Health
3. Substance Abuse
4. Early Intervention Services
5. Capacity Development

Amendment accepted.

Motion passed with 13 votes in the affirmative and one abstention.

<u>Prioritization process</u>

Jessica Forsyth provided an overview on the priorities process and why it is an important and distinct process from allocations. Maria shared recommendations from Leadership for the deprioritization of home health care and home and community-based health services. Brooke directed Planning Council members to fact sheets that were provided for these topics.

General Discussion and Clarifying Questions

- This process should take into account Medicaid and the Affordable Health Care Act
- Be clear that if we deprioritize a category then we cannot fund it
- We need to ask: Will this decision support our position in light of other changes on the horizon
- We are asked to make data-driven decisions, but we also need to take into account what we hear from people living with HIV/AIDS
- Request to split the vote on these two items

- **Motion** to deprioritize home health care (Forsyth, Gourley).

Motion passed with 14 votes in the affirmative and one abstention.

Discussion home and community-based health services

- Q: Would the 21 clients be eligible under the new HRSA standards? A: We can't know; the new standards require a doctor's referral.
- Q: If we remove this, can we bring it back? A: Yes, during next year's process.
- With so many unknowns, it's hard to make big decisions like this
- This has been on the table for a long time. With the changing nature of the disease, scarcity of funds and increased need across all categories, this is a hard choice we will have to make.
- Q: Is it backwards that we want to deprioritize it because no one uses it? A: Our clients will still receive the services, just not through Part A.
- This was not identified as a need or a gap.
- Four people is four too many to lose this service and potentially be lost to the system
- We could define this data either way: 1. Too few people, 2. Few people with high need who are very vulnerable
- There are issues with the data, start dates and end dates don't necessarily mean anything. There is no information on substance abuse or mental health issues among those served, or time living with HIV. How can we reassess continued need?
- It makes sense to cut this in a time of scarcity
- The only input we have is by those providing the service; it's hard to be objective
- We should throw the largest net possible, but that is hard when we don't know what the projections are
- Q: If we keep this prioritized, could we reduce the allocation and provide funding only to those who aren't linked to care? A: That would have to be handled in the standards and GARC.
- We should educate providers to make the medical referral into this category
- It's important to remember that not everyone is as high functioning as the people in this room and who attend community meetings

- **Motion** to deprioritize home and community-based health services (Forsyth, Pults).

The motion failed with five votes for and ten votes against the motion.

Prioritization Process

Jessica explained the Q-Sort process to be used for developing the FY 2012 prioritization. The Planning Council completed individual category prioritizations and turned them in for tabulation following the meeting with results to be emailed to the Planning Council no later than September 6, 2011 for review and discussion/vote at the September 8, 2011 meeting.

Directives

Maria Lopez provided an overview of the Planning Council's directives process. She shared a directive brought forward from Leadership:

A HRSA change to Emergency Financial Assistance no longer allows participants to access assistance for dental co-payments. These co-payments are necessary to cover the laboratory costs associated with dentures and crowns. Currently this assistance supports up to 115 clients annually.

After significant analysis and discussion, it was recommended that this issue be addressed through allocations rather than as a directive.

FY 2012 Allocations Preview

Maria provided a brief overview of topics for the September 8, 2011 meeting:

1. Health Insurance Update: Part B will not request funding for Health Insurance Premiums/Cost-Sharing freeing up approximately $195,000 for Part A in FY 2012
2. Housing services: Funding has been returned by providers for the last two years following an eligibility (standards) change. The Priorities Workgroup requested that staff explore with providers whether this funding would be utilized if eligibility is adjusted.
3. Food bank/home-delivered meals: The Denver Office of HIV Resources (DOHR) has asked that the Planning Council consider allocating funding within this category—a percentage to food bank and a percentage to home-delivered meals.

Adjourn

The meeting was adjourned at 4:30 p.m.

Denver HIV Resources Planning Council

Directives and Resource Allocations Meeting
Mi Casa Resource Center, 360 Acoma Street, Denver
Thursday, September 8, 2011
12:00—5:00 p.m.

Planning Council members present: Joshua Blum, M.D.; Bob Bongiovanni; Debi Bridge; Penny DeNoble; Ernie Duff; Jessica Forsyth; Ed Gardner, M.D.; Patrick Gourley; Kari Hartel; Scott Jackson; Steve Johnson, M.D.; Kate Leos; Leanne Lowenthal; Fabian Ortega; Ruth Pederson; Don Pults; Robert Riester; Richard Weinert

Staff/Facilitator present: Estevan Gastelum, Lynn Hough, Maria Lopez, Michele Shimomura, Anthony Stamper, Caryn Capriccioso (facilitator)

Community members and guests present: Matthew Bennett, Cathy Grimm, Laura Harter, Michael Pearl

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Welcome and introductions

Robert Riester, presiding Planning Council Co-Chair, welcomed the Planning Council and guests to the meeting.

Ground rules and agenda review

Facilitator, Caryn Capriccioso, reminded the Planning Council of the ground rules for the process and reviewed the agenda.

Fiscal Year 2012 Priorities

Results of the Q-Sort tabulation and FY 2012 Priorities recommendations:

Core	**Outpatient Ambulatory Health Services**	**1**
Core	**AIDS Drugs Assistance Program (ADAP) Treatment**	**2**
Core	**Medical Case Management**	**3**
Core	**Oral Health Care**	**4**
Core	**AIDS Pharmaceutical Assistance (local)**	**5**
Core	**Mental Health Services**	**6**
Core	**Early Intervention Services (EIS)**	**7**
Core	**Substance Abuse - Outpatient**	**8**
Core	**Health Insurance Premium & Cost Sharing Assistance**	**9**
Support	**Emergency Financial Assistance**	**10**
Support	**Housing Services**	**11**
Support	**Medical Transportation Services**	**12**
Support	**Food Bank/Home Delivered Meals**	**13**
Core	**Home and Community-based Health Services**	**14**

Caryn highlighted changes from FY 2011 to FY 2012:

FY 2011 Priority Ranking		Rank	FY 2012 Priority Ranking		Rank
Core	Outpatient/Ambulatory Health Services	1	Core	Outpatient Ambulatory Health Services	1
Core	AIDS Drugs Assistance Program (ADAP) Treatments	2	Core	AIDS Drugs Assistance Program (ADAP) Treatments	2
Core	Medical Case Management	3	Core	Medical Case Management	3
Core	AIDS Pharmaceutical Assistance (local)	4	Core	Oral Health Care	4
Core	Oral Health Care	5	Core	AIDS Pharmaceutical Assistance (local)	5
Core	Mental Health Services	6	Core	Mental Health Services	6
Core	Early Intervention Services (EIS)	7	Core	Early Intervention Services (EIS)	7
Core	Substance Abuse Services - outpatient	8	Core	Substance Abuse - Outpatient	8
Support	Housing Services	9	Core	Health Insurance Premium & Cost Sharing Assist.	9
Core	Health Insurance Premium & Cost Sharing Assist.	10	Support	Emergency Financial Assistance	10
Support	Emergency Financial Assistance	11	Support	Housing Services	11
Support	Food Bank/Home Delivered Meals	12	Support	Medical Transportation Services	12
Support	Medical Transportation Services	13	Support	Food Bank/Home Delivered Meals	13
Core	Home Health Care	14	Core	Home and Community-based Health Services	14
Core	Home and Community-based Health Services	15			

General Discussion and clarifying questions:

- Uncertainty about the future tends to lead to few changes in priorities
- Concerned about housing and food services dropping in priority when they were important findings in the needs assessment
- This is a more complex system than we think
- EIS is a major focus of the National HIV/AIDS Strategy and should be a local priority
- This seems to reflect the shift from a terminal to chronic disease

Motion to accept the FY 2012 Priority ranking as tabulated by DHRPC staff (Forsyth, Weinert)

Comments/discussion:

- We will need to consider more external factors next year; it is increasingly hard to connect needs, priorities and allocations
- Bob Bongiovanni: I would like to request specific data about how Medicaid changes will impact outpatient ambulatory services

Motion passed unanimously.

FY 2012 Minority AIDS Initiative allocations

Kari Hartel and Maria Lopez discussed a recommendation that the Planning Council allocate funding in the same percentages as it did in FY 2011 and that Leadership explore how and/or whether to recommend funding for EIS (or potentially outreach) under MAI in FY 2013.

General discussion/clarifying questions:

- Whether or not we have a provider to offer MAI EIS services not the right way to decide
- Q: Can MAI providers apply for Part A EIS? A: Yes.
- Q: Could EIS activities be offered in MAI, simply to gather data this year? A: It would be complicated to build that tracking into the grants process at this point.

- If we do not fund EIS, we are not addressing our data that shows that people of color enter the system later and that 50% of new HIV cases are among minority populations

Motion to accept Minority AIDS Initiative People of Color Leadership/Rebuilt + recommended allocations for FY 2012. (Hartel, Leos)

1. Medical Case Management – 33%
2. Mental Health – 32%
3. Substance Abuse – 35%
4. Early Intervention Services – 0%
5. Capacity Development – 0%

Motion failed with three votes for and twelve against.

Motion to allocate to MAI categories as follows:

1. Medical Cast Management – 20%
2. Mental Health – 20%
3. Substance Abuse – 20%
4. Early Intervention Services – 40%
5. Capacity Development – 0%

(Bongiovanni, Blum)

Discussion:

- What are the strategies for getting providers to offer EIS? "We can't do EIS" is not an acceptable answer.
- Forty percent is a lot. Not comfortable with that allocation given current EIS standards
- There is no time to revise standards prior to the RFP release and there is concern that the current EIS standards might not fit with MAI
- Given the line item for capacity development, could the RFP require new EIS providers to work closely with current EIS providers to build capacity?
- "I can't imagine how it will work" is not the right way to look at it. Let's let them imagine it and create it based on what they need.
- Q: What will happen to the other MAI categories? Are we destroying medical case management? A: Part A providers also offer services to people of color.
- Providers consistently rate substance abuse and mental health as significant needs. The amount proposed for EIS is too high

Friendly amendment to change the allocations as follows (Forsyth):

1. Medical Cast Management – 27%
2. Mental Health – 26%
3. Substance Abuse – 27%
4. Early Intervention Services – 20%
5. Capacity Development – 0%

The amendment was not accepted.

Friendly amendment to change the allocations as follows (Weinert):

1. Medical Case Management – 25%
2. Mental Health – 20%
3. Substance Abuse – 25%
4. Early Intervention Services – 30%
5. Capacity Development – 0%

Amendment accepted.

Motion carried with 10 votes for and 6 votes against.

DENVER HIV RESOURCES PLANNING COUNCIL
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FY 2012 Minority AIDS Initiative (MAI) Priority Setting and Resource

Service Category		Rank	FY 2012 $ 279,493.00	
			%	$
Core	Medical Case Management (MCM)	1	25%	$ 69,873
Core	Mental Health Services	2	20%	$ 55,899
Core	Substance Abuse Services (Outpatient)	3	25%	$ 69,873
Core	Early Intervention Services	4	30%	$ 83,848
	Capacity Development	5	0%	$ -
	Total		100%	$279,493

Fiscal Year 2012 Directives

Maria shared the recommendation that a directive brought forward through Leadership regarding oral health care be handled through allocations. She suggested that approximately $22,000 be shifted from unallocated funding (home health care and health insurance premium/cost-sharing savings) to oral health care. The Planning Council determined it did not need to vote on the directive as it was not formally being proposed.

Fiscal Year 2012 Allocations

Jessica Forsyth provided an overview of allocations and the importance of the process. Caryn Capriccioso shared the process that would be used including sharing of initial recommendations by the Planning Council followed by a small group activity to develop proposals for consideration. She reminded the group of ***unallocated funding (approx. 3.95%) available for consideration***:

Category	Funding
Health Insurance Premium/Cost Sharing	$195,664
Home Health Care	$56,723
Total	**$252,387**

She also shared that the Priorities Workgroup recommended that Planning Council focus on one scenario this year: ***a funding range of 95-105% of FY 2011***. The range is reflected in the table below:

FY 2012 Priorities		% Allocation	95%	100%	105%
Core	Outpatient Ambulatory Health Services	34.77%	$ 2,105,237	$ 2,216,039	$ 2,326,841
Core	AIDS Drugs Assistance Program (ADAP) Treatment	0.00%	$ -	$ -	$ -
Core	Medical Case Management	12.39%	$ 750,184	$ 789,667	$ 829,150
Core	Oral Health Care	11.66%	$ 705,984	$ 743,141	$ 780,298
Core	AIDS Pharmaceutical Assistance (local)	8.74%	$ 529,185	$ 557,037	$ 584,889
Core	Mental Health Services	6.14%	$ 371,762	$ 391,328	$ 410,894
Core	Early Intervention Services (EIS)	4.60%	$ 278,518	$ 293,177	$ 307,836
Core	Substance Abuse - Outpatient	6.31%	$ 382,055	$ 402,163	$ 422,271
Core	Health Insurance Premium & Cost Sharing Assistance	0.00%	*	*	*
Support	Emergency Financial Assistance	2.78%	$ 168,322	$ 177,181	$ 186,040
Support	Housing Services	5.02%	$ 303,949	$ 319,946	$ 335,943
Support	Medical Transportation Services	1.25%	$ 75,685	$ 79,668	$ 83,651
Support	Food Bank/Home Delivered Meals	1.89%	$ 114,435	$ 120,458	$ 126,481
Core	Home and Community-based Health Services	0.49%	$ 29,669	$ 31,230	$ 32,792
Unallocated Funds: $195,664 (Health Insurance Premium/Cost Sharing; $56,723 (Home Health Care) = $252,387					

Note: This table is an example based on FY 2011 priorities and allocations and is the information from which the breakout groups developed their recommendations.

If the final award for FY 2012 is less than 95% or more than 105%, the Planning Council will revisit and potentially adjust allocations.

Planning Council Recommendations for FY 2012 Allocations

- Reallocate $22,000 (or its equivalent percentage) from the unallocated funding to oral health care
- Consider an additional increase in Oral Health Care (x2)
- Increase the allocation to AIDS Pharmaceutical Local
- Reallocate a portion of the unallocated funding to medical case management
- After the $22,000 allocation to Oral Health Care, reallocate the remaining available percentage across categories based on FY 2011 allocations and/or based on the needs assessment/other factors
- Move 3.95% minus $22,000 (Oral Health Care) back to Outpatient Ambulatory, Medical Case Management and AIDS Pharmaceutical Local

Bob Bongiovanni provided an overview of the allocations spreadsheet and how to utilize it in the small groups.

The Planning Council counted off by threes and divided into three groups each with: a laptop, an allocations spreadsheet and flip chart pages.

Group Proposals for FY 2012 Allocations

<u>Group One</u>

1. Main priority is oral health care: increase by 2%
2. Reduce home and community-based health services by 50%; .49% to .25%
3. Increase medical case management by 1%
4. Increase outpatient ambulatory by 1%
5. Increase food bank/home-delivered meals by 1%
6. Increase medical transportation by .08%

Clarifying questions:

- Q: What is the rationale for reducing home and community-based health services? A: Eligibility requirements will increase and numbers of eligible people will decrease. And, Medicaid may fill the gap.
- Q: Will more money in oral health care address the issues? A: It may allow for more providers.

<u>Group Two</u>

1. Reallocate $22K to oral health care, but no more
2. Move 1% to EIS to support more people of color accessing the services in Part A
3. Move 1% to medical case management to support transition to Medicare

4. Move .5% to mental health and .5% to substance abuse services since both are always underfunded
5. Reallocate .15% to food service/home-delivered meals and .12% to transportation services based on the needs assessment

Group Three

1. Reallocate $22,000 plus an additional 1.3% to oral health care
2. Move 1% of the unallocated funding to medical case management
3. Move 1% to outpatient ambulatory
4. Move .61% to AIDS pharmaceutical local

Comparison of reallocation proposals:

Service Category	Group 1	Group 2	Group 3	Average
Outpatient/Ambulatory Health Services	35.77%	34.77%	35.77%	35.44%
AIDS Drugs Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
Medical Case Management	13.39%	13.39%	13.39%	13.39%
Oral Health Care	13.66%	12.01%	13.01%	12.89%
AIDS Pharmaceutical Assistance (local)	8.74%	8.74%	9.35%	8.94%
Mental Health Services	6.14%	6.64%	6.14%	6.31%
Early Intervention Services (EIS)	4.60%	5.60%	4.60%	4.94%
Substance Abuse Services - outpatient	6.31%	7.13%	6.31%	6.59%
Health Insurance Premium	0.00%	0.00%	0.00%	0.00%
Emergency Financial Assistance	2.78%	2.78%	2.78%	2.78%
Housing Services	5.02%	5.02%	5.02%	5.02%
Medical Transportation Services*	1.33%	1.40%	1.25%	1.32%
Food Bank/Home Delivered Meals	2.00%	2.03%	1.89%	1.97%
Home and Community-based Health Services*	0.25%	0.49%	0.49%	0.41%

The Planning Council discussed several key points of similarity and difference and asked questions of the various groups in order to narrow down options:

- Q: Could we use the average? A: It won't leave enough in oral health care to make a difference
- We need to increase capacity in oral health care and that might mean adding another provider
- The Planning Council has no control over whether new providers are added or how much funding might be needed to welcome a new provider
- Oral health care was the top need identified by consumers in the survey
- The average allows us to respect the group process and compromise

- This should be about data-based decision-making, not honoring the group process
- Data shows the need for more oral health service locally, nationally and based on personal experience
- We need to recognize community input and oral health is a consistent need
- We need to understand whether the need for oral health care is real or if it is related to people's perceptions of what it should be
- The alignment is surprising; these are difficult decisions, but the differences are not significant
- Want to point out that an increase in medical case management won't be used to support the transition to Medicare, the timing of this funding and the transition are the same
- Medical case management is over capacity. It took a hit with the addition of EIS and the need is increasing. MCM leads to self-management which helps the system in the long run.

Motion to accept the average of the allocations proposed by the small groups (Weinert, Loewenthal). See previous page for the average allocations. **Motion passed with 13 votes in favor and 2 opposed.**

The following is the final FY 2012 Priority Setting and Resource Allocation:

FY 2012 Priority Setting and Resource Allocation			Range (95-105%)	
Service Category		Rank	$6,373,423 (Note: Dollar amount is estimated on previous FY Award)	
			$	%
Core	Outpatient Ambulatory Health Services	1	$2,258,741	35.44%
Core	AIDS Drugs Assistance (ADAP)	2	$0	0.00%
Core	Medical Case Management	3	$853,401	13.39%
Core	Oral Health Care	4	$821,534	12.89%
Core	AIDS Pharmaceutical Assistance (local)	5	$569,784	8.94%
Core	Mental Health Services	6	$402,163	6.31%
Core	Early Intervention Services	7	$314,847	4.94%
Core	Substance Abuse - Outpatient	8	$420,009	6.59%
Core	Health Insurance/Cost Sharing	9	$0	0.00%
Support	Emergency Financial Asst.	10	$177,181	2.78%
Support	Housing Services	11	$319,946	5.02%
Support	Medical Transportation Svcs	12	$84,129	1.32%
Support	Food Bank/Home Meals	13	$125,556	1.97%
Core	Home & Comm-Based Health	14	$26,131	0.41%
		TOTAL	$6,373,423	100.00%
	CORE	TOTAL	$5,666,610	88.91%
	SUPPORT	TOTAL	$706,813	11.09%

FY 2012 Priorities		% Allocation	95%	100%	105%
Core	Outpatient Ambulatory Health Services	34.77%	$ 2,105,237	$ 2,216,039	$ 2,326,841
Core	AIDS Drugs Assistance Program (ADAP) Treatment	0.00%	$ -	$ -	$ -
Core	Medical Case Management	12.39%	$ 750,184	$ 789,667	$ 829,150
Core	Oral Health Care	11.66%	$ 705,984	$ 743,141	$ 780,298
Core	AIDS Pharmaceutical Assistance (local)	8.74%	$ 529,185	$ 557,037	$ 584,889
Core	Mental Health Services	6.14%	$ 371,762	$ 391,328	$ 410,894
Core	Early Intervention Services (EIS)	4.60%	$ 278,518	$ 293,177	$ 307,836
Core	Substance Abuse - Outpatient	6.31%	$ 382,055	$ 402,163	$ 422,271
Core	Health Insurance Premium & Cost Sharing Assistance	0.00%	*	*	*
Support	Emergency Financial Assistance	2.78%	$ 168,322	$ 177,181	$ 186,040
Support	Housing Services	5.02%	$ 303,949	$ 319,946	$ 335,943
Support	Medical Transportation Services	1.25%	$ 75,685	$ 79,668	$ 83,651
Support	Food Bank/Home Delivered Meals	1.89%	$ 114,435	$ 120,458	$ 126,481
Core	Home and Community-based Health Services	0.49%	$ 29,669	$ 31,230	$ 32,792
Unallocated Funds: $195,664 (Health Insurance Premium/Cost Sharing; $56,723 (Home Health Care) = $252,387					

Summary of Planning Council's Initial Steps in addressing issues identified in the needs assessment, community process and Priorities and Allocations Process

Emergency Financial Assistance
Oral health co-pays are no longer an option under EFA. Funding was allocated to Oral Health Care to cover those costs which should free up funds in Emergency Financial Assistance to support other emergency needs. Also, the Planning Council is working with community members to explore a way to share resources about other options for participants to access support.

Monitoring and Evaluation: Can we show improvement? What can we monitor? How to connect with Oral Health Needs Assessment?

Medical Transportation Services
Medical Transportation Services was prioritized one level higher this year by the Planning Council (12 instead of 13) and received an increase in allocations of .07% (approximately $4,500 if funding remains consistent). Planning Council will make a recommendation to DOHR to diversify token distribution sites.

Monitoring and Evaluation: How will we know we were successful?

Oral Health Care
Oral Health Care was prioritized one level higher this year by the Planning Council (4 instead of 5) and received an increase in allocations of 1.23% (approximately $78,500 if funding remains consistent). Also, the Planning Council is investigating oral health needs further through a specific oral health needs assessment.

Monitoring and Evaluation: Can we realistically connect the Oral Health Needs Assessment to the initial steps? How to measure dollar increases with clients served when we do not have units of cost per service? Waitlists and emergency issues? (Update: one provider is no longer providing emergency services to clients not of record.) How will we monitor that impact? What are the implications for standards of care?

Housing
While the funding allocation remains the same, the Planning Council is exploring expanding eligibility requirements for this category so that more people could access the short-term support.

Groceries / Prepared Meals
Planning Council increased allocations to this category by .08% (approximately $5,000 if funding remains consistent). In addition, the Planning Council is working with community representatives on compiling a resource list to help people with access to food within and beyond the Ryan White Part A system.

Next Steps

Caryn reminded the Planning Council of the final community meeting on September 15, 2011 at 5 p.m. at Mi Casa and encouraged members to attend.

Adjourn

The meeting was adjourned at 4:25 p.m.