



**FY 2013**

**Priority Setting and Resource Allocation**

**Report**

October 2012

**Prepared by:**

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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 2013 Priority Setting and Allocations Process on August 10 and August 17, 2012. During its planning work, the Priorities Workgroup explored how other Transitional Grant Areas (TGAs) conducted their processes and determined that for FY 2013, the Planning Council would utilize a process similar to that of FY 2012.

The Priorities Workgroup hired interSector Partners' Caryn Capriccioso, interSector Partners, L3C, to conduct research into other communities' processes and to facilitate and document the FY 2013 process.

### Key Decisions for FY 2013

(Please see "[FY 2013 Priority Setting and Resource Allocations Task List](#)" for a more detailed description of the discussions leading to these decisions.)

#### *Minority AIDS Initiative*

- The Planning Council will develop a data and needs assessment strategy for MAI.
- The Planning Council will conduct a cost analysis for MAI Mental Health and Substance Abuse Services to include Part A Mental Health, Substance Abuse and to include Outpatient Ambulatory.

#### *Housing*

MDASC will meet to discuss and assess issues with EFA and Housing and make recommendations about specific action steps to Leadership so that next steps can be determined and completed before FY 2013.

- The Planning Council will learn more about how it can work with housing locations (hotels, transitional housing, etc) to address transitional housing challenges
  - Part B will allocate Quality Assurance funding toward a paid consultant to support MDASC in this work; Bob requests that the consultant consider the region, not only the Denver TGA

#### *Monitoring*

- DOHR will monitor the outcomes of all categories and DHRPC will consider any reallocated funds for Medical Case Management

Overall prioritization of categories and allocations for FY 2013:

FY 2013 Priority Setting and Resource Allocation			Range (95-105%)*	
Service Category		Rank	\$6,122,763 (Note: Dollar amount is estimated on previous FY Award)	
			\$	%
Core	Outpatient Ambulatory Health Services	1	\$2,169,908	35.44%
Core	Medical Case Management	2	\$819,838	0.00%
Core	ADAP	3	0	13.39%
Core	Oral Health Care	4	\$789,224	12.89%
Core	Mental Health Services	5	\$ 386,346	8.94%
Core	Early Intervention Services	6	\$ 302,465	6.31%
Core	AIDS Pharmaceutical Assistance (local)	7	\$ 547,375	4.94%
Core	Substance Abuse - Outpatient	8	\$403,490	6.59%
Core	Health Insurance/Cost Sharing	9	\$0	0.00%
Support	Emergency Financial Asst.	10	\$170,213	2.78%
Support	Housing Services	11	\$307,363	5.02%
Support	Medical Transportation Services	12	\$80,820	1.32%
Support	Food Bank/Home Meals	13	\$120,618	1.97%
Core	Home & Community-Based Health	14	\$25,103	0.41%
<b>TOTAL</b>			<b>\$6,122,763</b>	<b>100.00%</b>

\*The Planning Council approved the above allocations for funding of 95—105% of the FY 2012 level. Allocations at a funding level of less than 95% or more than 105% will require review and potential reallocation by the Planning Council.

The following report shares highlights of the presentations, motions, discussion and results of the FY 2011 Priorities and Allocations Process.



**Denver HIV Resources Planning Council**

Priority Setting Meeting

Mi Casa Resource Center Community Hall, 360 Acoma Street, Denver

Friday, August 10, 2012

9:00 a.m.—3:00 p.m.

**Planning Council members present**

Bob Bongiovanni; Debi Bridge; Penny DeNoble; Ernie Duff; Jessica Forsyth; Edward Gardner, MD; Robert George; Kari Hartel; Scott Jackson, Co-Chair; Steven Johnson, MD; Imani Latif; Don Pultz; Robert Riester, Co-Chair; Jalene Salazar; Phil Stoltzfus; Larry Taylor; Diane Walker; Richard Weinert

**Staff/Facilitator present**

Maria Lopez, Planning Council; Lynn Hough, Denver Offices of HIV Resources; Berenice Ornelas, Denver Office of HIV Resources (DOHR); Michele Shimomura, DOHR; Anthony Stamper, DOHR; Caryn Capriccioso, interSector Partners, L3C (facilitator)

**Community members and guests present**

Bettina Harmon, Diverse Management Solutions; Eric Hoffman; Steve Pastor; Darrell Vigil, Colorado AIDS Project

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**Welcome and introductions**

Robert Riester, 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.

She provided an overview of the conflict of interest forms that are required for the annual Priority Setting and Allocations process, and the Planning Council members handed in their completed forms.

## Priority Setting Overview

Kari Hartel provided an overview of the Planning Council's role in priority-setting and allocations.

## 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.

Maria also shared the process utilized during the year to explore the potential addition of new categories in the TGA. She indicated that Leadership explored Outreach as a potential new category and determined not to put forward that recommendation in 2012 given the uncertainty of funding and healthcare reform.

Bob Bongiovanni suggested the potential need for outreach activities to enroll Part A participants on Medicaid. He stated that clinics will be swamped and that currently there is not a category for handling a one hour case management contact with a client/patient to help them get set-up for these services. He shared his experience partnering with Denver Health and that the process took several hours per person to enroll people in ADAP and to work through issues with the Colorado Benefits Management System.

The Planning Council discussed the need and opportunity for adding Outreach as a category:

- Is it possible that the roll-out of this is tied to the Affordable Care Act (ACA) or the election? We should understand if it's actually happening prior to setting up a system to respond to it.
- It appears that at least some level of subsidy—and some said a large portion—will remain, even if ACA isn't fully implemented.
- The category would not be added until March of 2013; the timing is not good. By next year's process, it may be too late to get something up and running, and/or Ryan White may no longer exist.
- An unfunded category is an option while we look further into the opportunities.
- Reallocation occurs based on the mid-year report. There is no guarantee that money would be available to fund the category and it would be tough to quickly release and receive responses to an RFP to select contractor(s).
- The issue here is whether this decision would allow us to be nimble and adapt to what happens between October and March when the funding year begins.
- Medical Case Management could handle this effort.
- We need to have flexibility and create contingency plans for several scenarios.

The group decided to continue the discussion during the priority-setting process.

## Community Meeting Update

Steve Pastor, volunteer representing the community members in attendance at the July 31, 2012 community meeting, provided an overview of the meeting and the community input.

Twenty-eight people attended the first community meeting including 14 consumers, 2 providers and 12 others. Many people had multiple affiliations.

The meeting was designed to provide education on the Planning Council and system, the Comprehensive Plan proposed goals, Medicaid expansion, but most importantly to gather input from the community on the special populations addressed in the comprehensive plan.

Steve highlighted the problem statements, goals and input from the community for four special populations: aging with HIV, foreign-born African Americans and refugees, foreign-born undocumented people and African Americans. He shared the community input for each group.

### Aging with HIV

- ❖ Educate doctors that people living with HIV/AIDS (PLWHA) are aging prematurely. They are experiencing bone loss, cardiovascular and other issues due to medications and the stress of living with HIV
- ❖ Educate policy makers to begin offering coverage at younger ages for PLWHA
- ❖ Generational resistance to accepting support/help is an issue; work to address this
- ❖ Mental health issues related to aging and aging with HIV are significant and will continue to grow
- ❖ We don't yet know the long-term effects of medications; we will learn more about this over time
- ❖ There will need to be nursing homes and assistance specifically for and/or accepting of PLWHA; the system may not be the place for this, but collaboration might be possible
- ❖ Increase testing for people over 50
- ❖ We need to define aging with HIV; for instance at 50 years of age, one person had been positive for 29 years; some people were diagnosed as children are only 30 now, but are aging with HIV (Note: this is hard to understand because we don't always know when people became positive, just when they tested positive)
- ❖ Need to be aware that some people may not have planned for and saved for the future because they didn't plan to age with HIV; they will need additional support and assistance
- ❖ Look at how to collaborate with existing services for older adults, those that are non-HIV focused; how can we improve information flow to Part A case managers about other community resources related to aging – they may not have ever needed to know about aging resources in the past)
- ❖ Some people aging with HIV aren't trying to be healthy; how can we support them so they want to be healthy?
- ❖ Self-sufficiency support will be important

### ***Foreign-born African immigrants and refugees***

- Peer advocacy is the key; make connections for people who think “they don’t have a group for me”
- Hire HIV+ people from this community as case managers
- This population tends to stay segregated; do direct outreach into their communities
- Understand language barriers and address them; translators should be unknown to the PLWHA, if possible
- Continue to hold community meetings with agencies serving these populations
- People getting diagnosed when they come into the U.S. are typically pretty advanced in their illness; how can we connect with them?
- Stigma and cultural norms are significant; try to reach people through people and networks of trust such as churches
- We need to learn from the community first about their needs

### ***Foreign-born Undocumented***

- ❖ Many strategies are the same including:
  - Peer Advocacy
  - Hiring people from the community who are HIV+ to serve as case managers
  - Understand language barriers
  - Consider stigma and cultural norms of the community
  - Work through people and networks of trust
- ❖ Undocumented people have trouble accessing other primary care funding or insurance; putting them at higher risk
- ❖ They are typically not eligible for services, do not have rights and are taken advantage of
- ❖ This leads to a lot of fear, stress and marginalization
- ❖ They have many basic needs in addition to HIV; multiple other challenges are present
- ❖ Once trust is built, however, high adherence levels occur
- ❖ We need to learn more about the need
- ❖ Use the Spanish-language media to build awareness
- ❖ Lots of opportunity to find unaware people in this community
- ❖ Continue to educate that undocumented people can access HIV services without fear
- ❖ Educate through Mexican Consulate; connect with people early on
- ❖ Provide information to resource centers / other community agencies about where undocumented people can go for HIV testing and care
- ❖ People tend to move from state to state and leave care; it’s hard to monitor adherence
- ❖ Improve linkage to care between medical and supportive services; need to build trust with one person who can then refer them for other services

- ❖ People travelling regularly between countries have unique needs, especially related to medications; what is the need here?
- ❖ We don't have to create this ourselves. What can we learn from other cities and other countries?

### ***African Americans***

- ❖ Housing support is key: affordability, suitability and timing
- ❖ A framework exists for successful housing; see the Oxford model, Samaritan House (Ft. Worth) and others (ask Don about this!)
- ❖ Make sure outreach is *\*in\** community; find people where they are such as churches
- ❖ Do “in your face reach” – outreach in African American communities is most successful with an “in your face” approach
- ❖ Teach community agencies, churches, etc. how to help; they may not be supporting our work because they don't know how
- ❖ Continue to work to reduce stigma
- ❖ Peer mentoring and advocacy; finding people like you who can share their stories and successes. Two keys:
  - Find good people
  - Train and educate them
- ❖ Create a marketing strategy that has customized messages for each community; focus on what you say and how people will receive it
- ❖ Don't be afraid to be direct and straightforward in language and messaging re: sex, IDU, etc.

Steve shared the ***common ideas across the groups*** included:

- ❖ Peer advocacy and networking
- ❖ Reducing stigma
- ❖ Get out into the community
- ❖ Create marketing strategies customized to each population
- ❖ Don't be afraid to use direct, straightforward messaging

The Planning Council discussed the input.

- At the community meeting, there was a strong voice for looking outside the box to learn from what others are doing in other states or even other countries.
- It sounds like what the community wants is outreach and early intervention services.
- Peer advocacy is really important; many agencies use peers in medical case management.
- We need to be careful not to generalize; African immigrants are resistant to peer advocates, for example.

The Planning Council thanked Steve for volunteering to represent the community and spending considerable time preparing for the presentation.

**Minority AIDS Initiative Priorities Recommendations**

Planning Council members Kari Hartel and Jalene Salazar shared the history and key facts about the Minority AIDS Initiative (MAI). They discussed the process used by the People of Color Leadership and Rebuilt+ Committee (POCL/Rebuilt+) to develop the FY 2013 MAI recommendations.

Maria shared that POCL/Rebuilt+ and Leadership both identified the need for more people of color specific data to support MAI decision-making. The current information is limited and over the next few months, the Planning Council will develop a data and needs assessment strategy for MAI.

The POCL/Rebuilt+ recommendations and comparison to last year’s MAI prioritization were:

<b>MAI FY 2012</b>	<b>MAI FY 2013</b>
1. Medical Case Management	1. Medical Case Management
2. Substance Abuse	2. Substance Abuse
3. Mental Health	3. Mental Health
4. Early Intervention Services	4. Early Intervention Services
5. Capacity Building	5. Capacity Building

Maria reviewed sections of the 2012 Data Book related to MAI with the Planning Council. The Planning Council discussed a few key items including data around substance abuse and mental health utilization.

- The majority of those accessing mental health services under MAI are Latino and the majority of those accessing substance abuse services are African American. This is likely because of where the services are offered.
- Mental health and substance abuse are not as separate as some might think. They are different, but related.
- The system is missing the idea of catching mental health and substance abuse issues upfront through assessments. If people are identified early as having these issues, we can help to reduce stigma and get them directed into care. Instead we force people to bottom out before they seek treatment.
- The mental health and substance abuse services offered by Part A are the only services of their type that undocumented PLWHA can access.
- Better care is not about screening, it's about outreach.
- CDPHE is implementing a system to identify people earlier, normalize the behavioral issues and connect them to more services sooner.
- Specialized services will shift with ACA; we'll need to be creative to tailor mental health services.
- This conversation stresses the need for co-location; we will need the expertise to adjust to a medical home model.

➤ **Motion** to approve the recommendations of the POCL/Rebuilt+ Committee and keep the MAI category prioritization the same as FY 2012.

**Motion passed with 17 votes in the affirmative.**

**(17 Planning Council members were in attendance at this time.)**

**Ed Gardner arrived at the meeting.**

**Imani Latif left the meeting.**

<b>Priority-setting process overview</b>
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Jessica Forsyth, Priorities Workgroup Co-Chair, shared information about research conducted by the Priorities Workgroup to explore options for category prioritization. The majority of systems researched utilized some type of Q-sort process. The system utilized in New York was of interest to the workgroup, however it was cost and time prohibitive to implement in a year with so much uncertainty.

She explained the Q-sort process and each Planning Council member received their Q-sort cards.

Prior to the Q-sort process, Bob Bongiovanni asked to revisit adding referral as a category.

The Planning Council discussed this idea:

- There is no guarantee funds would be available to support this category.
- HRSA has made it increasingly hard to add an unfunded category.
- There is no difference between adding a category without money and not adding the category.
- Other programs will be required to address Medicaid enrollment; it will be taken care of elsewhere with resources outside of Ryan White funding.
- We cannot tailor our system to meet every single need of PLWHA, other systems exist.
- Our clients aren't a priority to the other systems. Our people will go to their case managers first. This would be a placeholder for an uncertain future.
- We already have medical case management. Why not shift funding to support that category?
- We all want a flexible system, but we don't have enough information to make a good decision. The idea of a placeholder resonated, but with more thought, this is something that can be addressed through the Standards of Care.
- The cost to implement is unknown. *(A ballpark estimate of \$250,000 was shared.)*
- Medical case managers don't have the capacity to handle this. Believe in using existing systems where possible, but it's not possible.
- We've done a bad job of enrollment historically. We researched that 350 consumers at CAP would qualify for Medicaid (10% of FPL program) who haven't been enrolled. We just don't have the capacity.
- Is it possible for HCPF to conduct enrollment on site at ASOs and providers? *(Phil will check into this.)*
- This sends the message that we are looking for was to adapt to the change we see on the horizon.
- It's not a meaningful gesture. We can collaborate better than we do now.
- Part B will prioritize ADAP enrollees first in its referral system.

➤ **Motion** to add Referral as a category to cover benefits eligibility.

**Motion failed on a vote of 5 to 11 with 2 abstentions.  
(18 Planning Council members were in attendance at this time.)**

The Planning Council members individually completed their Q-Sort process and turned in their Q-Sort cards.

Caryn reminded the Planning Council that they would receive the FY 2013 Prioritization by email next week and would vote to accept this prioritization at the August 17, 2012 meeting.

## Directives Update and Discussion

Robert Riester shared what directives are and how they work with the Planning Council.

### How to Submit a Directive:

Submitting a directive to the Denver HIV Resources Planning Council (DHRPC) requires that the applicant proposing a new directive complete the Directive Submission Application Form. **The Leadership Committee of the Planning Council will convene to review all submitted directives, and shall provide the submitter with a written response regarding the directive within one (1) month of submission.**

1. The Issue or Need necessitating this Directive
2. How it may be used to impact a specific service model
3. Present the Data that validates the Need for this Directive
4. Outline and define outcomes of Directive
5. Monetary amount of application

He discussed DOHR's role in directives as well as lessons learned over the years in implementing directives.

- DOHR must implement Directive within a timely manner. Directive must be implemented to ensure impact within Fiscal Year.
- If applicable DOHR to provide bi-annual (mid-year and year end) updates on Directives based on clients served and outcomes in written format to the Planning Council

He gave an update on the proposed FY 2012 directive for oral health care as an example of how the process works and lessons learned.

Robert shared the one FY 2013 directive received first by the Leadership and presented for consideration today to the Planning Council from Carol Lease, a Planning Council member and a grantee of Part A funds: Confidentiality and Privacy of HIV/AIDS Records for Services Funded under the Denver Office of HIV Resources. The directive reads:

*This Directive will fill a gap in standards concerning the use of confidential HIV records of individuals who receive services funded through the Mayor's Office of HIV Resources (MOHR). The need was identified when an AIDS Service Organization (ASO) spent down its MOHR funding before the end of the grant period and closed its doors in late 2010. PLWHA who had received services from the ASO transferred to other ASOs or were already receiving services from other ASOs.*

*When the former Executive Director of the defunct ASO began working at another ASO, she contacted those PLWHAs informing them of her new position and offering them the opportunity to transfer their Medical Case Management services to her new employer if they wanted to do so. This information was verified by the Executive Director in an e-mail I received earlier this year. As a condition of their medical, substance abuse, mental health or social work licensing, almost all ASOs are legally and ethically bound by state, federal and professional licensing to adhere to standards concerning PLWHA records retention, dissemination and disposal.*

*This Directive will impact all services providers by providing a consistent standard for all ASOs who provide services funded through DOHR in the retention and disposal of confidential records of PLHWAs.*

*The data that validates the need for this Directive is represented in various Needs Assessments by the Denver HIV Resources Planning Council that shows that stigma continues to affect the care and treatment seeking behaviors of PLWHAs. PLWHAs must be able to trust ASOs to maintain the highest level of confidentiality and privacy in maintaining records*

*Implement standards that assure that the confidentiality and privacy of PLWHAs who receive services funded through MOHR are consistent regardless of external licensing requirements that the specific ASO must meet.*

*Leadership Committee Recommendations:*

- *Incorporate retention and disposal of client records through the contracts executed by DOHR.*
- *Through the City process have DOHR initiate an investigation to see if ethical violations occurred.*

The Planning Council discussed the directive in detail and explored a number of options for addressing the situation that occurred and ensuring this doesn't happen again going forward.

- The easiest way to correct the situation is to include language in the contracts, as for an investigation, the agency is now closed, so the investigation would be into the individual. If the investigation revealed actions to pursue, they would most likely be criminal rather than ethical.
- Are case management agencies covered by HIPPA? This is questionable and would need to be determined by the Attorney General's Office.
- Discussion of whether the actions violated Denver TGA standards or HRSA universal standards. The standards do not address the closing of an agency.
- DOHR indicated that the contracts are the rules and the contracts neglected to cover this situation; not sure that retroactively trying to investigate something that was a gap in the rules is useful

➤ **Motion: To adjust and approve the directive as follows:**

- **Incorporate retention and disposal of client records through the contracts executed by DOHR.**
- **DOHR will request that the City Attorney's Office initiate an investigation of legal, ethical and regulatory implications of this incident and future requirements for record retention.**  
**(Note: DHRPC Directives)**

**The Planning Council discussed the motion:**

- Not interested in what happened in the past, but we need to be sure this doesn't happen again. Not convinced, however, that the individual involved understands how serious this is. (DOHR responded that the office has communicated with this person who is aware of the ethical concerns of DOHR and the Planning Council.)
- Don't want to pursue criminal action. We need to close the loophole.

Following discussion, Bob Bongiovanni amended his motion to read:

- **Motion: To adjust and approve the directive as follows:**
- **DOHR will request the opinion of the City Attorney's Office regarding the ethical and regulatory requirements for record retention**
  - **Incorporate retention and disposal of client records through the contracts executed by DOHR.**

**Motion passed with 16 votes in the affirmative and one abstention.**

### **Allocations Meeting Preview**

Maria shared with the group that at the Allocations meeting next week the Planning Council will have some time to discuss pressing issues facing the system and consider their meaning for FY 2013 Allocations and for other priorities of the Planning Council in the coming year. She highlighted several issue areas and asked the Planning Council to share its thoughts as well:

#### ***Affordable Care Act & Medicaid expansion***

Timing, inflow and outflow of patients, closing of CICP, people who will be left out of the expansion

#### ***Reauthorization and Budget for Ryan White***

\$189 M reduction in Ryan White across the board

\$78M in ADAP

\$26M in HOPWA

How does this fit with the fiscal cliff and cuts across a wide variety of services?

***Economics of outpatient ambulatory;*** how do other TGAs and EMAs use outpatient ambulatory?

#### ***Housing***

- This category is under spent annually
- It is a National HIV/AIDS Strategy focus
- Need to look at eligibility guidelines
- Create options for longer-term transitional housing
- People are living longer, stabilized lives; how does this impact longer-term housing options (less turnover in units, fewer people can access housing)

***Upcoming mass release of incarcerated people***

***Food drought***

**Next Steps**

Caryn reminded the group that the Allocations meeting will be held on Friday, August 17<sup>th</sup> at 9:00 a.m. at Mi Casa. She also shared that those Planning Council members who were not present for Priority Setting will be able to participate in the process, but will not be eligible to vote at the Allocations meeting.

**Adjourn**

The meeting was adjourned at 2:45 p.m.



**Denver HIV Resources Planning Council**

Allocations Meeting

Mi Casa Resource Center Community Hall, 360 Acoma Street, Denver

Friday, August 17, 2012

9:00 a.m.—4:00 p.m.

**Planning Council members present**

Bob Bongiovanni; Debi Bridge; Penny DeNoble; Ernie Duff; Edward Gardner, MD; Robert George; Kari Hartel; Scott Jackson, Co-Chair; Steven Johnson, MD; Imani Latif; Michael Pearl; Don Pultz; Robert Riester, Co-Chair; Jalene Salazar; Phil Stoltzfus; Larry Taylor; Diane Walker; Richard Weinert

**Staff/Facilitator present**

Maria Lopez, Planning Council; Lynn Hough Denver Office of HIV Resources, Berenice Ornelas, Denver Office of HIV Resources (DOHR); Anthony Stamper, DOHR; Caryn Capriccioso, interSector Partners, L3C (facilitator)

**Community members and guests present**

Betina Harmon, Diverse Management Solutions; Eric Hoffman; Darrell Vigil, Colorado AIDS Project

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**Welcome and introductions**

Scott Jackson, 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**

Scott Jackson reviewed the Planning Council Ground Rules established at the August 10, 2012 Priority Setting meeting. The group asked to add one new ground rule for the purposes of the Allocations meeting regarding “removing provider hats” when making decisions about allocations for the Denver TGA.

Scott shared a reminder that this is Planning Council decision-making meeting and that community participation will occur through the community representatives’ presentation.

<b>FY 2013 Priorities</b>
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Robert Riester, Planning Council Co-Chair, reviewed the process for determining the FY 2013 priorities. He shared the results of the Planning Council Q-Sort process and resulting FY 2013 recommended priorities.

<b>FY 2013 Priority Ranking</b>		<b>Rank #</b>
<b>Core</b>	<b>Outpatient Ambulatory Health Services</b>	<b>1</b>
<b>Core</b>	<b>Medical Case Management</b>	<b>2</b>
<b>Core</b>	<b>AIDS Drugs Assistance (ADAP)</b>	<b>3</b>
<b>Core</b>	<b>Oral Health Care</b>	<b>4</b>
<b>Core</b>	<b>Mental Health Services</b>	<b>5</b>
<b>Core</b>	<b>Early Intervention Services</b>	<b>6</b>
<b>Core</b>	<b>AIDS Pharmaceutical Assistance (local)</b>	<b>7</b>
<b>Core</b>	<b>Substance Abuse - Outpatient</b>	<b>8</b>
<b>Core</b>	<b>Health Insurance/Cost Sharing</b>	<b>9</b>
<b>Support</b>	<b>Emergency Financial Asst.</b>	<b>10</b>
<b>Support</b>	<b>Housing Services</b>	<b>11</b>
<b>Support</b>	<b>Medical Transportation Services</b>	<b>12</b>
<b>Support</b>	<b>Food Bank/Home Meals</b>	<b>13</b>
<b>Core</b>	<b>Home &amp; Community-Based Health</b>	<b>14</b>

He also talked about the changes from FY 2012's priorities and shared his thoughts on why some of these shifts may have taken place.

SERVICE CATEGORY	FY 2013	FY 2012
Outpatient Ambulatory Health Services	1	1
Medical Case Management	2 (+1)	3
ADAP	3 (-1)	2
Oral Health Care	4	4
Mental Health	5 (+1)	6
Early Intervention Services (EIS)	6 (+1)	7
AIDS Pharmaceutical Assistance (Local)	7 (-2)	5
Substance Abuse – Outpatient	8	8
Health Insurance/Cost Sharing	9	9
Emergency Financial Assistance	10	10
Housing Services	11	11
Medical Transportation Services	12	12
Food Bank/Home Delivered Meals	13	13
Home & Community Based Healthcare	14	14

➤ **Motion** to approve FY 2013 Priorities as presented.

**Motion passed with 14 votes in the affirmative.**

**(15 Planning Council members were in attendance at this time with one ineligible to vote.)**

## Information and Discussion Topics

*Larry Taylor arrived at the meeting.*

*Jalene Salazar arrived at the meeting.*

*Ed Gardner arrived at the meeting.*

### **Medicaid Expansion**

Phil Stoltzfus, Planning Council, provided information from The Department of Health Care Policy and Financing (HCPF) about the upcoming shift to Medicaid and how this will impact Denver TGA consumers. He indicated that it is too early to know how this will play out, and that Dr. Zerzan will be attending an upcoming Planning Council meeting to share additional information.

The group discussed what information it would like to request from Dr. Zerzan and the timing of her visit to the Planning Council:

- After the election is probably a better time for her visit; to honor Dr. Zerzan's time, ask whether she would be willing to come in September and again after the election or if she thinks it would be best to wait
- The Planning Council's December meeting or the annual retreat might be good options
- The meeting will be a good time to hear an update from her as well as sharing the concerns of our community of providers and consumers
- We need to understand what plans HCPF has for addressing the influx of consumers to Medicaid
- Would like to understand the impacts of the shift on adults without dependent children
- At this meeting, it would also be helpful to have someone speak on Ryan White Reauthorization

### **Housing**

Maria Lopez, Planning Council Program Manager, reminded the group of its discussion at the Priorities Meeting around housing and asked for direction for addressing issues related to eligibility and unspent funds over the coming months. The Planning Council shared its ideas:

- Would like to see a presentation from HOPWA to help us all understand what is offered and what opportunities there are for us to coordinate
- A presentation on our Housing category would also help the Planning Council
- MDASC should explore eligibility for Housing and Emergency Financial Assistance (EFA); concern that MDASC has spent a lot of time discussing these issues, but hasn't been empowered to make decisions or take action
  - ✓ Review Eligibility Criteria for Housing and EFA so that money is not being under spent or overspent respectively. Would like to ensure eligibility is not too stringent so that folks who need the resource are able to access it
- The Planning Council will need time and resources to fully address the issue

- Items to address:
  - ✓ Be sure to coordinate with the city’s new housing plan
  - ✓ Explore different ways to use hotel funds including options for longer stays
  - ✓ Find out what transitional housing options Part A could partner with
  - ✓ Revisit the consumer input on this topic
  - ✓ Revisit the idea of a resource guide; this has been talked about many times
  - ✓ Look at geographic distribution of short-term housing options
  - ✓ We need options for today’s system
- Part B will allocate Quality Assurance funding toward a paid consultant to support MDASC in this work; Bob requests that the consultant consider the region, not only the Denver TGA

- **Motion:** MDASC will meet to discuss and assess issues with EFA and Housing and make recommendations about specific action steps to Leadership so that next steps can be determined and completed before FY 2013. The issues to be addressed will include:
1. Under spent funding; explore the Standards of Care (SOC) to see if eligibility can be adjusted
  2. Longer-term transitional housing options including options for all potential clients in the system
  3. Understand the resources and providers of housing (site visits, work with providers who know the housing sites, etc.)

**Motion passed with 17 votes in the affirmative.  
 (18 Planning Council members were in attendance at this time with one ineligible to vote.)**

<b>Minority AIDS Initiative Allocations</b>
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Jalene Salazar and Kari Hartel, Planning Council and POCL/Rebuilt+ Committee members, presented the FY 2013 Minority AIDS Initiative allocations recommendations:

Approved Category Rank Order	Recommended Resource Allocation by percent
Medical Case Management	25%
Mental Health Services	25%
Substance Abuse Services	25%
Early Intervention Services	25%
Capacity Building	0%

The Planning Council discussed the recommendation:

- Why would we move 5% from Early Intervention Services (EIS) to Mental Health when we have no specific data about this need for People of Color (POC) in the needs assessment?
  - There is a high need for mental health and substance abuse services; these services keep people in care, and mental health services are an entry point for many POC
  - Substance abuse can drive whether people are in care; we may be underestimating the importance of Substance Abuse Services for keeping people in care
  - CDPHE is focusing on mental health and substance abuse; we need to consistently support these categories to meet the need and support the National HIV/AIDS Strategy
  - We don't yet have any data on EIS; the mid-year reporting is due at the end of August, so it will be September before an update will be available
  - We need to look at outcomes; what are we trying to accomplish?
  - The Gardner Cascade is a good framework for us to use; we can look at the Cascade demographically. This has been done nationally and shows that African Americans and Latinos/Hispanics are the least likely to engage throughout the entire cascade
  - In FY 2012, we tried to invest along the cascade (adding EIS); right now 75% of funding is invested in the later stages of the Gardner Cascade.
  - This is not necessarily true since EIS includes linkage to care **and** retention
  - POC can access services beyond the MAI funds through Part A programs
- **Motion:** Accept the POCL/Rebuilt+ recommendation for FY 2013 MAI Allocations
- **Friendly Amendment:** To develop specific data regarding POC in the system and to monitor outcomes of the four MAI categories; the amendment was not accepted
  - **Friendly Amendment:** To develop specific data regarding all consumers in the MAI system; the amendment was not accepted
  - **Friendly Amendment:** To monitor the outcomes of MAI categories; the amendment was accepted
- **Final Motion:** Accept the POCL/Rebuilt+ recommendation for FY 2013 MAI Allocations, and to monitor the outcomes of MAI categories

**Motion passed with 17 votes in the affirmative.**

**(18 Planning Council members were in attendance at this time with one ineligible to vote.)**

Lynn Hough, Denver Office of HIV Resources, stated his discomfort with the motion that is both asking for something in the present (the allocations) and something in the future (monitoring). He felt the two should not be tied together.

## Allocations Process Overview

Caryn Capriccioso, facilitator, reviewed information about the Allocations Process for the Planning Council. She shared HRSA language about what allocations are and the information that can/should be used to make allocations decisions. Anthony Stamper, DOHR, discussed why the group creates allocations in percentages rather than dollar amounts.

Caryn shared that the Priorities Workgroup recommended approving allocations within one scenario. If the funding received from HRSA is between 95% and 105% of FY 2012 funding, the allocations decided on today will stand. If the funding falls below 95% or above 105%, the Planning Council will revisit its allocations decisions.

Bob Bongiovanni, Planning Council and CDPHE, shared the allocations spreadsheet that the small groups would use to make recommendations to the Planning Council.

*Jalene Salazar left the meeting.*

## Allocations Ideas and Recommendations

The Planning Council shared ideas, thoughts, data and concerns with the full group prior to breaking into the small group to do the detailed allocations work. The discussion included:

### General trends/influences

- The drought is and will be impacting food prices
- The Undocumented Waiver could impact the system; under the Affordable Care Act (ACA), undocumented people will not be eligible
- Medicaid roll-out impacts are unknown
- HIV Home-Test may challenge linkage to care; we aren't sure of the impact

### Data-specific

- 55% of newly diagnosed people stated that they need emotional support
- We continue to see an increase in foreign-born HIV cases
- Outpatient Ambulatory utilization is decreasing
- The number of Medical Case Management (MCM) clients served is going up, but the funding is going down. While the percentages haven't changed much, the dollars are impacted when the funding decreases
- Medical transportation utilization increased dramatically
- MCM moved up in priority; I advocate for more support for MCM
- The top three categories (Outpatient Ambulatory, MCM and ADAP) are essentially unchanged since ADAP is unfunded
- Mental Health moved up in priority and has been consistently identified as being important to consumers

## Opinions/ideas

- Support services are very important in the spectrum of services
- This is the last year for stability in the system; we have no rationale to make changes and need to better understand the economic consequences to providers of the Medicaid shift
- Do we need to fund AIDS Pharmaceutical Local at the current amount? This funds the HIV/AIDS specialty pharmacies and reduces some burden on Part B. Non-Ryan White PLWHA go to these pharmacies too; they improve adherence. CDPHE will provide utilization and adherence data
- We need to message the importance of Part A Services through local data and national data that is evidence-based (and therefore can be applied locally)

## Group Allocations Proposals

The Planning Council divided into three small groups to develop FY 2013 Allocations proposals. They then reported their recommendations to the full Planning Council.

*Jalene Salazar returned to the meeting.*

### Group One

Had a rich discussion focused on a number of categories and the needs assessment (including needed and received services). Ultimately the group asked what changes to the allocations would accomplish in a year with so much uncertainty.

**Recommendation:** No changes.

### Group Two

Discussed the data related to MCM, Mental Health, Substance Abuse and Housing categories. Given the Medicaid changes coming in January 2014 and the increased burden on the system, Group Two felt that MCM could use additional support.

**Recommendation:** Increase MCM by 1%; decrease Housing by 1%

### **Group Three:**

This group discussed that Mental Health services was the only meaningful change in priorities (MCM and ADAP switch does not impact things since ADAP is unfunded). The changing landscape and uncertainty, coupled with data concerns (low confidence in understanding why certain categories were unspent), influenced the group's recommendation.

The top three categories (Outpatient Ambulatory, MCM and ADAP) are essentially unchanged since ADAP is unfunded

**Recommendation:** No changes

The Planning Council discussed the proposals.

- We need to figure out coordination on a system level for enrollments; ACA will absolutely add burden to MCM
- Can we state the use of funds if we increase MCM? Answer: That would be best as a directive
- Will these decisions change our decision to address housing? Answer: no.
- Why would we take money from housing when we decided this morning to focus on housing? Answer: Group Two felt that the changes in housing will take at least a year. Answer: The changes will take place with the revisions to the SOC in March. The plan is to make decision about these changes in time to change the SOC and implement for FY 2013 (March, 2013).
- Can we earmark any reallocatable funds to MCM? Answer: Yes.

➤ **Motion:** Approve Allocations at FY 2012 Percentages for FY 2013, monitor the outcomes of all categories and consider any reallocated funds for Medical Case Management

**Motion passed with 17 votes in the affirmative.**

**(18 Planning Council members were in attendance at this time with one ineligible to vote.)**

### **Next Steps**

Scott Jackson reminded the Planning Council of the upcoming community meeting on August 29<sup>th</sup> and encouraged them to attend.

Scott thanked the Planning Council and the Priorities Workgroup for their efforts this year.

### **Adjourn**

The meeting was adjourned at 3:05 p.m.