DEPARTMENT OF HEALTH AND HUMAN SERVICES

COUNTY OF MARIN *Larry Meredith, Ph.D., Director*

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Marin HIV/AIDS CARE Council Meeting
MINUTES
July 11, 2007
3:30 - 6:30p.m.
899 Northgate, 4th Floor Conference Room

Council Members Present: *Roy Bateman, Diva Berry, Will Boemer, Jeff Byers, Wade Flores, James Frazier, Elyse Graham, Peter Hansen, Pam Lynott, Jennifer Malone.*
Council Members Absent: *Lisa Becher (Leave of Absence), David Witt.*
Staff Present *Cicily Emerson, Chris Santini, Michael Schieble, Sparkie Spaeth.*
Public: *Walter Kelley*

I. Call to Order

Meeting called to order at 3:39p.m. by Co-Chair Graham.

II. Roll Call

At the time of the roll call, quorum was not established with 7 of 11 (63.6%) Council Members present- CM Boemer, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Lynott, CM Malone.
Note: CM Flores was present via conference call / telecom. CM Bateman arrived at 3:44p.m to establish a quorum of 8 of 11 (72.7%). CM Byers arrived at 3:49p.m. CM Berry arrives at 4:19p.m. CM Becher is on a Leave on Absence. CM Witt absent.

III. Review and Approval of Agenda - VOTE

The agenda was reviewed.
Agenda IV. was edited to read, "Review and approval of May 29th and June 6th, 2007 Minutes". The June 13, 2007 minutes were not complete. CM Flores requested that Agenda VIII. Membership Committee – Potential Nomination of Walter Kelley be tabled. CM Malone voiced concern that 1 hour 10 minutes was not enough time for Agenda XIV. Prioritization.

CM Malone motioned to approve the agenda as edited. CM Lynott seconded. A voice **vote** was conducted. All were in Favor. None were Opposed. The agenda was approved as edited.

IV. Review and Approval of May 29, 2007, and June 6, 2007 Minutes – VOTE

CM Boemer made motion to approve the May 29, 2007 minutes. CM Graham seconded.
The May 29, 2007, minutes were approved.
Vote:
AYES: CM Boemer, CM Byers, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Malone.
Noes: none
Abstain: CM Bateman, CM Lynott.
Recuse: none.

CM Graham made motion to approve the June 6, 2007 minutes. CM Frazier seconded.
The June 6, 2007, minutes were approved.
Vote:
AYES: CM Boemer, CM Byers, CM Frazier, CM Graham, CM Hansen, CM Lynott, CM Malone.
Noes: none
Abstain: CM Bateman, CM Flores.
Recuse: none.

V. General Announcements

CM Flores announced that CM Witt had given him voting proxy. Co-Chair Graham stated that the proxy did not meet the Bylaw requirement. "Members who are absent due to HIV/AIDS related illness may appoint a proxy according to guidelines,"

CM Flores announced that the Folsom Street Fair was looking for volunteers.

CM Malone announced the Marin Gay Pride Picnic on August 5, 2007, 1:00p.m.-5:00p.m. Piper Park, 240 Doherty Drive, Larkspur. The event is sponsored by MAP and Spectrum and hamburgers and hotdogs will be provided.

CM Bateman requested clarification of the next CARE Council meeting? Co-Chair Graham stated; July 25, 2007- 3:30p.m to 6:30p.m. The agenda will be focused on allocation.

VI. Public Comment

None.

VII. Co-Chairs Report

Co-Chair Graham stated that there was a very full agenda and encouraged everyone to stay on the agenda topic. When making a motion, please state it clearly for all and the tape. The Co-Chair would repeat the motion prior to the vote.

Co-Chair Boemer thanked and acknowledged Larry Meredith for his participation. He stated that he had sent a letter of thanks on behalf of the CARE Council.

CM Malone asked the Co-Chairs about current year funding. "I understand that there may be other funding." C. Emerson stated that that would be addressed during the Division of Public Health report.

Public Comment: None

VIII. Membership Committee Report. – VOTES

CM Graham stated that she and CM Boemer were acting Co-Chairs for the Membership Committee due to the leave of absence of CM Becher. The Committee had elected interim Co-Chairs CM Frazier and CM Hansen.

1. Co-Chair Graham stated that the Membership Committee was recommending CM Boemer for renewal. No motion required since this was coming from Committee.

Public Comment: W. Kelley- "He's great!"

CM Boemers' Membership term was renewed
Vote:
AYES: CM Bateman, CM Byers, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Lynott,, CM Malone.
Noes: none
Abstain: CM Boemer
Recuse: none.

2. New Quorum Policy.
CM Graham stated that the Membership Committee was bringing to the Full Council a Bylaw change.
Article VI – Meetings, Section 1 to read as:
"Quorum. A quorum of the CARE Council must be present at all times during a regular or specially scheduled meeting when the Council engages in formal decision-making. A quorum is defined as fifty percent of the membership plus one Member, excluding those members on an authorized leave of absence."

CM Malone asked it this applied to Committee meetings and if there was a minimum number of Members to make up a Committee? CM Graham stated that the quorum change applied to Committee meetings and the smallest Committee is 4, so 3 would be needed to meet.

CM Malone asked about rounding down. CM Graham clarified saying, "fifty percent plus on full member".

The Bylaw change was passed unanimously. [*** *See August 8, 2007 vote is void. This agenda item was a notice of Bylaw change, not vote*].

Vote:

AYES: CM Bateman, CM Boemer, CM Byers, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Lynott, CM Malone.
Noes: none
Abstain: none.
Recuse: none.

IX. Community Outreach and Advocacy Report.

Committee Co-Chair Flores gave a recap of the May 25, 2007 Community Forum in San Rafael. 13 people attended and it was the most diverse attendance at a Forum to date. Attendees reported that, "they learned something". Standout topics were: case management, benefits counseling, and food. The least used services were home health care, acupuncture.

C. Emerson stated that there was a complete summary of the surveys posted on the web.

Public Comment: None

X. Division of Public Health Report

S. Spaeth reported the funding for $8,725 for food cards. The food cards would be going to Case Manager to go to Clients that met the "severe need" criteria. *See Attachment #1- Eligibility Criteria, Severe Need, and Special Population Definition.* C. Emerson stated that the cards would be distributed by Case Managers and the Specialty Clinic.

CM Byers reported on possible State funding to address the loss of Ryan White funds. He gave a status report that all TGA (s) "would be made whole once the Governor signs the budget". There is $906K to EMA (San Francisco). County Staff and Council Members asked questions about Title I / II restrictions and the timing of the State Allocations. CM Byers stated, "It depends on when the budget is signed. There is no exact time frame".

Public Comment: None

XI. Conflict of Interest Disclosure by Council Members

Each Council Member was asked to report if they had an Actual conflict of interest and/or a Perceived conflict of interest.

CM Bateman: Yes Actual and the same as last year. CM Bateman read a statement that is on file with a list of Actual or Perceived conflicts of interest starting with the fact that he is an employee of Marin County.
CM Berry: No Actual / No Perceived conflict of interest.
CM Boemer: No Actual / Yes Perceived conflict of interest as a MAP Client.
CM Byers: No Actual / No Perceived conflict of interest.
CM Flores: No Actual / Yes Perceived conflict of interest since he is a consumer.
CM Frazier: No Actual / Yes Perceived conflict of interest as a MAP Client.
CM Graham: No Actual / No Perceived conflict of interest.
CM Hansen: No Actual / No Perceived conflict of interest.
CM Lynott: No Actual / No Perceived conflict of interest.
CM Malone: Yes Actual conflict of interest as the Director of the Marin AIDS Project. Service provider of

Title 1 funds for case management, non-medical case management, oral health, and transportation.

Public Comment: None

XII. Epidemiology Update – Deborah Gallagher, MPH

D. Gallagher presented slides summarizing and detailing the "Demographics of HIV/AIDS and Update on Name-Based HIV Reporting in Marin County". *See Attachment #2.*
Data was current through July 1, 2007.
Council Members asked question about the data and trends.

The following Summary was presented:

1. [Marin County] averaging 11 fewer cases each year.
2. No big change in sex distribution.
3. Risk Factors- Decrease in IDU in women 35% to 8%. Decrease in MSM & IDU in men 13% to 4%. Increase of unknown risk for both sexes.
4. Race / Ethnicity summary
5. No Change in distribution of age at diagnosis.

The CDC origin and Sate development of name base HIV reporting was overviewed.

XIII. Infrastructure Work Group Recommendations – VOTE

CM Graham introduced the report from the Infrastructure Work Group -System Assessment Project. The report was presented by Susan Strong**,** the consultant that facilitated of the group.
*** Note: *Below are excerpts from full report. Please read entire report for complete recommendations and suggested action.*

1. Develop effective, quality and culturally/ethnically appropriate communication tools for clients and service providers.

- Improvement and promotion of the existing County web site.
- Development of a county-wide resource book
- Development of a consolidated transportation system overview document.

2. CARE service providers to attend training designed to improve cross-agency communication about shared clients.

- County-wide case conference for all clients involved with three (3) or more agencies every six months
- Marin case managers to come to a consensus on the Marin Model
- Standards of care implementation
- RWCA funded organizations to read the Cultural Competency Report.

3. Ryan White funding services in the 25% categories be entirely focused on PLWH/A with severe need, or currently in severe crisis in the following categories: a.) Transportation b.) Food c.) Residential Substance Abuse d.) Emergency Financial Support.

4. Services focus on retaining PLWH/A in care.

- Episodic medical care.
- Attempt to find individuals who do not keep medical appointments.
- Make enrollment in services user friendly and provide intensive case management for those in need.
- Develop system to follow-up with PLWH/A who drop out of care and have not been seen for care within six months.
- Develop a simple orientation for all new HIV+ clients.
- Develop information campaign to educate hard to reach/out of care consumers.

5. Continue to be provided services in the major population centers of the County.

6. Services to be evaluated and funded according to their ability to implement and adhere to the approved standards of care.

With regret, the IWG has acknowledged that circumstances now prevent the Council from actively pursuing the following:

a. Providing HIV-specific services to small populations of infected persons in outlying areas of the County, specifically West Marin.
b. Adding new services to the current continuum or attempting to deliver all potential services to all clients.
c. Assessing the quality, availability and accessibility of services to persons incarcerated in the County jail system.
d. Determining which clients are receiving services in San Francisco and why they seek those services out of County.
e. Attempting to develop services to enhance already existing case finding efforts which are the responsibility of the Public Health Department and are a focus of prevention services in the County.

S. Strong answered questions about the report and recommendations. The definition of "severe needs or in crisis" was discussed considering compliance with the 25% definition. Transportation to access services was also a concern.

CM Graham made motion to accept the report and six (6) recommendations in total. CM Byers seconded.

Public Comment: None.

The report and recommendations were accepted.
Vote:
AYES: CM Bateman, CM Berry, CM Boemer, CM Byers, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Lynott,
Noes: none
Abstain: CM Malone
Recuse: none.

XIV. Prioritization – VOTE

Council Members received a handout *(See Attachment #3)* titled, "Marin County HIV/AIDS CARE Council Prioritization Allocation Process [Draft].

CM Byers stated that the EMA in not changing the order of priority that it used in the past. The needs of the population has not changed and the counties in the EMA may be asked to accept the priorities.

CM Berry stated that "Prioritization of Clients is important". CM Byers stated that we are prioritizing service categories for Clients." CM Graham suggested that we just went through the process and we use the last list. CM Boemer, "We as a Council need to make the statement. That is our responsibility". CM Bateman stated that we have our own list that is Marin based. "The importance is how much money we fund". CM Malone stated that in preparing for the meeting her ranking included outside funding sources. "We need to have a correlation". She stated her concern that not all Council Members used the same instructions to rank. CM Flores suggested that we consider outside funding and he is in favor of prior ranking order. CM Lynott expressed concern about substance abuse outpatient funding. C. Emerson indicated that there was funding from other sources in addition to Ryan White. CM Malone noted, "we didn't do much for residential [substance abuse]. The general discussion came to a close.

CM Bateman made motion to use the same prioritization ranking as the 2007-'08 budget. CM Lynott seconded.

Public Comment: None.

The motion was passed.

Vote:
AYES: CM Bateman, CM Boemer, CM Byers, CM Flores, CM Frazier, CM Graham, CM Hansen, CM Lynott, CM Malone
Noes: none
Abstain: CM Berry
Recuse: none.

The 2006-'07 Ryan White Decision Matrix and 2007-'08 Ryan White Decision Matrix were distributed. *(See Attachment #4 and #5)*
CM Flores requested (attending via telecom) that the handout be mailed to him. C. Santini noted that she would not be available to attend the 07/25/07 meeting. The information was reviewed and general questions and comments were made.

Public Comment: M. Schieble- If the new Council Members don't understand the information in the handout or Decision Matrix, who do they call? Call C. Emerson.

XV. Next Step – New Business

- Hold "Special Meeting": for new Council Member Prioritization Training.
- Next Meeting. July 25, 2007- 3:30p.m to 6:30p.m.

Public Comment: None

XVI. Meeting Adjourned at 6:32p.m.

ATTACHMENT 1

Eligibility Criteria, Severe Need, and Special Populations Definition

Approved by the HIV Health Services Planning Council on June 28, 2004/updated April 23, 2007

Eligibility

The proposal is to redefine the eligibility criteria for Ryan White CARE Act Title I & II funded services in the San Francisco EMA. To receive services, an individual must meet *all* of the following criteria:

- Be HIV positive. For some family services, such as childcare, there must be an HIV positive family member.
- Live in the EMA where they are accessing services.
- Be uninsured or underinsured for the service being provided.
- Have a low income, defined as an annual federal adjusted gross income equal to or less than 400% of the Federal Poverty Level (FPL), which for 2007 is **$40,840** for one person. This is the same criteria as that used by the California AIDS Drug Assistance Program.

Severe Need

The following is to define severe need and special populations for the purposes of prioritizing and targeting CARE-funded services.

To be in the "severe need" category, an individual must meet all of the following criteria:

- Disabled by HIV/AIDS or with symptomatic HIV diagnosis
- Active substance abuse or mental illness
- Poverty, defined as an annual federal adjusted gross income equal to or less than 150% of FPL, which for 2007 is **$15,315** for one person, or **$20,535** for two people.

Special Populations

The Council recognizes special populations which have unique or disproportionate barriers to care. They need additional or unique services, or require a special level of expertise to maintain them in care. The following populations were identified, based on the data that has been presented to the Council:

- Transgender individuals.
- Populations with the lowest rates of use of HAART.
- Communities with linguistic or cultural barriers to care. The Committee included undocumented individuals in this category, as well as monolingual Spanish speakers.
- Individuals who are being released from incarceration in jails or prisons, or who have a recent criminal justice history.

Demographics of HIV/AIDS & Update on Name-Based HIV Reporting in Marin County

July 11, 2007

Deborah Gallagher, MPH
dgallagher@co.marin.ca.us

Epidemiology Data Notes

- All epidemiology data from Marin County HIV/AIDS Reporting System (HARS).
- All data are current as of July 1, 2007.
- Data exclude cases diagnosed at San Quentin State Prison unless otherwise stated.
- Data only include persons who were residents of Marin County at the time of HIV or AIDS diagnosis, regardless of current residence.

2004 Population Estimates for Marin County

	Female		Male		Combined	
	#	%	#	%	#	%
Total	126,178	100%	124,976	100%	251,154	100%
Ethnicity						
Non-Hispanic White	99,009	78.5%	92,765	74.2%	191,774	76.4%
Black/African Amer.	2,335	1.9%	4,997	4.0%	7,332	2.9%
Hispanic/Latino	15,895	12.6%	19,470	15.6%	35,365	14.1%
Asian/Pacific Islander	6,079	4.8%	4,941	4.0%	11,020	4.4%
American Indian	310	0.2%	422	0.3%	732	0.3%
Multirace	2,551	2.0%	2,380	1.9%	4,931	2.0%
Age						
Under 15	20,364	16.1%	21,228	17.0%	41,592	16.6%
15-24	11,926	9.5%	13,459	10.8%	25,385	10.1%
25-34	11,099	8.8%	13,574	10.9%	24,673	9.8%
35-44	19,698	15.6%	20,758	16.6%	40,456	16.1%
45-54	23,255	18.4%	22,199	17.8%	45,454	18.1%
55-64	19,031	15.1%	17,677	14.1%	36,708	14.6%
65 or older	20,805	16.5%	16,080	12.9%	36,885	14.7%

Source: State of California, Department of Finance, *Estimated Race/Ethnic Population with Age and Sex Detail, 2000-2004*. Sacramento, CA, April 2006.

Cases Reported to Date

Cumulative Reports

	Total Reported*	Deaths**	Living Cases†
Community			
AIDS cases	1061	705	356
HIV, not AIDS	244	14	230
Subtotal	**1305**	**719**	**586**
San Quentin			
AIDS cases	535	253	282
HIV, not AIDS	145	1	144
Subtotal	**680**	**254**	**426**

* Does not include cases that were later found to be duplicates.
**Deaths from all causes
† Includes cases of unknown vital status.

Biological Sex & Probable Risk Factor of Persons Living with HIV or AIDS, Marin Community

Biological Sex	#	%
Male	522	89%
Female	64	11%

Probable Risk Factor, Females	#	%
Injection Drug Use	12	19%
Heterosexual contact	44	69%
Other/Unknown	8	13%

Probable Risk Factor, Males	#	%
Male-to-Male Sexual Contact (MSM)	383	73%
Injection Drug Use (IDU)	32	6%
MSM & IDU	51	10%
Heterosexual contact	28	5%
Other/Unknown	28	5%

* Heterosexual sex with an IDU, an MSM, a hemophiliac, a transfusion or transplant recipient with documented HIV infection, or a person with AIDS or documented HIV infection

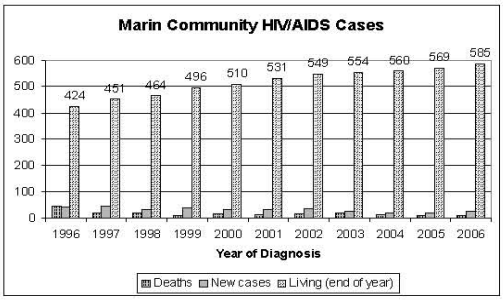
Ethnicity/Race & Current Age of Persons Living with HIV or AIDS, Marin Community

Race/Ethnicity	#	%	US born*	Foreign born	Unknown birthplace
Non-Hispanic White	442	75%	89%	4%	7%
African American/Black	40	7%	78%	18%	5%
Latino/Hispanic	83	14%	39%	60%	1%
Asian/Pacific Islander	13	2%	31%	62%	8%
Other/Multi-racial/Unknown	8	1%	13%	13%	75%

* includes US territories

Current Age	#	%
<13 years	2	<1%
13-24	6	1%
25-34	32	5%
35-44	177	31%
45-54	217	37%
55-64	115	19%
65+	36	6%

Trend in Number Living with HIV/AIDS



Persons Diagnosed with HIV in the past 10 years, Marin County Community

Community Diagnoses of HIV Infection*, Marin Co.			
1997-2001		2002-2006	
Year of Diagnosis	Number of People	Year of Diagnosis	Number of People
1997	44	2002	33
1998	31	2003	25
1999	39	2004	18
2000	29	2005	18
2001	31	2006	25
Total	**174**	**Total**	**119**
Avg/Year	**35**	**Avg/Year**	**24**

*regardless of current HIV/AIDS status or vital status

Biological Sex & Probable Risk Factor of Persons Diagnosed with HIV/AIDS, Marin Community

Biological Sex & Probable Risk	1997-2001 #	%	Rate†	2002-2006 #	%	Rate†
Male	**151**	**87%**	**26.0**	**107**	**90%**	**18.0**
Male-to-Male Sexual Contact (MSM)	104	69%		72	67%	
Injection Drug Use (IDU)	10	7%		8	7%	
MSM & IDU	19	13%		4	4%	⇦
Heterosexual contact*	10	7%		9	8%	
Other/Unknown	8	5%		14	13%	
Female	**23**	**13%**	**3.7**	**12**	**10%**	**1.9**
Injection Drug Use	8	35%		1	8%	⇦
Heterosexual contact*	14	61%		9	75%	
Other/Unknown	1	4%		2	17%	

†Average Annual Incidence Rate per 100,000 males or females, as appropriate
*Heterosexual sex with an IDU, an MSM, a hemophiliac, a transfusion or transplant recipient with documented HIV infection, or a person with AIDS or documented HIV infection

Race/Ethnicity & Age at Diagnosis of Persons Diagnosed with HIV/AIDS, Marin Community

Race/Ethnicity	1997-2001 #	%	Rate†	2002-2006 #	%	Rate†
Non-Hispanic White	134	77%	14.0	75	63%	7.9
African American/Black	9	5%	40.7	9	8%	37.5
Latino/Hispanic	23	13%	17.7	26	22%	15.3
Asian/Pacific Islander	5	3%	8.9	5	4%	9.2
Other/Multi-racial/Unknown	3	2%	8.4	4	3%	14.6

†Average Annual Incidence Rate per 100,000 population of specific race/ethnicity

Age at Diagnosis	1997-2001 #	%	Rate†	2002-2006 #	%	Rate†	
<13	1	1%	0.5	0	0%	0	
13-24	8	5%	7.6	6	5%	4.9	
25-34	46	26%	30.8	35	29%	31.1	⇦
35-44	68	39%	32.2	44	37%	23.1	⇦
45-54	39	22%	17.5	24	20%	10.8	
55-64	9	5%	6.5	10	8%	5.5	
65+	3	2%	1.8	0	0%	0	

†Average Annual Incidence Rate per 100,000 population of specific age range

Summary

- Averaging 11 fewer cases per year
- No big change in sex distribution
  - 29% fewer cases among men
  - 48% fewer cases among women
- Risk factors
  - Decrease of IDU in women 35% to 8%
  - Decrease of MSM&IDU in men 13% to 4%
  - Increase of unknown risk for both sexes

Summary, cont.

- Race/Ethnicity
  - Decrease in proportion of non-Hisp. white
  - Increase in proportion of all others
    - Latino/Hisp. from 13% to 22%
  - However, # of cases and rates stayed the same for all except non-Hisp. white (44% decrease)
  - Foreign-born Latino/Hisp. increased from 61% to 77%, do not know length of time in US prior to diagnosis
- No change in distribution of Age at Diagnosis
  - 13% of cases are <30 and 14% are 50+
  - 73% are between 30-49 years old when diagnosed

Name-Based HIV Reporting

- December 2005 CDC letter to the Governor
  - CDC will only accept HIV data from jurisdictions with name-based systems
- April 17, 2006 Gov. Schwarzenegger signed SB 699 into law
  - changed CA's HIV reporting system from code-based to name-based
  - Health & Safety Code 121022 effective immed.
- Office of AIDS purged non-name HIV cases
  - Counties did NOT
  - Cases have to be "Reascertained"

Name-Based HIV Reporting

- CA DHS given 12 months to issue new regulations
- Emergency regulations amending CCR Title 17, Article 3.5 adopted January 8, 2007
  - Name reporting, no codes
  - Confidentiality agreement
  - Data transmission practices
    - Disallow faxing of lab/case reports
    - Require lab/case reports be sent by traceable mail
  - LHD technical assistance to providers
  - Updated Case Report Forms
- Do not have criteria for reascertainment

Issues

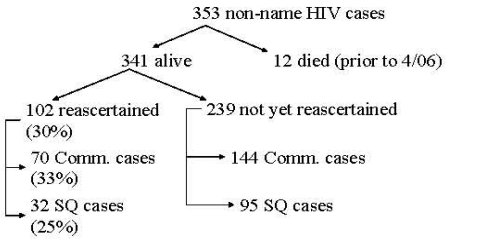
- Previously referred to County Counsel
  - Consensus that should have a lab after 4/17/06 before reascertaining a case
- Why no lab?
  - Not in care
  - Receiving care out of County
  - No longer live in Marin
- Marin County
  - Community cases (2/3)
  - San Quentin cases (1/3)

Statewide Update

- CA goal is to have the same number of name-based HIV cases by December 2008 as the number of non-name HIV cases on March 31, 2006 (41,155)
  - As of June 30, 2007: 17,593
  - Includes new cases as well as reascertained cases

Marin County Update

389 reported HIV cases vs. 124 HIV cases recognized by OA



Future

- Uncertain, many variables
  - Other counties forward labs for our cases
    - How will they know it is our case?
  - Possible OA matching of new cases and old non-name cases for reassignment
  - Continued requirement for new lab
- Unlikely we will have ~350 name-based HIV cases by December 2008

Marin County HIV / AIDS CARE Council Prioritization & Allocation Process-DRAFT FY 08-09

Table of Contents

What are the Priority Setting and Allocation Processes?

Priority Setting and Resource Allocation refer to the process Title I Planning Councils go through in finding ways to meet the needs of people living with HIV / AIDS (PLWH) in the Eligible Metropolitan Area (EMA).

1. This is an organized process of establishing what is of most importance **(priorities)** amongst the extensive needs of PLWH in the EMA. This is **priority setting**.

2. The second phase requires allocation of dollars to meet those priorities. This is **resource allocation**.

3. The process of allocation may require evaluating different sources of funding for established priorities, and determining the comparative cost of funding specified programs, even though one may hold a higher place on the prioritized list.

4. Resource allocation requires that Council members determine the amount or percentage of funds (out of total available dollars) for each established service category.

The FY 08-09 Priority Setting and Allocation Processes

The Process	**Priority Setting**
Step 1	Receive, review, and understand relevant data.
Step 2	Identify the list of service categories currently funded in Marin.
Step 3	Review complete list of HRSA service categories for consideration in priority setting. Council members add any additional service categories to list that they would like to prioritize.
Step 4	Council members decide individually on priority rank for categories.
Step 5	Review the averaged rankings, and discuss data-based rationale for ranking.
Step 6	Decide as a group on the priority order for service categories.

The Process	**Allocation**
Step 1	Review current funding for service categories using Decision Matrix.
Step 2	Council members recommend to increase, decrease, or not change funding levels (percentages) for each category.
Step 3	For changing allocation levels, decide level of change.
Step 4	Allocate resources to service categories.

Step 5	Create funding scenarios for decreased total award.
Step 6	Create funding scenarios for increased total award.

FY 2007 Part A and Part B Fundable Program Services List

Highlighted Areas are currently funded

Part A and Part B Allowable Program Services	
Core Medical Services	
a.	*Outpatient /Ambulatory health services*
b.	AIDS Drug Assistance Program (ADAP) treatments
c.	*AIDS Pharmaceutical Assistance (local)*
d.	*Oral health care*
e.	Early Intervention Services
f.	Health Insurance Premium & Cost Sharing Assistance
g.	*Home health care*
h.	*Home and Community-based Health Services*
i.	Hospice Services
j.	*Mental health services*
k.	Medical Nutrition Therapy
l.	*Medical Case Management (including Treatment Adherence)*
m.	*Substance abuse services–outpatient*
Support Services	
n.	*Case Management (non-Medical)*
o.	Child care services
p.	*Emergency financial assistance*
q.	*Food bank/home-delivered meals*
r	Health education/risk reduction
s	Housing services
t	Legal services
u	Linguistics Services
v	*Medical Transportation Services*
w	*Outreach services*
x	Psychosocial support services
y	Referral for health care/supportive services
z	Rehabilitation services
aa.	Respite care
ab.	Treatment adherence counseling
ac.	Residential substance abuse treatment

Funding Scenarios

Flat Funding Scenario:

Allocate funding in prioritized service category such that at least 75% of the resources are allocated to the CORE services and at most 25% of the resources are allocated to the non core services.

Decrease Funding Scenario

Determine which services will be decreased by what percent if the funding is decreased.

Increased Funding Scenario:

Determine which services will be increased by what percent if the funding is increased.

Data Sources for Priority Setting

Data Source	Description	Uses
Epidemiological data	This is information that describes the state of HIV / AIDS in Marin.	• To understand where the epidemic is and what it looks like • To determine what is happening within specific population demographics
Service category summary sheets	This includes information for each type of service funded by Title I as follows: • Definition of the services • Program descriptions and target population • Definitions of units of service • Utilization analysis • Other funding sources • Client demographics from client database	• Describes services provided and allocations • Identifies other funding sources for services • Shows who is being reached by each service • Gives information on the relative costs of different kinds of services • Indicates whether targets are being reached in terms of clients and service deliverables • Indicates whether dollars are being fully spent • Indicates demographics for clients using various service categories
Decision matrix	Provides at-a-glance information on FY 06-07 utilization rates and allocation and compares these with similar allocations for FY 07-08.	• Gives information on the relative costs of different kinds of services • Indicates whether targets are being reached in terms of clients and service deliverables • Indicates whether dollars are being fully spent

Guidelines for Council Members on Priority Setting

- Council members must remember to look at the whole, big picture through the process of decision making. Your role as a Council member is to review available data and represent the needs of all people living with HIV / AIDS in Marin.

- Council members are encouraged to speak to what they know but in a way that respects other's opinions. Remember that disagreement is likely, and that the Council has agreed to Rules of Respectful Engagement.

- Council members should think about how their decision making will impact particular populations of people living with HIV / AIDS in Marin.

- Council members should be aware that they will never have the perfect data ser for decision making. It is important the Council members not be paralyzed by this, but that they work to make the best decisions they can with the given information.

Questions to Ask When Reviewing Data for Priority Setting

- What does this tell me about the needs of PLWH/A? Are there groups, populations, or communities of PLWH/A that have particular unmet needs? What are those needs?

- What do this data tell me about the relative importance of each service? Does it make me think that a particular service is more or less important?

- What makes a specific priority less or more important than another?

- What does this tell me about the need for each service category? Do we need more of this service, less of it, or the same amount?

- What is the cost and the benefit of funding one service category over another? What happens if funding for this category is cut?

- Is there another source of funding for this service?

08-09 MARIN HIV/AIDS CARE COUNCIL PRIORITIZATION WORKSHEET				
Step 1=Review HRSA service categories definitions				
Step 2=Rank your top 10 CORE services				
Step=3 Rank your top 10 SUPPORT services				
Step 4= Put an X in the column for those you do not think should be funded/ranked				
Core Medical Services		**07-08 Rank**	**Suggested 08-09 Rank**	**No Rank (Do not fund)**
a.	**Outpatient /Ambulatory health services**	**1**		
j.	**Mental health services**	**2**		
l.	**Medical Case Management (including Treatment Adherence)**	**4**		
g.	**Home health care (nursing)**	**5**		
h.	**Home and Community-based Health Services (attendant care)**	**5**		
m.	**Substance abuse services–outpatient**	**6**		
d.	**Oral health care**	**7**		
c.	**AIDS Pharmaceutical Assistance (local)**	**8**		
i.	Hospice Services			
b.	AIDS Drug Assistance Program (ADAP) treatments			
e.	Early Intervention Services			
f.	Health Insurance Premium & Cost Sharing Assistance			
k.	Medical Nutrition Therapy			
Support Services				
n.	**Case Management (non-Medical)**	**3**		
p.	**Emergency financial assistance**	**8**		
q.	**Food bank/home-delivered meals**	**9**		
v	**Medical Transportation Services**	**12**		
ac.	Residential substance abuse treatment	6		
w	Outreach services	14		
s	Housing services	15		
t	Legal services	17		
o.	Child care services	18		
r	Health education/risk reduction			
u	Linguistics Services			
x	Psychosocial support services			
y	Referral for health care/supportive services			
z	Rehabilitation services			
aa.	Respite care			
ab.	Treatment adherence counseling			

08-09 MARIN HIV/AIDS CARE COUNCIL FUNDING ALLOCATION WORKSHEET				
Step 1=Review 07-08 Funding Alllocations and Service Category Summary Sheets				
Step 2=Suggest funding amount based for 08-09 based on a flat funding scenario of 677,137				
Step=3 Check to Make Sure your CORE services total at LEAST $507,853, and your SUPPORT services at MOST $169,284				
Core Medical Services		**08-09 Rank**	**07-08 Amt**	**08-09 Suggestion**
a.	**Outpatient /Ambulatory health services**		136,000	
j.	**Mental health services**		65,000	
l.	**Medical Case Management (including Treatment Adherence)**		182,000	
g.	**Home health care (nursing)**		20,000	
h.	**Home and Community-based Health Services (attendant care)**		41,000	
m.	**Substance abuse services–outpatient**		35,000	
d.	**Oral health care**		14,853	
c.	**AIDS Pharmaceutical Assistance (local)**		14,000	
i.	Hospice Services			
b.	AIDS Drug Assistance Program (ADAP) treatments			
e.	Early Intervention Services			
f.	Health Insurance Premium & Cost Sharing Assistance			
k.	Medical Nutrition Therapy			
			TOTAL	**507,853**
Support Services				
n.	**Case Management (non-Medical)**		88,451	
p.	**Emergency financial assistance**		10,000	
q.	**Food bank/home-delivered meals**		34,500	
v	**Medical Transportation Services**		3,000	
ac.	Residential substance abuse treatment			
w	Outreach services			
s	Housing services			
t	Legal services			
o.	Child care services			
r	Health education/risk reduction			
u	Linguistics Services			
x	Psychosocial support services			
y	Referral for health care/supportive services			
z	Rehabilitation services			
aa.	Respite care			
ab.	Treatment adherence counseling			
OTHER	**Planning Council Support**		3,000	
			TOTAL	**169,284**

ATTACHMENT 4

06/7 Ryan White Decision Matrix

A	B	C	D	E	F	G	H	I	J	K
Priority Order	**Service Category**	**06/7 CARE Contract Allocation**	**% of total 06/7 CARE award**	**Actual 06/7 dollars spent**	**% of 06/7 Award actually Spent**	**Number of UDC served**	**Cost per Unduplicated Client (UDC)**	**Number of UOS provided**	**Cost per Unit of Service (UOS)**	**Cost Cap for UOS**
1	**Primary Medical Care**	$125,000	12.7%	$125,000	100%	89	$1,404.49	496	$252.02	$250 per encounter
2	**Mental Health**	$50,000	5.1%	$43,500	87%	26 Indiv 5 Group 10 Psychiatrist	$1,450.00	329 Indiv 39 Group 33 Psychiatrist	$108.48	Indiv-$70-$125/hr-$250/entr DOQ Grp-$100-$150/hr DOQ
4	**Medical Case Management**	$232,500	23.7%	$238,792	103%	188	$1,270.17	2,330	$102.49	$60-$125/hour DOQ
5	**Home Health - Attendant and Professional Care**	$72,241	7.4%	$71,449	99%	16 Att care 20 Sk nrsg	$3,244.06 $977.20	1037 207	$50.05 $94.42	$110/2hr visit-Att $200-$250 2hr visit-RN
6	**Substance Abuse Treatment**	$60,000	6.1%	$40,829	68%	5 res 3 NRT	$1,627.00 res $3,070.33 NRT (w/o admin)	135 res 655 NRT dses 289 NRT cnslg	$60.26 res $14.06 NRT (w/o admin)	$200-$250/day res MediCal rates NRT
7	**Oral Health**	$30,000	3.1%	$34,000	113%	34	$1,000.00	54	$629.63	DentiCal rates
8	**Direct Emergency Financial Assistance-Pharmaceuticals**	$37,000	3.8%	$34,500	93%	35	$115.83 (w/o admin)	64	$63.34 (w/o admin)	None
3	**Non Medical Case Management (Advocacy & Benefits Counseling)**	$87,500	8.9%	$87,500	100%	138	$634.06	1,263	$69.28	None in 06/7
8	**Direct Emergency Financial Assistance-$**	See above	See above	See above	See above	54 general 3 Housing	$167.77 (w/o admin)	117	$81.74 (w/o admin)	None
9	**Food**	$63,300	6.4%	$63,300	100%	86	$736.05	877	$72.18	None
	Food Gift Cards	$23,400	2.4%	$19,600	84%	not available	not available	not available	not available	None
10	**Complementary Therapies - Acupuncture**	$40,000	4.1%	$40,000	100%	28	$1,428.57	373	$107.24	Indiv-$85 per encntr
11	**Transportation**	$8,000	0.8%	$16,000	200%	83	$192.77	1742 (w/carryover)	$9.19	None
12	**Buddy / Companion / Volunteer**	$50,000	5.1%	$48,000	96%	61	$786.89	1,449	$33.13	None
13	**Vitamins**	$11,700	1.2%	$11,700	100%	78	$150.00	738	$15.85	None
17	**Planning Council Support**	8000	0.8%	$10,552	132%	N/A	N/A	N/A	N/A	N/A

ATTACHMENT 5

07/8 Ryan White Decision Matrix

A	*B*	*C*	D	E	F
Priority Order	**Service Category**	**Final Allocation of CARE Award**	**Percentage of Award (Allowable Services Only)***	**Number of UDC served-3 months**	**Number of UOS served-3 months**
1	**Primary Medical Care**	**$136,000**	21.0%	85	280 visits
2	**Mental Health**	**$65,000**	10.1%	19 7 9	145 hours psychotherapy 20 group sessions (1.5 hours) 19 hours psychiatry
4	**Medical Case Management**	**$182,000**	28.1%	168	973
5	**Home Health - Attendant and Professional Care**	**$61,000**	9.4%	13 10	264 2 hr attendant care visits 18 2 hr skilled nursing visits
6	**Outpatient Substance Abuse Treatment**	**$35,000**	5.4%	3	235 doses of narcotic replacement therapy 94 10 min individual counseling sessions
7	**Oral Health**	**$14,853**	2.3%	9	9 filled requests
8	**Direct Emergency Financial Assistance-Pharmaceuticals**	**$14,000**	2.2%	15	24 filled requests
3	**Non Medical Case Management (Advocacy & Benefits Counseling)**	**$88,451**	13.6%	66	548 hours
8	**Direct Emergency Financial Assistance-$**	**$10,000**	1.6%	38	48 filled requests
9	**Food**	**$34,500**	5.3%	67	251 food boxes (through April)
10	**Complementary Therapies - Acupuncture**	**$13,333**		22	79 acupuncture visits (through April)
11	**Transportation**	**$3,000**	0.5%	52	737 filled requests
12	**Buddy / Companion / Volunteer**	**$17,000**		11 16 19	146 hrs practical support 256 hours emotional support 159 hours transportation
13	**Vitamins**	**included with food**		62	232 monthly allocations (through April)
14	**Outreach**	**eliminated**			
17	**Planning Council Support**	**$3,000**	0.5%		N/A
	TOTAL	**$677,137**	100.0%		

*Based on $646,804