PENNSYLVANIA DEPARTMENT OF HEALTH

HIV PLANNING GROUP MINUTES

Park Inn Harrisburg West, 5401 Carlisle Pike, Mechanicsburg, PA
November 12th, 2014

Members: Wesley Anderson, Jr., Dan Campion, Principe Castro, Melissa Davis, Doyin Desalu, Wayne Fenton, Sharita Flaherty, Linda Frank, Jeffery Haskins, Shannon McElroy, Briana Morgan, Daiquiri Robinson, Tamara Robinson, Susan Rubinstein , Grace Shu, Pamela Smith, Richard Smith, Rob Smith, Nathan Townsend, Tony Strobel, Shubra Shetty, Ann Stewart Thacker, Wayne Williams, Derick Wilson, Paul Yabor

Not Present: Alicia Beatty, Daniel Harris, Ron Johnson,

Dept. of Health: John Haines, Kyle Fait, Jill Garland, Cheryl Henne, Sara Luby, Ken McGarvey, Julia Montgomery, Benjamin Muthambi, Robin Rothermel, Jon Steiner, Brad VanNostrand, Christine Quimby, Jon Morgan

University of Pittsburgh: Mack Friedman, David Givens, Daniel Hinkson, Sarah Krier, Kayla Long

HRSA/CDC: Rob McKenna

Guests: Jim Ealy, Leah Magagnotti, Jeanne Caldwell, Susan Goldy, Susan Thompson, Tricia Fonzi, Lou Ann Masden

Welcome & Introductions

[9:00am]

Chairwoman Sharita Flaherty: Welcome, everyone. We have a busy schedule these next two days, as we have reached the culmination of a year of planning.

Director Ken McGarvey: Consequently, we are holding our regular announcements until tomorrow; I do need to announce that our HRSA [Health Resources and Services Administration] consultant Hila is not well and cannot attend as planned today, and that member Daniel Harris will be late. I'd also like to welcome all our guests - Daniel Hinkson has a member survey that we'd like for you to complete so we know how we engage people from around the state. Additionally, member Mike Hellman has retired from the HPG, and we have a certificate for him and a card you can sign in the back.

Chairwoman Flaherty: Has everyone had a chance to review minutes? [Motion to pass the minutes called and passed unanimously.]

Priority Setting

Melissa Davis: Welcome, everyone. It has been a long year for the PSRA [Priority Setting and Resource Allocation] process – we are excited to get into the next two days. We'll now go over how the process will work.

[Presentation: Melissa Davis and David Givens: Outline of Priority Setting Activities]

Melissa Davis: For conflict of interest (COI), please keep in mind that priorities do not necessarily translate into more money in a category, and also that more money in any area will not necessarily mean it will reach any particular group or provider. None of us are direct service members; we receive multiple service categories. Richard Smith will keep his eye on our members COI list.

Director McGarvey: It is important for members to understand PA is unique in that we have integrated prevention and care….this PSRA for Care is just part of it. We are not prioritizing CDC HIV prevention services because that is determined directly by the CDC. So even though we are integrated group, now we are just prioritizing care services. We are a Ryan White Part B recipient. HRSA does not mandate that we need to do this…this process is really a best practice, based on Part A priority setting. So although we are not required to do this we are implementing it as a best practice recommendation.

Melissa Davis: Please also note that we are creating these as *recommendations* so the DOH can change these if needed. We will now have ten minute summaries from all of our PS presentations from the past year.

[Presenting: Benjamin Muthambi, Jill Garland, Julia Montgomery, Cheryl Henne, Sarah Krier; see attached slides.]

Questions:

Bethany Blackburn: How you are incorporating the Healthy PA insurance marketplace – how is that connected to Linkage to Care? Do you see major changes coming for SPBP [Special Pharmaceutical Benefits Program]?

Julia Montgomery: Part B case managers are actively encouraging clients to enroll through the ACA marketplace and now through Healthy PA. We are attempting to track this through a field added to CareWare to see if they have insurance through private or ACA marketplace insurance plans.

Cheryl Henne: We have been making changes to reimbursements since August 1st – at this point we have seen some changes but nothing we can specifically say. There are more challenges in the systems changes than funding. For our program we need to see what those changes equate to, but at the moment large dollar amount changes are not something we've seen. Other than about 500-600 claims every month, all claims are being submitted as 340 B purchases. Basically our costs have stayed the same. Claims that are not 340 B are still being sent to manufacturers for reimbursement. Compliance has stayed the same.

Paul Yabor: Would telemedicine support this process? How can I support telemedicine?

Briana Morgan: We're talking about this afternoon – it is one of the things we are pursuing in the Needs Assessment workgroup.

Doyin Desalu: In terms of gap analysis, are there more regions that are implementing ARTAS than the three you mentioned?

Julia Montgomery: There are other regions that are interested in training.

Derrick Wilson: Do we have any data speaking to efficacy of ARTAS? 100% of those trained were successfully linked to care – 18 people - is that right?

Julia Montgomery: Yes.

[**Melissa Davis**: Overview of service definitions (see slides)]

Shubra Shetty: The respite care category… would that include a child with special needs?

Melisa Davis: No, it must be for an HIV positive person.

Guest: Is Nonmedical case management less intensive than case management?

Melissa Davis: Usually – it depends on where you are located and what else is available.

Linda Frank: Are there certain skill and knowledge competencies that are for non-medical and medical case managers that are consistent across the state?

Melissa Davis: Yes, the state has a list of things. Medical Case Managers are not required to be nurses or any type of certification in PA, but they are required to attend 20 hours of standardized trainings. That is not something that is funded by these Part B services. Now we will have an overview of the consumer input process and the Priority Setting voting from September that Pitt analyzed for us.

[**David Givens**: PSRA voting presentation]

Ann Thacker: I'm having a hard time with these colors….it says blue is highest?

David Givens: Yes, unfortunately the color hierarchy is not the same from one chart to the next. So you need to look closely at the key in each graph.

Melissa Davis: We are going to start with our top ten priorities. David and the Pitt Team will be passing out your clicker voting pads. So our first voting options: there are three. Green light: fully support how the top ten look at this time. The yellow light: yes you support but more discussions to have but if there are enough people you will be ok. Red light: no I don't support it moving it on. We will use index cards to write down specific issues. And we will address those as we move ahead. After each round of issues we will open it up to another full vote until we have 2/3 (18 members) voting for full support of the priorities. Then we will repeat the process for the next ten slots and so on.

So, here are the rankings as set by the HPG votes in September. What are preliminary thoughts in terms of how these top ten look? Are there things that should be there and are not there?

Derrick Wilson: Substance Abuse (SA) Services need to be in top ten. As far as Philly part A and surrounding counties go, transportation is an issue. But since counties aren't the area of focus, if we look at number of people with HIV statewide transportation isn't an issue.

Richard Smith: My own experience in Philly is that it is an issue.

Briana Morgan: In Philly medical transportation is in top ten every year.

Linda Frank: SPBP is listed as the top one… but it has its own line of funding, so why is it there? I also agree that SA services needs to be in top ten. How do we manage that SPBP is a separate funding stream?

Melissa Davis: In prioritizing we need to keep it in list since it is a service category. In order to spend money on it must be a priority. It will be in the top ten with 0% once we start the Resource allocation process since it has earmarked money. But remember, again, that we cannot consider funding sources when setting priorities.

Linda Frank: So why aren't we including top 11 if the money isn't going to SPBP?

Paul Yabor: Perhaps we can just think of the top eleven that way… also, I see where Medical Case Management is in top ten, I just wonder if it should be as high as number 2.

Melissa Davis: Let's do a preliminary vote on the top ten, and structure further discussion around that.

[Voting]

Melissa Davis: Let's start with any services missing from top ten. Please write down what you think and pass it down. Pitt members will collect them.

Kayla Long: There is a comment that SA outpatient should be in top ten.

Paul Yabor: I support that because one of the big things we have to do to make cascade work. We need to help people become stable. If I can dump anything from the top ten to make room, it would be SPBP.

Richard Smith: It might be good to explain how we are ranking these. How we rank them does not mean that that is how resources will be allocated.

Melissa Davis: Correct. You will have percentage of funding from last year when we meet tomorrow. Forget about the funding for now.

Linda Frank: I just think that the discussion about behavioral health services, SA and mental health is good. The whole push into primary care and into HIV services including SA would be in keeping with federal priorities.

Melissa Davis: In order to access any supportive services they need to be in medical case management for many regions of the state, so I argue that priority must remain included.

Paul Yabor: How much are insurance costs in the ACA [Affordable Care Act] environment….regarding health insurance premiums and costs… how much is this relevant under ACA.

Comment: Even the ACA has premiums.

Richard Smith: Who knows with the marketplace? The money we have spent in that category has actually increased… is Healthy PA still even happening?

Doyin Desalu: I suggest taking health insurance premiums and costs out because we don't know what ACA is going to do. We can move that one to #11.

Shannon McElroy: in terms of Healthy PA, HIV clients are in the 'high risk' category, which only has 40,000 labs covered a year, so there likely, will be an increasing need for this, not less.

Briana Morgan: I say we move SA up and emergency financial assistance [EFA] down, since EFA is a one-off service.

Derrick Wilson: I can make argument that EFA keeps people in care…ultimately it depends on how we implement it in our system…it has to keep people in care and there is a direct correlation. I would say health insurance pre down and SA in. As for the ACA lab cost coverage, med providers must cover labs for insurance. If you just drop health insurance down you can move SA in.

Tony Strobel: My thought is that we should consider the top 11.

Robert Smith: for utilization purposes that is equivalent.

Ann Thacker: I would agree with Tony, or else we take SPBP out of it and focus on others…

Melissa Davis: I was told not to take it out but to keep it at number 1. So we could add another line and look at the top eleven as if they were the top ten. What ranking to we want for SA?

Ann Thacker: are we keeping all of them?

Melissa Davis: If we keep 11 we will see percentages tomorrow to assess percentages. Do we want to move SA up?

Derrick Wilson: I would move it to 6 so drop early intervention services down.

[Vote: 2/3 Majority does NOT support moving SA to #6]

Do you support the proposed movement of service categories, placing SA in the number eleven slot?

[Vote: 2/3 Majority APPROVE]

[Lunch break]

Melissa Davis: Welcome back. To recap, we have moved substance abuse to #11.

Kayla Long: The next card issue [from HPG members] suggests that EFA [emergency financial assistance] should not be in top 10.

[Vote: 2/3 Majority does NOT support dropping EFA]

David Givens: The next card asks if Oral Health care be moved out of top 10.

[Vote: 2/3 Majority does NOT support dropping oral health care]

David Givens: The next card asks if Housing should be moved out of top 10.

Derrick Wilson: how is HOPWA related to Ryan White [RW] housing?

Melissa Davis: It's different. Short term rental, first month rent, security deposit. HOPWA short term is using similarly. Sometimes RW is used where HOPWA can't be, like for emergencies.

[Vote: 2/3 Majority does NOT support dropping Housing.]

David Givens: The next card asks if food banks should be moved up into the top 10.

[Vote: 2/3 Majority does NOT support adding Food Banks.]

Kayla Long: The next card asks if medical case management [MCM] should be moved out of top 10.

[Vote: 2/3 Majority does NOT support dropping MCM.]

David Givens: The next card asks if SPBP should be moved down to #12.

[Vote: 2/3 Majority does NOT support moving SPBP.]

David Givens: The next card asks if SA should be moved to top 10 and insurance premiums moved out.

[Vote: 2/3 Majority does NOT support proposed change.]

Paul Yabor: I feel EFA should be higher in list if we are talking about things that stabilize you. Sometimes it means not being stabilized by losing home and heat, and those are expensive.

Melissa Davis: Perhaps, but you must get funding out of your head. We are just asking today what the essential services for HIV Care in Pennsylvania are.

Ann Thacker: What are the non-core services in that list? Housing, medical transport support and EFA support.

Melissa Davis: We'll now collect index card questions again: if there is one that you'd like ranked differently, state that.

Linda Frank: I still don't understand why we can't include the 11th priority in the top ten.

Kayla Long: this card asks if the EFA can more up the list.

[Vote: 2/3 Majority does NOT support, so it stays at #9.]

David Givens: This card asks to move Housing down from 4 to 10.

[Vote: 2/3 Majority does NOT support moving Housing.]

David Givens: The next card asks to move outpatient/ambulatory higher.

[Vote: 2/3 Majority does NOT support moving Outpatient Care higher.]

David Givens: This card suggests that outpatient/ambulatory medical (3) should be switched with medical case management [MCM] (2).

Derrick Wilson: Outpatient is a lynchpin that HRSA cares about: MCM plugs people into care….

Tamara Robinson: you have to be established in care to get a case manager.

Linda Frank: I agree: you have to have outpatient first and then case management. I'd also like to see SPBP lower down. I'd see ambulatory first, case management and then SPBP.

Paul Yabor: Ambulatory care is a lynchpin to get people into care: I do believe we need to move that up.

Chairwoman Flaherty: everyone needs ambulatory care, but not everyone needs case management.

Ann Thacker: medical case management is very important with linkage to care.

Tony Strobel: I'd say the first three are interchangeable, really.

[Vote: 2/3 Majority SUPPORT switching medical case management and Ambulatory care.]

David Givens: The next card asks if the HPG wants to move EIS [Early Intervention Services] up?

[Vote: 2/3 Majority does NOT support moving EIS higher.]

David Givens: The next card asks if transportation should be moved up the list.

[Vote: 2/3 Majority does NOT support moving transportation higher.]

David Givens: The next card asks if oral health care should be moved higher again.

[Vote: 2/3 Majority does NOT support moving oral health care higher.]

David Givens: The final card asks if mental health services should be moved up to #4.

[Vote: 2/3 Majority does NOT support moving mental health higher.]

Melissa Davis: Ok, now we've been through all the issue cards. Do you fully support these top 10 as they are ranked?

[Vote: 100% majority SUPPORT current ranking.]

Melissa Davis: OK, now we are looking at next ten. Regardless of order, are these the next ten services?

[Vote: 2/3 Majority does NOT support current ranking.]

Ok, then, we will do another round of index cards. Remember, this is not about the order so much as it is whether something should be pushed out and replaced in that next ten.

Kayla Long: The first card suggests that nonmedical case management should be moved out of top 20 to bottom nine.

Richard Smith: I would say it should stay because if we are going to be allowed to offer this it might relieve some burden on medical case management for people who don't need MCM.

Derrick Wilson: But the future is not today. We may go back to Non-MCM in the future but that will need to be used in the RFA.

Melissa Davis: if we can make a case for a triaged case management system we can use that as a recommendation for the DOH.

Paul Yabor: Do navigators fall under that? [YES] Then that might be a case where it would work well.

[Vote: 2/3 Majority does NOT support moving Non-MCM out and into the bottom 9.]

David Givens: The next card asks if medical nutrition therapy should be moved up into 11-20?

Wes Anderson: In addition to transportation, it was mentioned as supportive in rural areas.

Paul Yabor: Food security is an issue.

Susan Rubenstein: This service is part of outpatient visits, though.

Paul Yabor: At first I thought medical nutrition therapy [MNT] is food banks. The food bank/home delivered meals is separate, though. MNT is a visit by a registered dietician.

Shubra Shetty: we are seeing more diabetes, high BP, heart issues…my patients are dying from others things, not AIDS. Obesity related problems is rampant in clinical practice.

[Vote: 2/3 Majority SUPPORTS medical nutrition therapy moving into 11-20.]

David Givens: Ok, so now we have a follow-up suggestion that AIDS Pharmaceutical Assistance should be moved out and Medical nutrition therapy put in its place at #14?

[Vote: 2/3 Majority SUPPORTS medical nutrition therapy moving into #14.]

David Givens: The next card suggests that legal services be moved up higher on the list.

Tony Strobel: This is important because 75% of HIV positive people are living in poverty and in most cases they don't have legal capacity to deal with HIV related issues.

Briana Morgan: also there may be emerging legal needs related to Healthy PA.

Robert Smith: some people have said that they can't get services so that might help.

Melissa Davis: this covers things like power of attorney, foster care, housing discrimination, discrimination issues, insurance, wills and custody.

[Vote: 2/3 Majority does NOT support moving legal services into 11-20.]

Votes with no discussion:

[2/3 Majority does NOT support moving respite care into 11-20.]

[2/3 Majority does NOT support moving linguistic services into 11-20.]

[2/3 Majority does NOT support moving food bank out of 11-20.]

[2/3 Majority does NOT support moving outreach services into the bottom nine.]

David Givens: This card suggests residential Substance Abuse [RSA] should be moved into the bottom nine.

Paul Yabor: I'm against it. Again, we're asking for viral load to be a static number. People's behavior is not a static number. Anyone we can support, including RSA, should be a priority.

Linda Frank: I echo that: when we identify people the big drop in terms of care/retention is related to mental health/sa.

Ann Thacker: It is cost prohibitive, though.

Paul Yabor: I just spend five days in Pittsburgh, and we spoke about lost to care. We know that when they have support they make their appointments.

Derrick Wilson: But RSA is cost prohibitive.

Linda Frank: we should not consider that in our voting.

Melissa Davis: Cost is not a consideration, but cost effectiveness is part of the guiding principles.

[Vote: 2/3 Majority does NOT support moving residential Substance Abuse out of 11-20.]

David Givens: This card suggests switching child care services into 11-20.

Linda Frank: I really felt that it should be moved higher to try to get women into care and keep them in care. If they don't have childcare they are not going to come and will miss appointments.

[Vote: 2/3 Majority does NOT support moving childcare services up the list.]

Melissa Davis: Let's take another vote about the order of these 11-20 priorities.

[Vote: 2/3 Majority does NOT support current order of priorities.]

Ok, we will do another round of index cards.

Kayla Long: this first card suggests that the food bank be moved down the list.

[Vote: 2/3 Majority does NOT support moving food bank down the list.]

David Givens: This card asks to move health education/risk reduction down the list.

[Vote: 2/3 Majority does NOT support moving health education down the list.]

Votes with no discussion:

[2/3 Majority does NOT support moving psycho-social support services up the list.]

[2/3 Majority does NOT support moving outreach services up the list.]

[2/3 Majority does NOT support moving non-medical case management up the list.]

[2/3 Majority does NOT support moving Substance Abuse services up the list.]

[2/3 Majority SUPPORTS the current ranking of priorities 11-20.]

[2/3 Majority SUPPORTS the ranking of the bottom nine.]

Melissa Davis: Great. Now the final vote is a cumulative vote about whether you support the full ranking of all priorities.

[Vote: 100% majority SUPPORTS the full priority listing. See Appendix A for list.]

Melissa Davis: Ok, congratulations everyone. The final thing we need for today is rationale for the top ten priorities. We discussed the top three at length, so what can we say about number four?

Robert Smith: for Housing, if you don't have stable living environment you are not going to keep medical appointments or eat well; you need a stable place to be stable.

Doyin Desalu: Housing is healthcare.

Derrick Wilson: Even temporary housing is important.

Jeffery Haskins: A lot of people who are homeless, recovery and mental health housing is essential so that people are stable enough to take medication and stay healthy and well.

Melissa Davis: Ok, for #5, oral healthcare: people tend to avoid or neglect dentists so it is important to make that preventative step a priority.

Ann Thacker: with people living longer it is much more of a priority.

Derrick Wilson: There are a variety of opportunistic diseases that can only be detected by oral exams.

Linda Frank: They have been encouraging dentists to do HIV testing… so this is another avenue for partners to get tested.

Melissa Davis: For #6, EIS, this supports the continuum, addresses first two portions of that continuum. We talked at length about number seven. For #8, mental health services…

Dan Campion: People can be traumatized by HIV, and need coping mechanism to manage living with HIV.

Linda Frank: Treatment cascade behavioral health as factor in staying in care. There a lot of people who have mental health issues before and also develop post diagnosis.

Briana Morgan: And we also have Lost to Care – mental health is a limitation there.

Wayne Fenton: A lot of people have depression.

Melissa Davis: Ok, that should cover it since we talked about 9 and 10 a lot, too. Thank you, everyone.

Linda Frank: I'd like to thank you for the great job you did, Melissa.

Melissa Davis: Thank you, I'd like to thank David and the whole Pitt team for all their work behind the scenes and in between meetings.

Subcommittees

Director McGarvey: We will now break into subcommittees, and then have brief reports before we adjourn.

Announcements from the sub-committees:

Shannon McElroy: As you know, our co-chair, Michael Hellman, stepped down, so we will be holding an election for a new chair in January. In the meantime Dan Campion and I will co-chair.

Membership and Stakeholder will stay in place, the other committees may need to change for next year. We also spoke about stakeholder engagement and Tony Silvestre will present our five year plan we will be doing with Pitt. The Nominations committee is finalizing application decisions.

Briana Morgan: Sharita and Shannon have mentioned a new committee structure and we spoke about that. We also looked at key informant issues and those who have long wait time. We will try to understand the transportation landscape. We will make formal request to HRSA about

telemedicine as integrated for Part B as part of ambulatory care. We looked at gaps in linkage with subsequent appointments. We might look at how Alabama works with telemedicine.

Paul Yabor: When you talk about telemedicine you should look at not just HIV, but with Hep C treatments might also work well.

Melissa Davis: Our subcommittee spent time looking at gaps in data from today, how to make recommendations, transportation came up in our discussion as well. We went over the strengths of process.

Chairwoman Flaherty: Thank you so much and we will see you tomorrow.

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University of Pittsburgh: Mack Friedman, David Givens, Daniel Hinkson, Sarah Krier, Kayla Long

HRSA/CDC:

Guests: Adam Bocek, Leah Magagnotti, Jeanne Caldwell, Lou Ann Masden

Welcome & Introductions

[9:00am]

Director McGarvey: Welcome back. Please complete a membership survey if you haven't, and remember our technology policy; please turn your phone off. Also, we've had a very good turnout of guests and interested parties, but I do need to note that we are limited by our contract with the hotel to 60 meals at lunch, so we may have to limit that. Finally, Greta will be here to assist you with travel, since we will need your receipts.

Announcements

Division of HIV/AIDS news

Julia Montgomery: We do have a new staff person. Her name is Catherine. We sent staff to a technical assistance 3 day meeting about Ryan White Part B in DC. Soon they will be able to apply that knowledge into what they do. We are happy to have full staff in Care section. In other news, we

started our annual site visits to regional grantees – we will have two more visits before holidays, with the remainder after the holidays.

Jill Garland: For the prevention section we have a staffing update: one administrator has been added, Marijane. She will officially start in January, and then we are at full capacity. We have been on the road visiting some the county health departments. In terms of setting up logistics, Lisa will be handling those.

We attended a conference. Nicole actually has been asked to present on a NASTAD panel. The session itself was entitled raising the bars, about approaches we are taking to try to raise standards and reporting for prevention. We have been able to improve our performance measures. Over 60 people attended. She got a lot of positive feedback.

We have no word on our CDC technical review or notice of award.

Cheryl Henne: Our staff is not yet at full capacity but will be soon. Additionally we are looking to bring in a part-time person to help train the new person. We are excited about that. Brad was down at the reverse site visit. Manufacturer agreements are drafted and mailed, so we are pleased with that.

John Haines: SPBP is in the process of updating the arrangements with manufacturers. In July we had mailed the new agreements to each of the new manufacturers. We delayed deadline for agreements to July 2015. Some manufacturers are working on it but it takes a while to get thru their legal and review committees.

Doyin Desalu: Is this the first time with the new manufacturer agreement?

John Haines: This will be the first time we will have our own agreement. A new state law requires us to do this.

Susan Rubenstein: Does every ADAP program need to have these agreements?

John Haines: It is just a requirement for us in PA. Other states just need to let them know how many rebates to expect.

Shubra Shetty: Did you also inform clients and prescribers? They probably won't notice if you just send it to card holders.

Cheryl Henne: Eli Lilly has actually asked to end their contract by Nov. 1 so we ran reports to see how many card holders used that brand, and we contacted them to let them know to contact their pharmacist.

Ann Thacker: What would be a good day to check the formularies if we wanted to do that?

John Haines: It could be up by January 1st – we'll notify cardholders ahead of time.

Paul Yabor: With the last new contract recently, a lot of pharmacies held out. Is there something we need to do?

John Haines: We haven't seen the influx like we did with the pharmacies. At this point we are notifying pharmacies to notify which manufacturers have yet to sign agreements.

Director McGarvey: As far as anti-retrovirals, they have gotten their agreements in or let us know that they are in the last stages of review. So for anti-retrovirals we are in good shape. But we have a very extensive formulary – more than most states – so there are a lot of other drugs that are important but more up in the air. If manufacturers don't return the agreements we have to take their drugs off the formulary.

Ann Thacker: Are there any other manufacturers that produce similar meds?

Paul Yabor: And is there room for advocacy?

John Steiner: We can provide a list of those manufacturers.

Director McGarvey: Keep in mind that big drug manufacturers are a different animal all together from pharmacies…

Rob McKenna: I can speak about HHS. On World AIDS Day Dr. Frank has asked me to present. On December 2nd we would like to convene and learn about the experiences of consumers in marketplace enrollment - what efforts have been made and how we can help. As you can imagine the AAC remains a priority.

David Givens: For Pitt announcements, at the membership and stakeholder groups request we are reaching out to former IPG and CPG members to let them know what the HPG has been doing and what new stakeholder efforts will be getting underway. We also have minutes and the membership application available on our website both in English and Spanish, so you can send people there to stay abreast of the meetings and HPG. We are also preparing to update our faith base prevention and outreach webpage, and are excited about that. We also have our intern here with us this meeting, Kayla Long, and are happy to welcome her. She has been a great help and helped prepare some of the information you've been reviewing this fall. I'll ask Sarah to say a few words about our Acceptance Journeys project.

Sarah Krier: Our Acceptance Journeys project is a CDC funded intervention that works to reduce stigma for LGBTQ youth and African Americans, primarily. It works by depicting and sharing stories of acceptance between LGBTQ persons and their family or loved ones. We have finished our photos and stories, and so the first billboards will be going up soon in Pittsburgh. We have proofs to send around for you to see. We are also keeping an eye on scale-ability to see if and how this can be adapted to other areas of PA.

Linda Frank: For AETC, we are gearing up for the world AIDS day event. Our website highlights really up-to-date information and archived webinars. AETC continues to offer mini-residencies where we sent clinicians out to sites.

Daniel Harris: In Philly we had an event on prep and black gay men and we had amazing event with 50 people.

Shubra Shetty: Our clinics activities will include case presentations with wright center and medical center. We've escalated the number of students who are coming thru our clinic. The students are taking the lead. I'd love to hear more ideas of how you all have engaged with students.

HPG Business

Director McGarvey: Thank you all. We now have some HPG business.

Shannon McElroy: The membership group is meeting over lunch to finalize our decision on new members.

> [Presentation: Anthony Silvestre: Video on the 5 Year Stakeholder Engagement Plan. No Questions were raised.]

Resource Allocation

> [Powerpoint presentation: Melissa Davis: Preparing for Resource Allocation
>
> Powerpoint presentation: Julia Montgomery: State Services Presentation]

Paul Yabor: 2011/2012 numbers are measured in percentages – with this shift of services what was the popularity of the activity?

Susan Rubenstein: In 2011/2012 outpatient and MCM are significantly higher than for 2013. Why?

Julia Montgomery: We used to report everything parts A-D, but in 2013 we started reporting only part B.

Robert Smith: That was the difference in what was proposed and used?

Julia Montgomery: In general the proposed versus the actual had very little change. I'm happy to do a presentation on that next year. With us receiving all the CareWare data we will have better data to work with.

Linda Frank: Do we know what 100% of funding is– what is the total amount? What are these percentages all based off of? We kept talking about taking SPBP off.

Melissa Davis: It's on the slide.

Julie Montgomery: It is earmarked, but we can't say it doesn't exist.

Linda Frank: I have a question about the outpatient/ambulatory care. Whether or not it is covered under ACA– do we have any data on that?

Julia Montgomery: The 2013 grant ended in March of 2014 so the impact of ACA was only 3 months. We don't have monthly report of funds expended. The regions around the table might be able to address this: are patients accessing these services less since March?

Linda Frank: Going forward it is important to think about where we would put limited part B money if more reimbursement is coming from ACA. I'm not sure how to address that in terms of allocating funds for it.

Briana Morgan: We've been looking at this in AACO. 70 clients enrolled, and 26,000 did not.

Ann Thacker: We also see very few people enrolling. It's not mandatory for HRSA. If someone doesn't sign up they can still get Ryan White funds.

Richard Smith: SW region ACA first year part B clients: 17 total.

Linda Frank: It's interesting that numbers are so low.

Melissa Davis: The RA process will be reevaluated every year. So now we are going to get started and look at the top 10.

Shubra Shetty: So we start with the overall funding as flat. How are we moving things around if at all?

Melissa Davis: We need to focus first on our first ten.

Linda Frank: If we increased some of these we could decrease in others.

Melissa Davis: EIIHA is under EIS usually but we are using state funds for that.

Julia Montgomery: We have no intention to reduce it.

Linda Frank: Where does the EIIHA money go?

Julia Montgomery: When you are looking at partner services and identifying at risk folks……

Melissa Davis: We are going to spend time today talking about what we want these to look like.

Director McGarvey: You may set these numbers from actual expenditures, if you choose, but keep in mind that contractors can move funds where they need to move funds based upon how the contracts are written. That's the other reason that the priorities from yesterday are really important.

Paul Yabor: A concern with EIS with prevention is that it's moving toward scarce resources. Will funding streams for testing hold up?

Jill Garland: I haven't heard anything about that. Keep in mind with CDC funds we also have the ability to move funds around. 75% of our funds are for direct services… none of those dollars are maintained in Harrisburg.

Melissa Davis: We still want to be mindful of keeping these numbers realistic. So what do we think? We're looking at level funding here. Is there a service category here that we're anticipating changes?

Ann Thacker: Is there a regional perspective allowed here? Because core services expenses are going up in our region.

Linda Frank: Perhaps we should put more money in health insurance premiums? Maybe it's cheaper to put more money in insurance rather than treatment.

Director McGarvey: We don't know that though.

Paul Yabor: I've heard a lot of testimony and information regarding the inadequacy of transportation in rural areas. Should we address that?

Richard Smith: Transportation is a big problem and a barrier to care. But we rarely spend all the transportation money available in our region.

Melissa Davis: Maybe it's not a money problem, but maybe we need more creative ways to meet the need. The need and the funds may be two different issues.

Jeffery Haskins: Grantees have said in the Needs Assessment that transportation issues are not addressed by the money.

Daiquiri Robinson: Maybe we should put more money into mental health.

Melissa Davis: Ok - what other funding sources go into that category?

Ann Thacker: In Philadelphia there is Behavioral Health Department that covers that.

Richard Smith: In Allegheny County we don't spend all that money – plus, the county can cover that, Ryan White is a payer of last resort.

Robert Smith: In south central, it can be a long wait to use Ryan White funds for mental health.

Comment: Organizations could look more at collocated mental health services; instead of "it's not available, we can't do it." Maybe we should consider it in those terms.

Tony Strobel: We always look at CDC, SAMSHA, HRSA, but in HHS there are other sources available.

Wesley Anderson: I agree with Tony over here. We should increase the category, HIV and mental health is becoming much more specific with regard specifically to the issues of HIV and mental health. At U Penn, we've already established a CFAR just for HIV and mental health.

Richard Smith: We're working within a specific framework that is going to exist in the future. I like Tony's idea, but we bill off of unit costs. They have to have the clients to bill for the service. They can't bill unless they have the clients coming in.

Susan Rubenstein: Psychologists are really hard to find, I spent 2 years trying to find one in Lehigh Valley. Models where mental health is provided right in the HIV clinic, especially in rural settings, would be useful.

Linda Frank: How Mental Health is funded under Part B, it sounds like the funding mechanism needs to be looked at as we move forward. It doesn't always have to be a psychiatrist—e.g. nurses, etc. There could be innovative ways of providing that service other than every single agency hiring someone. There could be a core group regionally of MH providers – an interdisciplinary approach – that might be able to work that could be available per agency need. HRSA likes interdisciplinary collaboration. In many ways you can't talk about MH w/o substance use, because they are intertwined.

Melissa Davis: Ok… and we haven't discussed oral health yet.

Linda Frank: And I mentioned insurance premiums.

Melissa Davis: Let's vote on increasing the mental health allocation.

[Vote: 2/3 majority does NOT support increasing mental health.]

Melissa Davis: Oral health was the next one suggested for an increase. Any thoughts?

Susan Rubenstein: There's really no other funding for oral health, so I think it's important for B money to fund that.

Daiquiri Robinson: A lot of our clients by the time they get to us, they have a lot of other problems they haven't addressed, including dental health issues, abscesses, etc.

Robert Smith: The need is there, sometimes we need to be creative to get people to appointments.

Melissa Davis: 'No other funding streams' is the main rationale.

Richard Smith: We have seen an increase in oral health in our region. But in rural health, we're lucky to find one doctor who will meet with our clients.

Melissa Davis: That's a problem in our region as well.

Ann Thacker: It's a lot of work to find them, to contract with them.

Shubra Shetty: Our patients are getting older—45 plus is our largest population—life issues along with HIV related stuff, I think oral health is really important.

[Vote: 2/3 majority SUPPORT increasing funding to oral health.]

Melissa Davis: Ok, discussing Health insurance premiums is next.

Susan Rubenstein: I'm just wondering about the regions, do they run out of money?

Melissa Davis: We can move money between categories, so we don't run out.

Richard Smith: We use it.

Melissa Davis: Do we want to increase this, or not?

> [Vote: 2/3 Majority does NOT support increasing the health insurance premium support category.]

Melissa Davis: Finally we'll vote on the full top ten whether we are happy with the categories we want to change, and we'll come back to which categories get how much after the vote. There is no middle option this time, it's yes/no.

Robert Smith: Is emergency financial assistance need increasing or decreasing?

Melissa Davis: We've seen it remain stable.

Paul Yabor: What housing services are covered under Part B?

Melissa Davis: Several, but not HOPWA. It could be short-term, temp housing, it could also be a facility that provides Mental Health, substance use, services.

Julia Montgomery: It could also be emergency housing for specialized treatment away from their home.

Richard Smith: It could be used to secure permanent housing; security deposits, first/last month rent… it's useful.

Linda Frank: A comment. Yesterday we spent a lot of time prioritizing, yet upon voting we have not changed any of the allocations besides oral health. Maybe it's because yes/no response, and if there were a middle ground. I thought we were doing 3 options for all things.

Melissa Davis: No, 3 options is only for the slate of priorities. We decided that format in October.

Linda Frank: If we were to do it again, I think some of the things might have gotten more discussion, and we could have reallocated them.

Dan Campion: Maybe that's because this setup is working in the regions.

Melissa Davis: We could zero out one of these categories if we did find other funding sources.

Ann Thacker: These are recommendations, DOH makes the final decisions anyway. We did change the prioritization, what they do with it as far as funding is their call.

David Givens: The options we have chosen accounts for 80% of the costs.

Paul Yabor: I have a hard time figuring out which to take money from with level funding.

Melissa Davis: Lock in this 10—with a 3 option vote—we will discuss oral health later.

Doyin Desalu: Locked in means percentages in the top 10 allocations don't change at all.

Chairwoman Sharita Flaherty: That's why we're taking the vote.

Melissa Davis: There's been no talk of decreasing anything here in the top 10—keep these at least level funding. With the exception of oral health, if there's suggestion for that, now's the time to make it.

Doyin Desalu: Can't you shave a little bit off medical case management?

Chairwoman Flaherty: Either we're voting to keep these completely the same other than oral, or we're going to make changes. Let's take that vote off the table then.

Shubra Shetty: If we can't find the money for oral health somewhere else, then I think holding is wise, because don't have all the facts yet for the other categories, otherwise it's kind of hard to wrap your head around it.

Melissa Davis: OK, we'll hold on the case management discussion.

Doyin Desalu: Yes, please, thank you.

Melissa Davis: Items 11-20. Of these 10, recommendations are out now.

Richard Smith: I vote to reduce Health Ed [HE]/Risk Reduction [RR]. The return from providers on these services, it's a very difficult thing to measure, and there is also money for other sources here.

Susan Rubenstein: I agree with Richard.

Linda Frank: I agree as well.

Shubra Shetty: Echoing what everyone else says, in most offices, everybody's taught to do this, so anyone can do this. Is retention separate?

Melissa Davis: Yes.

Jeffery Haskins: I would talk about an increase in outpatient substance use. We're seeing poly substance users, more people are coming in with that.

Melissa Davis: Let's hold substance use for a moment.

Robert Smith: What services are they currently providing under HE/RR?

Melissa Davis: Education, risk of transmission, secondary prevention.

Robert Smith: We use State 106 funds for that, so I agree with Richard.

Melissa Davis: Let's open up the HE/RR vote, Yes to reduce, No to stay the same.

[Vote: 2/3 Majority SUPPORTS reducing Health Education and Risk Reduction to zero.]

Melissa Davis: Discussion to increase substance use outpatient.

Richard Smith: I am going to say keep it the same, in my opinion.

Melissa Davis: What other services available?

Richard Smith: County services, medical assistance.

Comment*:* I would vote to increase it. We did move it, people thought it was a really important thing. With that in mind, it seems like it SA outpatient is an increasing need, so we should put our money where our mouths are. We are seeing more poly-substance use, stigma and discrimination, and those systems are stretched.

Melissa Davis: I think currently that the need is met by other funding streams in all but one region, from what's on paper. 3 regions use it. ADAP pays $500.

Paul Yabor: One of my concerns is people accessing treatment. If they don't have insurance they can get DHSI, then usually medical insurance kicks in.

Linda Frank: When it comes to behavioral health resources, outside of Pittsburgh, Philadelphia, AIDSNET, it's a different kettle of fish. Not a lot of services available outside. We should be thinking about the entire state.

Chairwoman Flaherty: Just putting more money in the category won't fix the structural deficit if there are transportation barriers.

Linda Frank: But you can't even begin looking if you have no money to do it.

Paul Yabor: Along with Mental Health, 1 thing that comes to mind are people who are lost to care, homeless, they're vulnerable, if there was more money, maybe that could go there.

Melissa Davis: All regions have the service line. But not all regions have utilized it. What that means is that service is being provided elsewhere.

[Vote: 2/3 Majority does NOT support increasing the Substance Abuse Outpatient category.]

Linda Frank: I think when it' so close there should be more discussion.

Chairwoman Flaherty: But we agreed on the 2/3 voting ratio. It was proposed by your committee.

Linda Frank: I don't think we have consensus on this.

Susan Rubenstein: People on the other side have not always been vocal. People who voted the other way didn't speak out.

Melissa Davis: I haven't heard any argument – we haven't identified that needs not being met. I would argue that with 3 regions funding that, there is need to have that service available, and other regions have found other funds to provide that service. I haven't heard "increased need" yet. I can hear that now.

Shubra Shetty: Everyone agree the need is there, but not that it isn't being met. Specific regions can tweak it, which gives flexibility on the ground.

Chairwoman Flaherty: With mental health, there are other funding sources, and we're allowed to say that today. It hasn't been identified that there's a deficit today.

Paul Yabor: One of my goals was to be prepared for changes in the near future, between ACA, other FQHC, a new governor; I'm just wondering, am I fulfilling that? Are we prepared, does this reflect the needs for the immediate future?

Melissa Davis: All we can do is try to look ahead, but there are so many uncertainties.

Chairwoman Flaherty: We have 2 things built in to address future needs. This is done yearly (allocations) and regions have ways to flex.

Melissa Davis: We have that ability to be flexible.

Shubra Shetty: Process-wise, it is 11:30, and some of us haven't checked out.

Tony Strobel: The fact that you can tweak things, it affects the whole process. Why are we sitting here, really? We're going through a process that shouldn't be gone through in a way, that's a conflict of interest.

Linda Frank: I agree, that is a conflict.

Melissa Davis: We can jsut set percentages of funding to these and eliminate all discussion.

Linda Frank: We don't have the data.

Melissa Davis: We have the data in front of us. [Restates utilization of SU-outpatient data.]

Paul Yabor: There's a third possibility, that the need is not being met, adequately. What is going on with this issue in this particular area.

Melissa Davis: In a perfect world, we would see from all providers which service providers use which alternate service, but we don't have that here.

Chairwoman Flaherty: It is being said, these are the things—sources—that are being used.

Susan Rubenstein: I just want to ground myself again. We're voting for what period again? I know there's been talk about change in the regions and what they can do, and is that going to happen in the period that we're voting on?

Director McGarvey: As far as the time frame, we're putting forth recommendations for allocations, for next year or whatever we decide—it's up to the HPG. We'll have to wait and see next year. This will go into a Plan..

Julia Montgomery: This will go into a funding plan—it will go into the next time we put money out.

Director McGarvey: This is a framework.

Susan Rubenstein: So whatever we come up with is it likely or possible that the state's change in the regional structure that might happen during this plan?

Director McGarvey: Yes.

Susan Rubenstein: The regions are all tweaking it themselves.

Richard Smith: We're not tweaking…we wait and see what hasn't been spent in Southwest, and then we can move that remainder.

Susan Rubenstein: The process might change when the regional structure changes.

Director McGarvey: The bottom line is that you have to give providers flexibility in contracts.

Susan Rubenstein: Ok.

Director McGarvey: There may be a high demand for services or an unmet need because a provider's not there, but unspent monies can be moved. You're giving us one set of priorities, one general framework for allocation of services for the entire state. But—we still need to be flexible at the end of the day to meet the different needs of providers in different region.

Wayne Fenton: For the process that we are in right now, for this purpose, I think we did an excellent job in prioritizing. But another level, if we are meeting the need of the people—who's watching the watchers, so to speak. The problem isn't the prioritization; it's that are we meeting the needs that have already been allocated. We may be spending too much time talking about what to take from what.

Melissa Davis: Resource allocation we always heavily rely on our utilization. We are missing some information—but this is not a worthless activity. Yesterday our prioritization is our biggest task, so if they are needed that is brought up in case of funding reductions. Do we have to get hung up on 1% to 2%? No, but this is not a worthless activity, that give us the wiggle room to not overthink.

Briana Morgan: I think it's important to remember that it's not just because of DOH, but also our funders (HRSA/CDC).

Melissa Davis: At this point let's just break and check out and reconvene after lunch. Any other service categories that we are interested in changing?

Robert Smith: I just wanted to touch on nonmedical case management. About some of the things that medical case management does that are not paid – maybe increasing in nonmedical services.

Julia Montgomery; I don't have a finalized opinion on that. There were some regions that did not want to fund nonmedical case management.

Director McGarvey: I remember some direction on HRSA. They highly encouraged us to eliminate nonmedical since it's not core.

Rob McKenna*:* And it is not just PA that has been told this.

Director McGarvey: HRSA says to fund medical case management and rethink and reinvest funds previously budgeted for nonmedical case management.

Paul Yabor: As we move forward in the cascade with treatment as prevention, I think in terms of adherence and to locate those lost to care we need those services.

Richard Smith: I think we need to have a conversation about case management. We have to rethink how we do case management. We're not. No one is doing it right.

Susan Rubenstein: If we are talking about decreasing something what about home healthcare?

Paul Yabor: Does ACA cover it?

Melissa Davis: No.

Doyin Desalu: does anyone know if the AIDS labor program is still functioning?

Tony Strobel: It must be on a monthly basis. The AIDS waver can do that – the people who are coming to homes are not as savvy with waivers. A lot of times insurance will only do home healthcare. There is a need but just isn't as great.

Richard Smith: We know that Philadelphia gets the majority of this.

Briana Morgan: My perspective is from part A: so I don't know how it is provided in aaco.

Richard Smith: We had a nurse who received it and it seemed to support those who used it. The person went and did a lot of adherence work.

Susan Rubenstein: That didn't help me at all actually. I vote to decrease it.

Melissa Davis: Do you want to decrease home healthcare?

[Vote: 2/3 Majority does NOT support decreasing the Home Healthcare category.]

Paul Yabor: I respect what HRSA recommendations are but sometimes they don't translate to what is best for Pennsylvania. It has been found that hospitals are better in finding results for HIV positive people versus outreach. Reality is different from statistics. I have to question anything that comes from federal level.

Richard Smith: we are not offering nonmedical case management as it is.

Rob McKenna*:* our recommendation is not to defund – simply to rethink – so wherever you come down is fine.

Briana Morgan: is it possible that there are certain needs covered by nonmedical cm that can be met in a different service category?

[Vote: 2/3 Majority SUPPORTS decreasing the nonmedical case management category.]

Melissa Davis: So where should we move this money? Oral health, since that is what we voted for increasing?

[Vote: 2/3 Majority SUPPORTS moving the funding to the Oral Healthcare category.]

Linda Frank: We didn't go through all the other ones to see if there are other places we'd like to move it. I feel like it is being pushed it in a certain direction and we haven't gotten through all the options in this section.

Ann Thacker: I think that question should have been raised before we voted.

Dan Campion: Why don't we just revote since we know that now?

Linda Frank: Voting on this like we did eliminated the opportunity to move it somewhere else. I'd go through all of them first.

Richard Smith: Treatment adherence counseling should be zero-ed out. It is covered under doctors visits and medical case management.

Paul Yabor: I feel that some services/programs exist that are useful in this category.

Melisa Davis: Southwest is only region that funds this. Paul: are they current part B providers? Should we zero this out?

Briana Morgan: part A only funds adherence under medical case management.

Melissa Davis: Should we zero this category out?

[Vote: 2/3 Majority SUPPORTS removing funding from the treatment adherence category.]

Shubra Shetty: What does rehab services encompass, Physical and rehabilitation? There is a real need for therapy for them. Chronic pain, injuries, they fall through the cracks. I think we should increase that category.

Tony Strobel: If a regional funder has a zero in that category it can't be changed? [Correct]

Paul Yabor: So why don't we leave a little money so we can be more flexible?

Chairwoman Flaherty: That is definitely a consideration. Should we put a .01 in every category to keep it on table?

Linda Frank: There was so much discussion about flexible. I would support that we leave some money in every category so that people can adapt to their own regional needs.

Ann Thacker: Even if the budget has 0.01 it doesn't mean people will leave it in there if it hasn't been used in 10 years. For those who need rehab do they have other insurance to cover it?

Shubra Shetty: Sometimes we struggle to get people comprehensive care. The copays are expensive, people don't write off anything. The working people who have pain issues don't have other options.

Melissa Davis: if we did .01 it wouldn't add up across regions to serve anyone. We have prioritized all categories and this gives DOH ability to work with that.

Linda Frank: I withdraw my motion.

Melissa Davis: the DOH has flexibility to say we can allocate based on need and allocate to regions. We would leave a pot of money (2.6%) to leave up to the DOH to allocate to those nine categories?

[Vote: 2/3 Majority SUPPORT allocating 2.6% collectively to the bottom nine priority categories.]

Chairwoman Flaherty: Is there anything else we'd like to increase? What else would we add to oral health? Is .06 sufficient?

Melissa Davis: What level of funding?

Shubra Shetty: Somewhere between 5-6%. That's a big deal and dental care is not cheap and we need real money.

Susan Rubenstein: take 3% from Health Education/Risk Reduction [HE/RR] and move it to oral health.

Julie Montgomery: 3% is 240,000.

Melissa Davis: Do we want to move 3% to oral health?

[Vote: 2/3 Majority SUPPORTS the above motion.]

Should we continue to reduce the HE/RR*?* Do we feel that 6.87 is enough in oral health?

Shubra Shetty: I would propose to move that .6 from adherence to oral health.

Ann Thacker: We had to limit our clients to 2000 a year since so expensive?

Linda Frank: Under ACA does not pay for dental care, and oral health is essential to overhaul health.

Chairwoman Flaherty: We all agree that it is awesome and we have to decide how much.

[Vote: 2/3 Majority SUPPORTS ending discussion on oral health care.]

Linda Frank: For future iterations of this process – I think when it is that close I don't feel comfortable. We took 2/3 to change something. I think that is has to be looked at.

Chairwoman Flaherty: Please take note of that, PRSA.

Melissa Davis: What level do we find adequate for HE and RR. Decrease it? Zero it out?

Robert Smith: We did have it but not now. For those who are using it, how is it being used?

Briana Morgan: In Southeast it is funded but not under part A, so I don't know about it.

Richard Smith: I believe it goes to one agency for peer education and secondary prevention.

Jeffery Haskins: It goes to ethnic minorities.

Paul Yabor: I think Project Teach has been key in keeping people in care. That's Part B.

Melissa Davis: Do we want to further decrease it? Or keep it the same?

[Vote: 2/3 Majority SUPPORTS keeping he funding level the same.]

The percentage of .6 is still to be allocated. Where do we want to put it?

Richard Smith: I motion .3 to Substance Abuse and .3 to Mental Health.

[Vote: 2/3 Majority SUPPORTS the above motion.]

Melissa Davis: Thank you so much for your help with this. We are done!

David Givens: I believe the process requires a final vote approving the whole of the allocations.

[Vote: 98% Majority SUPPORTS the Resource Allocations as listed. See Appendix B.]

Subcommittee Sessions/Closing Remarks

Director Ken McGarvey: Thank you so much. Do subcommittees want to meet?

[Subcommittees meet for 45 minutes]

Julia Montgomery: We are passing out the dates for next year's meetings.

Chairwoman Flaherty: For membership and recruitment we have 3 members that need mentors.

Director McGarvey: This has been a great year for us. We are a leader in integrated planning and you should take pride in that. We worked hard.

Chairwoman Flaherty: Do we have a motion to adjourn?

[Motion called and seconded. Meeting adjourned.]

Appendix A:

Priority Listing of Part B Services

1	AIDS Drug Assistance Program (SPBP)
2	Outpatient/Ambulatory Medical Care
3	Medical Case Management
4	Housing Services
5	Oral (Dental) Health Care
6	Early Intervention Services
7	Medical Transportation Services
8	Mental Health Services
9	Emergency Financial Assistance
10	Health Insurance Prem & Cost Sh. Asst
11	Substance Abuse Services - Outpatient
12	Food Bank/Home Delivered Meals
13	Health Education/Risk Reduction
14	Medical Nutrition Therapy
15	Treatment Adherence Counseling
16	Psychosocial Support Services
17	Outreach Services
18	Substance Abuse Services - Residential
19	Home Health Care
20	Non-Medical Case Management
21	AIDS Pharmaceutical Asst (local)
22	Legal Services
23	Home & Cmty-Based Health Services
24	Linguistic Services
25	Referral for Health Care/Supp Services
26	Rehabilitation Services
27	Child Care Services
28	Hospice Services
29	Respite Care

Appendix B

Resource Allocation Recommendations

Service Category in Priority Order	Priority Ranking	Previous Years' (2014) % of Funding	Allocation - % of Funding (2015)
ADAP/SPBP	1		
Outpatient/Ambulatory Care	2	11.58	11.58
Medical Case Management	3	50.92	50.92
Housing Services	4	2.82	2.82
Oral Health Care	5	3.81	6.87
Early Intervention Services	6	0	0
Medical Transportation Services	7	2.9	2.9
Mental Health Services	8	0.89	1.19
Emergency Financial Assistance	9	5.6	5.6
Health Insurance Prems & Cost Sharing Assistance	10	2.18	2.18
Substance Abuse - Outpatient	11	0.64	0.94
Food Bank/Home Delivered Meals	12	6.24	6.24
Health Education/Risk Reduction	13	6.18	3.18
Medical Nutritional Therapy	14	0.35	0.35
Treatment Adherence Counseling	15	0.6	0
Psychosocial Support Services	16	1.25	1.25
Outreach Services	17	0.41	0.41
Substance Abuse - Residential	18	0	0
Home Health Care	19	0.97	0.97
Non-Medical Case Management	20	0.06	0
AIDS Pharm. Assistance (local)	21	0	
Legal Services	24	1.05	
Home & Community-Based Health Services	19	0.03	
Linguistic Services	27	0.5	
Referral for Health Care/Supportive Services	25	0	2.6
Rehabilitation Services	20	0	(TBD by DOH)
Child Care Services	26	0	
Hospice Services	28	0.58	
Respite Care	29	0.44	

Key:

Black: Core service
Yellow: Support service
Green: Increased funding (recommendation)
Red: Decreased funding (recommendation)