Oakland Transitional Grant Area (TGA)

COLLABORATIVE COMMUNITY PLANNING COUNCIL

"Serving Alameda and Contra Costa Counties"

PRIORITY SETTING AND ALLOCATIONS MANUAL

Fiscal Year 2012-2013

MEETING SCHEDULE:

Wednesday, June 22, 2011

12:00 noon to 8:00 pm

Location: West Oakland Senior Center, 1724 Adeline Street, Oakland, California

Town Hall Meeting/Public Comment: 12:00 noon - 2:00 pm

Thursday, July 28, 2011

10:00 am to 6:00 pm

Location: South County Castro Valley Library, 3600 Norbridge Avenue, Castro Valley, California

Town Hall Meeting/Public Comment: 10:00 am to 12:00 noon

Wednesday, August 24, 2011

10:00 am - 3:00 pm

Location: Office of AIDS Administration, 1000 Broadway, 5th Floor, Room 5000A, Oakland, California

Wednesday, September 28, 2011

10:00 am - 3:00 pm

Location: Office of AIDS Administration, 1000 Broadway, 5th Floor, Room 5000A, Oakland, California

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OVERVIEW

In accordance with the Ryan White Part "A" Planning Council Primer, the Planning Council sets priorities. This means the members decide which services to fund. The Planning Council makes these decisions about priorities for funding based on many factors. The Council will use these guiding principles and values that were developed as part of the Comprehensive Plan.

The Planning Council must prioritize only service categories that are included in the Ryan White legislation as core medical services or approved by the Secretary of Health and Human Services as support services. In setting priorities, the planning councils need to focus on the legislative requirement that at least 75% of funds go to core medical services and not more than 25% to supportive services. Support services must contribute to positive medical outcomes for clients.

After it sets priorities, the Planning Council must allocate resources, which means it decides how much funding will be used for each of these service priorities. For example, the Planning Council decides how much funding should go for primary care services, mental health services, etc.

The Planning Council members may also include further instruction to the Grantee regarding how best to meet each priority and indicate additional factors, the Grantee should consider in allocating funds to the prioritized service. It may direct the Grantee to fund services in particular parts of the EMA or TGA (such as outlying counties), or to use specific service models. It may tell the grantee to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month). It may also require that services be appropriate for particular populations—for example, it may specify funding for primary care services that target gay men of color. However, the Planning Council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will quality. The Planning Council cannot be involved in any aspect of contractor selection (procurement) or in managing or monitoring Part A contracts.

The goals as stated in the Comprehensive Plan were developed to reduce the number of people out of care and improve health outcomes for PLWH/A. These principles and values are essential to outreach, recruitment and retention of PLWH/A in this TGA.

The Goals are:

1. Provide access to and retain in high quality HIV medical care those who are aware of their status but not in care.
2. Optimize the continuum of care's impact
3. Enroll out of care clients in care
4. Insure that all services are of the highest quality through implementation and monitoring of a Quality Management Plan.

The Guiding Principles are:

- Maintain a commitment to ending health disparities
- Proved client centered and coordinated services
- Integrate Prevention and Care
- Maintain and require collaborative partnerships among service providers
- Encourage early and meaningful involvement on the part of PLWH/A in the design, development and evaluation of service delivery.
- Engage continuous training, capacity building and leadership development
- Provide culturally and linguistically appropriate services

The Values are:

- Respect and Compassion
- Trust and Empathy
- Access to services and an end to disparities
- Accountability
- Professionalism
- Seamless, Integration, Continuity and Coordination within the continuum of care
- Flexibility and Adaptability

Priorities and allocations are data based. Decisions are based on the data, not on personal preferences. The Planning Council will have access to information to enhance their efforts in the decision making process. The data collected includes:

- Epidemiological Data
- OAA Fiscal & Service Utilization Data
- Needs Assessment Data
- Public Comment Data
- Various other data reports

Other factors to consider are:

- Funds from other sources such as Medicaid and Medicare
- State Children's Insurance Programs
- Developing capacity for HIV services in historically underserved communities
- Priorities of people living with HIV who will use services
- Changes in legislative requirements
- National HIV/AIDS Strategy
- Affordable Care Act

MINORITY AIDS INITIATIVE (MAI)

Since 1999, Congress has also dedicated funds for the Minority AIDS Initiative (MAI) to expand or support new initiatives that are intended to reduce HIV-related health disparities and to improve HIV-related health outcomes for HIV-infected African Americans, Latinos, and other ethnic minorities. The overall goal of the MAI is to improve HIV/AIDS-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS. It allows communities to expand local service capacity primarily through minority community-based organizations, to increase the availability of medications, primary care, support services, and outreach services to communities of color, and support the development of new and innovative programs designed to reduce HIV-related health disparities. The MAI takes a multi-pronged approach to HIV/AIDS, focusing on HIV prevention, care, treatment, and research.

The Oakland Transitional Grant Area, Community Collaborative Planning Council voted on March 24, 2010 to fund the formerly incarcerated HIV individuals. These services cover the same core medical and support services as Part A of the Ryan White Program. The Council used

the same guiding principles and values that were developed as part of the Comprehensive Plan to establish priorities and allocate funding.

The HRSA fundable Service Categories are listed below:

❧ **Core Medical Services, including:**

1. Outpatient/ambulatory medical care
2. AIDS Drug Assistance Program (ADAP treatments)
3. AIDS pharmaceutical assistance (local)
4. Oral health (dental) care
5. Early intervention services (EIS)
6. Health insurance premium & cost-sharing assistance
7. Home health care
8. Home and community-based health services
9. Hospice services
10. Mental Health services
11. Medical Nutrition therapy
12. Medical case management
13. Substance abuse services - outpatient

❧ **Support Services, including:**

1. Case management (non-medical)
2. Child care services
3. Emergency financial assistance
4. Food bank/home-delivered meals
5. Health education/risk reduction
6. Housing services
7. Legal services
8. Linguistics services (interpretation and translation)
9. Medical transportation services
10. Outreach services
11. Psychosocial support services
12. Referral for health care/supportive services
13. Rehabilitation services
14. Respite care
15. Pediatric Development Assessment & Early Intervention Services
16. Permanency Planning
17. Substance abuse Services (residential)
18. Syringe Services Program
19. Treatment Adherence Counseling

Timeline for Priority Setting & Allocations

DATE	TASK	ACTION ITEM
May 25, 2011 10:00am – 2:00pm 1000 Broadway 5th Floor Oakland, Ca	❧ **Service Utilization Data** by Service Category with the number of Unduplicated Clients (UDC) served and the number of Units of Service (UOS). ❧ **Service Category "Gap Analysis**" of Target & Actual UDC and UOS	Informational
June 22, 2011 **12:00 noon** **To 8:00 pm** West Oakland Senior Center, 1724 Adeline Street, Oakland, Ca **Town Hall Meeting** **12-2pm**	Review the Service Category definitions, Priority Setting Guidelines and Timeline and Orientation of the allocation process. The CCPC will hear the following reports: ❧ **Fiscal Report** will be presented by OAA ❧ **Patient Satisfaction Survey Report**	Review the **Service Category Definitions, Priority Setting & Allocations Guidelines & Timeline**
July 28, 2011 **10:00 noon** **to 4:00pm** South County Castro Valley Library, 3600 Norbridge Avenue, Castro Valley, Ca **Town Hall Meeting** **10:00-12:00pm**	The CCPC will hear the following: ❧ **Epidemiology Data:** Current Alameda County Public Health Department Epidemiology Data with a focus on three Priority Populations for Care & Treatment services: 1. African American with special emphasis on MSM 2. Latino MSM 3. Transgender ❧ **Priority Populations:** The CCPC will select the Fiscal Year 2012-13 Priority Populations for Ryan White Part "A" ❧ **Comprehensive Plan** ❧ **HIV Prevention Plan** ❧ **HOPWA Report**	Vote to Approve: **Priority Populations** for Fiscal Year 2012-2013 for Ryan White Part "A"

Timeline for Priority Setting & Allocations

DATE	TASK	ACTION ITEM
August 24, 2011 **10:00 am** **to** **3:00 pm** Office of AIDS Administration Building 1000 Broadway 5th Floor 5000A Conference Room Oakland, Ca	**2011 Community Needs Assessment** The CCPC will hear the following recommendations: ❧ Contra Costa County Priority Setting & Allocations presentation ❧ Committee recommendations for CORE and SUPPORT Services ❧ Content Analysis of all public comments from January 2011 through July 2011 ❧ The People Living with HIV/AIDS Committee recommends priority setting ranking. ❧ The Quality Data and Services Planning Committee recommend priority setting ranking. ❧ The Policy Education and Review Committee recommend priority setting ranking.	Informational
September 28, 2011 **10:00 am** **-** **3:00 pm** Office of AIDS Administration 1000 Broadway 5th Floor Oakland, Ca	**Core and Support Service Ranking:** Vote to approve the Core and Support Services ranking for Ryan White Part "A" **Allocation Percentage**: Recommend percentages and vote to approve Core and Support Services percentage. **Contingency Planning:** The CCPC will adjust its regular meeting agenda to schedule time for Contingency Planning. **Evaluation**: The CCPC will evaluate the Priority Setting and Allocation process using the Evaluation Tool enclosed within this manual.	**Vote to Approve:** Ranking of Categories, Allocation Percentage and Contingency Planning. All CCPC members to complete the evaluation tool.

Priority Setting Policy and Allocation Procedures

PURPOSE

This **Priority Setting and Allocation (PSA) Process** is designed to engage all Planning Council members in priority setting and allocations and in the development of directives to the Grantee.

POLICY

This policy will ensure informed decision-making of all Planning Council members in the process of priority-setting and resource-allocation and in the development of directives to the Grantee, and to outline a process regarding service categories that will facilitate access to HIV medical care and that is responsive to the needs of the client in the interest of producing positive health outcomes.

DEFINITIONS

A. **Priorities:** List of service categories, in order of importance, eligible for funding in the TGA.

B. **Directives (How Best to Deliver Services):** How best to meet each priority and additional factors that the grantee should consider in allocating funds (e.g. service interventions, subpopulations, service areas, organization characteristics).

C. **Allocations:** Determination of the percentage or amount of dollars to be allocated to each prioritized service category.

PRINCIPLES AND CRITERIA

A. Priorities and allocations are databased. Decisions are based on the data, not on personal preferences. Planning Council members are strongly encouraged to participate in the data presentation sessions prior to priority setting and resource allocations.

B. Conflicts of interest are stated and managed. Each member of the CCPC must have an updated FORM 700 and a Conflict of Interest form on file with the CCPC support staff. The support staff will prepare a conflict of interest matrix that will be distributed to each member at the beginning of the allocations process. Throughout the priority-setting process and resource allocations processes, individuals making arguments for or against specific services must make explicit any conflicts of interest they may have. Each member must state their conflict, they may participate in the discussions; however, they cannot vote on the service category in which they have a conflict as stated in the Oakland TGA CCPC By-laws.

C. The data provides the basis for changes in priorities or allocations from the previous year. The data indicates changes in service needs/gaps and availability based on information from the various data sources. Each Planning Council member makes his/her own assessment based on the data presentation meetings.

D. Equality of Votes: All voting members in the priority setting and allocations process have equal votes in the process; no person or group of persons will have a vote of greater weight then others. All CCPC members are eligible to vote if:

1. They have been seated after attending all orientation trainings;
2. They have met all attendance requirements for planning council; **and**,
3. They have completed all conflict of interest documents.

Voting will be conducted as follows:

- Vote to move funding between categories will occur by simple majority;
- Final vote for entire package is by roll call;
- A vote to extend the allocations discussion beyond the allotted time will require a 2/3 vote; and,
- Simple majority determines a passing vote of the entire allocation recommendations.

E. Needs of specific populations and geographic areas are an integral part of the discussion in the data presentations and the decision-making. They may also lead to directives to the Grantee on how best to meet the priorities.

Priority Setting and Allocation STEPS

A. All Planning Council members can participate. Only non-conflict Planning Council members may vote.

B. Planning Council Support and Facilitator will facilitate the PSA portion of the meeting.

C. Planning Council members must attend the presentation of data and be present for the entire PSA process. Once a quorum is established, Planning Council Support Staff will document all yeas, nays, and abstentions by name. Members who must abstain as a result of conflict of interest will be counted as abstentions.

Priority Setting and Allocation PROCESS

A. **Priority Setting Process**

Note: The priority setting process should consider services needed to be provided and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource-allocation process.

1. The list of HRSA fundable service categories (*Core and Support*) and the definitions of these services will be presented to the Planning Council (PC).

2. Priority Setting Ranking Form

i. Each Planning Council member will be given a Ranking Form for Core services and Support services.
ii. Planning Council members will be asked to rank the Core separate from Support with the:

- Highest priority ranking given a **number 1**,
- Second highest ranking is given a **number 2**
- Third highest ranking is given a **number 3**
- And so on …

iii. Planning Council members **may not give the same ranking more than once**.

4. Data Sources

i. In making decisions, Planning Council members should rely on the priority-setting data presentations.
ii. Planning Council members will be asked to rank the data used for decision- making and prioritization, as follows.
- Highest priority ranking given a **number 1**
- Second highest ranking is given a **number 2**
- Third highest ranking is given a **number 3**
- And so on …

5. Directives (How Best to Deliver Services)

i. Planning Council members may also include further instruction to the Grantee regarding how best to meet each priority and indicate additional factors the Grantee should consider in allocating funds to the prioritized service (e.g. service interventions, subpopulations, service areas, organization characteristics).

6. Aggregating the Votes

i. Planning Council Support Staff will collect the Priority Setting Ranking Form.
ii. Planning Council Support Staff will tally the votes.
iii. The service category with the highest total number 1 is ranked number 1; the category with the second highest number 2 is ranked 2, and so on.
iv. All service categories receiving a vote are ranked and placed on the list of categories to consider for funding. Service categories not voted for will not be considered for funding.
v. PC Support Staff and/or the facilitator will present the ranked list of selected service categories.

7. Aggregating the Directives (How Best to Deliver Services)

i. PC Support Staff will aggregate the directives.
ii. The aggregated list of directives will be sent to the Quality Data and Services Planning Committee for refinement. The QDASPC will discuss, refine, and develop a set of recommended directives and forward to Executive Committee and Planning Council for approval.
iii. Planning Council will vote and approve the final set of directives.
iv. The directives will be forwarded to the Grantee for implementation if these are deemed to be feasible by the Grantee.
v. The Grantee will review the directives and report to the Planning Council the timeline for implementation.

B. **Allocations Process**

1. Allocations

i. Prior to discussion and any vote, all Planning Council members who have conflicts of interest in that category will be identified and be required to abstain from voting *(Conflict of Interest form).*
ii. Each category will be determined independently on a line-by- line basis, beginning with the top priority.
iii. At the beginning of the discussion for each service category's funding, the Grantee and Planning Council Support Staff may provide Allocations recommendations based on analysis of service gaps and other relevant data.
iv. Eligible, non-conflicted Planning Council members will be able to discuss any data previously provided during a data presentation, and ask questions of the Grantee and/or Planning Council Support Staff. However, no Planning Council member is allowed to offer any new data for consideration.
v. Allocations will continue through the list of prioritized services until a set of completed allocations is reached.
vi. Once complete, the full Planning Council will approve the prioritizations and allocations for submission to the Grantee.

2. Reallocations

i. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved.
ii. Prior to discussion and any vote, all Planning Council members who have conflicts of interest in that category will be identified and be required to abstain from discussion and voting.
iii. The reallocations recommendations will be forwarded to the OAA, along with supporting data.

3. Contingency Planning

The CCPC will use the same guiding principles and values that were developed as part of the Comprehensive Plan to establish priorities and allocate funding. If the upcoming year's funding level is higher or lower than expected, increased funds are to be allocated proportionately to current and new services or cuts applied equally to all services.

Presentations

Check if Used	Presentations	Current As of (Mo/Yr)	Used by Full Planning Council
√	**Epidemiological Data** with a focus on the three Priority Populations: African American with a special emphasis on MSM; Latino MSM; and Transgender. ❧ Trends/changes in HIV Incidence an/or Prevalence ❧ Trends/changes in AIDS Incidence and/or Prevalence ❧ Changes in demographics of TGA's HIV/AIDS cases in relation to total population as a measure of disproportionate impact on specific populations		Y
√	**Service Utilization Data** ❧ Service Utilization Data by Service Category with the number of Unduplicated Clients (UDC) served and the number of Units of Service (UOS) provided ❧ "Gap Analysis" of Target & Actual UDC and UOS by Service Categories	5/2011	Y
√	**OAA Fiscal report presentation**	6/22/11	Y
√	**Needs Assessment Data** with a focus on three Priority Populations for Care & Treatment services: African American with a special emphasis on MSM; Latino MSM; and Transgender. ❧ 2010 Community Needs Assessment ❧ 2011 Community Needs Assessment	2011	Y

Check if Used	Presentations	Current As of (Mo/Yr)	Used by Full Planning Council
√	**Public Comment Data** ❧ Content Analysis Compilation, January – July 2011 ❧ Town Hall Meetings	7/2011	**Y**
√	**Comprehensive HIV Services Plan** with a focus on the Priority Populations for Care & Treatment services: 1. African American with a special emphasis on MSM 2. Latino MSM **3.** Transgender	2009-2012	**Y**
	Others, includes the following possible data reports (handout only): : • HIV Access (Part C Primary Care Clinics) Services • HOPWA Realignment and Services • Family Care Network (FCN / Part D) Report • HIV/AIDS Strategy Report	6/2010 and 6/2010	**Y**

Priority Populations for Care & Treatment Services

In accordance with the Oakland TGA HRSA Application for FY 2011-2012, the CCPC has identified six priority populations with special needs:

1. African American with a special emphasis on MSM
2. Latino MSM
3. Transgender

Assessment of Emerging Populations with Special Needs The Planning Council has identified six emerging populations with special needs: African American & Latino MSM, IDUs, Women of Color, Youth 13-24 years of age, and Transgender women. The table below displays the costs for providing HIV primary care and support services for each special population based on service cost estimates from the AIDS Healthcare Foundation. The service costs estimates for each emerging population are calculated based on three factors: 1) percentage of the total of each population in care, 2) annual cost per client determined on cost adjustments factors correlated with the special needs of each population, and 3) projected total cost of care per population (total # in care x annual cost per client). Detailed explanations of how these costs calculations were derived based on the respective special needs and challenges for providing care (cost adjustment factors) have been provided for each emerging population.

Figure 13 Populations with Special Needs Oakland TGA

Populations	Total # of each Emerging Population PLWH/A	% In care	Total Population # In Care	Annual Cost per client	Projected Total Cost of Care by Population
African American & Latino MSM	1850	60%	1110	$4,000	$4,440,000
Women of Color	1096	60%	658	$4000	$$2,632,200
IDUs	881	60%	530	$3750	$1,987,500
Youth Ages 13-24	470	60%	262	$5000	$1,310,000
Transgender M-F	54	60%	32	$5500	$176,000

African American and Latino MSM: *Unique Challenges and Service gaps*: MSM continue to account for the largest proportion of HIV/AIDS prevalence in the TGA, with 57.3% of total cases reported as of 12/31/2008. Moreover, during a recent analysis of delayed access to care in Contra Costa County found that, 70 % of the MSM in Contra Costa received an AIDS diagnoses simultaneous with their first HIV test results. There is a high correlation between late testing/delayed entry into care and

increased cost of care due to the need for more complicated care in the absence of early intervention.

Many MSM of color in the Oakland TGA are not gay identified. Focus groups conducted as part of the Oakland TGA s 2002 Out of Care Summit and the 2007 Needs Assessment reveal that MSM of color feel stigmatized by both the larger community of color and the gay community. It is widely understood that stigma fuels the unwillingness of men of color to test or seek care after a positive test result. In Alameda County, about one third of African American MSM have never tested to determine their HIV status, and a significant proportion of those who have been tested have not been tested recently, despite continued high –risk behavior. Large numbers of those tested never receive their results.[24] Non-Gay Identified MSM pose a significant challenge for care providers since they are frequently unresponsive to care or testing messages aimed at bisexual or gay men. Moreover, unemployment, homelessness and poverty lead many African American men not to prioritize health care and to focus instead on basic survival needs.

Methamphetamine Use by MSM: A collaborative study involving the University of California AIDS Research Program, the grantee and Tri Cities community clinic found a notable diversity in the ethnic background of methamphetamine using HIV positive MSM in Alameda County. Investigators conducted ethnographic mapping, field observations and qualitative interviews, and found that after learning about their positive status many MSM engaged in a period of accelerated meth use and suffered deteriorating health.

Estimated Costs Associated with Complexity of Care to African American and Latino MSM: MSM generally are increasingly encountering antiretroviral drug resistance as well as complications from long periods of time on these drugs. Genotyping is needed more frequently. Patients with AIDS should be seen four times a year while someone with HIV (Not AIDS) may only need one to two visits annually. Treatment of these complications and drug resistance are costly. Among the service needs cited by African American MSM in the TGA s Needs Assessment were dental care, home health care, and nutrition services. As we have noted elsewhere, dental services are especially costly because many clients delay oral health care to the point that they need expensive specialty care. Since Dent-CAL ended as of 7/1/2009, we fully expect that this population will need to seek dental services with other funding sources, i.e.: Ryan White. This will require additional funding allocated to the Oral Health Care category. Latinos in both counties are uninsured and diagnosed with AIDS at their initial HIV test at rates disproportionate to their percentage of the population. These two factors indicate that many in this population enter care late in the course of HIV disease, and clearly show an unmet need for primary HIV care. Late entry into care results in increased cost of treatment.[26] By some estimates, direct care costs in the year following HIV diagnosis are more than 200% higher for patients who present late. The mean costs for late presenters are as much as twice as high ($18 448 vs. $8,455, respectively) [27] as for those who seek care soon after infection. Some of this isolation is related to language barriers. The most recent census data shows that approximately 26% of all Contra Costa County residents speak a language other than English at home. The percentage is higher in West Contra Costa County where 36.2% of residents speak a language other than English at home, and 19.4% indicate that they speak English "less than very well Additional services required by Latino MSM therefore include translation and interpreting services, intensive case management involving outreach targeting Latino and African American

clients as well as additional medical services related to late entry into care. Local health officials estimate that the additional clinical, diagnostic/laboratory costs as well as substance abuse treatment and mental health services associated with treating this population raise the average cost per client by a factor of 2 to approximately $4,000 per patient for a total cost of treating MSM clients, provision of specialty oral health services, additional cost of $3,330,000 as illustrated in the table.

1. IDUs

Unique Challenges and Service Gaps: IDUs typically require multiple substance use treatment episodes. Medical care challenges include treatment of abscesses and treatment of Hepatitis C and other blood borne diseases. Typically IDUs have great difficulty remaining in care for extended periods of time. 25% of IDU respondents to the Needs Assessment Consumer Survey reported waiting for one to four years after testing positive to see a doctor. 5% of respondents waited more than five years. Inconsistent medication adherence makes them especially vulnerable to HIV strain mutations. They require prevention services to address risk behavior including survival sex and poor compliance with care and treatment. The loss of California Department of Alcohol and other Drugs treatment slots further compounds the difficulty of serving this population.

Estimated Costs Associated with Complexity of Care to IDUs: As we have noted above, outpatient methadone maintenance treatment costs approximately $12.00 daily on a sliding scale. Residential Treatment for men ranges from $52 to $85 a day and for women from $49 to $55 a day. Detoxification treatment typically lasts between 21 days and six months, however methadone maintenance can last for many years. Perinatal treatment costs between $66 to $122/day and lasts an average of 90 days for those who test negative for drugs upon admission or show low signs of withdrawal. Local health officials estimate that the additional detoxification, residential treatment, methadone maintenance, specialty oral health services, clinic visits and mental health services associated with treating this population raise the average cost per client by a factor of 2.5 to approximately $5,000 per patient for a total cost of treating IDU clients of $2,650,000 as illustrated in the table below.

2. Women of Color

Unique Challenges and Service Gaps: The number of heterosexual women who become infected through intravenous drug use or by unprotected sexual intercourse with their IDU partners has increased over the course of the epidemic. Almost half of women ever diagnosed with AIDS in Contra Costa County are intravenous drug users. Many of the female clients seeking RW funded services have been pregnant women living in poverty who seek prenatal care late or not at all and discover their HIV status during pregnancy or labor. Many providers report that a large percentage of their female clients are domestic violence victims. Due to the threat of violence and out of a general fear of the stigma associated with HIV or an AIDS diagnosis, many women avoid treatment. Women often fail to prioritize their HIV care because of competing survival needs, such as childcare.
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Estimated Costs Associated with Complexity of Care to Women of Color: Women tend to be unemployed at higher rates than men in the Oakland TGA that causes them to rely more heavily

than men on emergency financial assistance for such things as utilities. In the 2007 Needs Assessment women indicated a substantial gap in need for assistance with housing services including emergency hotel vouchers and emergency rent assistance. Preventing perinatal transmission represents added costs for medical care of some women as do the increasing number of female IDU who require substance abuse treatment. Although Alameda County's teen birth rates are on the decline, from 58.2 per 100,000 in 1991 to 28.0 in 2002, for 15 – 19 year olds, for Latinas it is substantially higher (76.1) as well as for African Americans (58.2). High rates of Chlamydia and other sexually transmitted disease also add to the cost of care. As we noted in our discussion of STIs, the proportion of infections occurring in women of color in Alameda and Contra Costa County is as high as 80%. The additional housing services, perinatal transmission prevention, STI treatment, substance abuse treatment, training and use of Spanish speaking "promotoras" (patient navigators who conduct outreach targeting Latinas in an effort to keep them in care) are estimated to increase the cost of serving this population by a factor of 2 for an annual cost per client of $4,000 and a total cost of $2,632,000.

3. Youth 13-24

Unique Challenges and Service Gaps: Young people within our target population fit the same demographic profile as adult Ryan White clients. They are typically youth of color, low income and they frequently present with a number of co-morbidities including STIs, chronic illnesses and alcohol and other drug use disorders. Within this population, MSM are frequently reluctant to seek care in a timely manner because of the fear of stigma. 26% of youth respondents to the Needs Assessment reported being diagnosed and treated for substance abuse within the 12-month period preceding the survey. A large percentage reported using a variety of substances including alcohol, meth and ecstasy. Young adolescents have typically not developed the cognitive thinking skills necessary to manage their own care effectively. Many have personal or mental health problems that act as barriers to accessing care and complying with care plans. For example, 28% of youth Needs Assessment survey respondents reported skipping medication once or twice a month usually due to side effects, and 40% reported being diagnosed with depression. Clinics and medical facilities that primarily treat adult HIV patients are often not appropriately staffed or structurally and organizationally designed to serve young people effectively. Cultural competence in the instance of HIV medical care for youth must include flexibility in scheduling processes and procedures such as drop-in and same day appointments with staff and clinicians who have the knowledge, skills and abilities that enable them to correctly identify the developmental stage of young clients in order to provide effective HIV health care.

Other barriers to care for this population include: legal issues such as parental consent and immigration status; lack of transportation or a reliance on inadequate public transportation; cultural barriers including language and/or literacy; situational barriers such as school and employment commitments or restrictive parental authority.

Estimated Costs Associated with Complexity of Care: There are very high rates of STIs among youth, especially youth of color. In Contra Costa County the case rates (per 100,000 people) for Chlamydia among women aged 20-24 was 712. Repeated infections, delayed access to care and treatment, and aggravation of other conditions due to untreated Chlamydia and other STIs increase the cost of care for this vulnerable population and place them at heightened risk for transmission of HIV and other sexually transmitted diseases. The specialized youth services, STI treatment, and substance abuse treatment required by this population increase the costs of serving this population by a factor of 2.5 for an annual cost per client of $5,000 and a total cost of $1,410,000.

4. Transgender (MTF)

Unique Challenges and Service Gaps: The combination of enormous stigma and poverty has led to a high degree of social isolation for this community. At their worst, these phenomena sometimes result in transgender populations resorting to sex work and other illegal activities to support themselves, or experiencing repeated incarceration. There is no centralized agency or gathering place for the LGBT community and MTF transgender individuals have few opportunities to receive health care services specifically designed for them. Because many young, low income transgender women of color in Alameda County especially do not trust health care providers and are unwilling to identify as transgender at clinics and laboratories, HARS data regarding transgender women in the TGA is limited. Available information indicates an extremely high HIV infection rate with seroprevalence rates as high as 11%. The majority of infections occur in African Americans.[28] Tri Cities Health Center, a Ryan White funded primary care clinic, recently conducted an anonymous interview of 104 transgender women in Alameda County in order to fill this information gap. Findings suggest that infection rates and numbers of people out of care are higher than HARS data indicates. 58% of respondents reported being HIV positive and over 60% reported mental health issues including suicidal ideation and depression. In a social network-based HIV testing campaign conducted by this same organization, 11 out of thirteen test results were positive and two of the nine were known positive but out of care. The survey also measured service needs. The services needed the most were primary health care (45%), support groups (43%), housing (38%), mental health services (28%) and HIV care services (16%). When asked whether they had access to these services, 69% knew where to go for services, but 81% were not accessing them. Barriers to care included concerns about confidentiality, drug use, and prioritizing economic survival over health care.

Estimated Costs Associated with Complexity of Care: Isolation and the low priority that many transgender women (MTF) give to health care mean that outreach and case management are costly and time consuming. Typically street outreach through one-on-one encounters is the only effective, albeit sometimes dangerous, way to reach this population. Effective care requires specially trained clinicians and retraining of existing staff and clinicians to increase awareness and sensitivity to the needs of this community. Crime and violence tend to permeate the areas in which many transgender women live and work which has a negative impact on the ability to provide care. TGA health officials estimate that the additional costs of street outreach, staff training, as well as the additional time required for case management for this population increases the costs of HIV services by a factor of 2.75 for an annual cost per client of $5,500 and a total cost of $176,000.

Unique Service Delivery Challenges

Diversity in Population: The Oakland TGA is a racially and ethnically diverse geographic area where Ryan White service providers serve clients from different racial and ethnic backgrounds that are living with HIV or AIDS and respond to being infected in different ways. Such diversity calls for culturally competent networks of service providers, yet the 2009-2011 Comprehensive Plan cites cultural competency and language barriers as challenges in delivering services. Delivering a comprehensive continuum of services for diverse and vulnerable clients is further complicated by staff turnover; funding restrictions that diminish the ability of agency administrators to conduct long-term planning; the absence of a system-wide structure that supports and enforces ongoing collaboration, referral and communication among service providers; and weak coordination and/or collaboration across other Ryan White Parts and prevention services. These issues make a complex service delivery system even more challenging for ethnic/racial groups.

Limited Integration of Public Health Care Services: The Oakland TGA is home to a number of large health care systems spread across a large geographic area. Because public health services are not generally integrated into these large health care systems, the TGA has found it difficult to identify out-of-care individuals or to measure the full extent of the epidemic -- including treatment cost. Additionally, the Alameda County Behavioral Health Care Services agency does not track HIV status of its clients receiving services for mental health and substance abuse.

Appointment Show Rates: A significant proportion of the clients in the TGA live lives affected by poverty, the use of alcohol and other substances and mental illness. These psychosocial factors create competing issues in their lives and make it more difficult for them to keep scheduled appointment. Providers then contend with higher no show rates, which increase costs and make service delivery more difficult. In Contra Costa County's Infectious Disease Clinics, the no show rate in past years has varied between 30% and 46% depending on the season. Although aggressive outreach has raised the show rate in some of Contra Costa County's regional health clinics to 80%, missed appointments remain a problem in other Contra Costa County clinics. In Alameda County, HIV primary care contractors report that missed appointment rates can range from 10% to 50% depending on the time of year and clinic location.

Evaluation Tool completed in 2011

The CCPC will use the new evaluation tool that is included in this manual to evaluate the process.

Legend:	**CCPC:** Collaborative Community Planning Council	**PLWH/A:** People Living with HIV/AIDS
	OAA: Office of AIDS Administration	**TGA:** Transitional Grant Area

Please select one:

CCPC or Com. Chair	CCPC Member	CCPC Staff
OAA Staff	Community	Other

<u>Design of the Priority Setting and Resource Allocation Process</u>

Objective 1			
Involves all CCPC and interested members of the community in the resource allocation process except those who have a conflict of interest.			
Indicators			
• All CCPC members and any interested members of the community are involved • The conflict of interest policies, guidelines and procedures are clearly written and easily understood			
Questions			
	Yes	No	Not Sure
1. Was there opportunity for all CCPC members to participate in the priority setting and allocations discussions?			
2. Was there opportunity for interested community members to participate?			
3. During priority setting and resource allocation, was the point of view of PLWH/A represented by the CCPC members?			
4. Were conflict of interest guidelines or policies written in advance?			
5. Was the conflict of interest policy followed during priority setting and resource allocation?			
6. In cases where there was a conflict of interest, was the conflict handled according to the written procedure?			

Comments *(If you answered 'no' or 'not sure' to any of the above questions, please explain)*

Objective 2
Establish a written priority setting and resource allocation process that defines the principles, criteria, and decision-making methods to be used and ensures participation by PLWH/A throughout the process.
Indicators
• The priority setting and resource allocation process included participation by PLWH/A throughout the process. • A priority setting and resource allocation process was defined that specified: ❧ The principles to be used to guide decisions ❧ The criteria to be used for setting priorities and allocating resources ❧ The process to be used for setting priorities or allocating resources • The priority setting and resource allocation process was approved in advance by the CCPC.

Questions			
	Yes	No	Not Sure
1. Did PLWH/A participate in all stages of the priority setting and resource allocation process?			
2. Did the CCPC approve principles to guide their decisions before beginning the process? (**Examples of principles**: CARE Act will be the funder of last resort or CARE Act will not be able to meet all needs)			
3. Did the CCPC approve the principles used to guide decision making?			
4. Did the CCPC establish clear criteria for setting priorities and allocating resources before beginning the process?			
5. Did the CCPC approve the criteria to be used for setting priorities and allocating resources?			
6. Did the CCPC decide what process to use before beginning the priority setting and resource allocation process?			

Comments *(If you answered 'no' or 'not sure' to any of the above questions, please explain)*

Implementation of the Priority Setting & Resource Allocation Process

Objective 3

Use an effective process to set priorities and allocate resources that is understood and approved by all CCPC members.

Indicators

- The priority setting and resource allocation process included a review of:
  - priorities and allocations from the previous year.
  - the availability of other resources, governmental and non-governmental
- CCPC members agreed that this process is an effective method for setting of priorities and allocation of resources.
- CCPC members understood and approved the process.

Questions			
	Yes	No	Not Sure
1. Did the priority setting and resource allocation process include a review of priorities and allocations from the previous year?			
2. Did the resource allocation process include a specific formula for allocating resources?			
3. Did the resource allocation process include a review of the availability of other resources including funds from government or other sources?			
4. Did the priority setting and resource allocation process include a review of the services needed by PLWH/A?			
5. Did the CCPC approve the process for priority setting and resource allocation?			
6. Did you understand the process?			
7. Were efforts made to provide training or assistance to members who might not understand the process?			
8. Was the priority setting and resource allocation process an effective one?			
9. Were the binders helpful during the priority setting and resource allocation process?			

Comments *(If you answered 'no' or 'not sure' to any of the above questions, please explain)*

Results of the Priority Setting & Resource Allocation Process

Objective 4
Develop priority settings and resource allocations that are in line with the TGA Comprehensive Plan.
Indicators
• Consistency with the goals of the TGA Comprehensive Plan.

Questions			
	Yes	No	Not Sure
1. Did the ranked service priorities resulting from the priority setting process differ from those revealed by the needs assessment process			
2. Did the CCPC approve of a list of service categories?			
3. Does the allocation of resources to the ranked priorities reflect the need for services?			
4. Did the CCPC take into account other possible (or available) resources when allocating resources to the ranked priorities?			
4. Was the priority setting and resource allocation process clearly documented in writing?			
5. Were the areas of need that lacked funding identified in the needs assessment and priority setting process?			
6. Were these areas of need taken into account during this priority setting and resource allocation process?			
7. Does the priority setting and allocation of resources support the goals of the TGA Comprehensive Plan?			

Comments *(If you answered 'no' or 'not sure' to any of the above questions, please explain)*

Objective 5
Develop an easy-to-understand summary of resource allocations by prioritized service categories and share with interested parties (i.e., CCPC, OAA, HIV service providers, PLWH/As, consumers, etc.).
Indicators
• Priority settings and resource allocations are clearly documented in an easy-to-understand summary (e.g., chart or graphics) that shows the percentage or amount of money allocated to each prioritized category. • Summary of priority setting and resource allocations is made public and distributed to all stakeholders.

Questions			
	Yes	No	Not Sure
1. Were the priority setting and resource allocations approved by the CCPC?			
2. Were the priority setting and resource allocations presented in an easy-to-understand format such as a chart or table?			
3. Was the summary of priority setting and resource allocations made public?			
4. Was the summary of priority setting and resource allocations made available to stakeholders?			

Comments *(If you answered 'no' or 'not sure' to any of the questions in this section, please explain)*

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Please complete and return to Sweetwine Associates by September 30, 2011.