Oakland Transitional Grant Area (TGA)

COLLABORATIVE COMMUNITY PLANNING COUNCIL

"Serving Alameda and Contra Costa Counties"

PRIORITY SETTING AND RESOURCE ALLOCATIONS MANUAL

For Fiscal Year 2014-2015

MEETING SCHEDULE:

Tuesday June 25, 2013

9:00 am to 5:00 pm

Location: Hayward City Hall, 777 "B" Street, 2ND floor, Hayward, California

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

Wednesday July 24, 2013

9:00 am to 5:00 pm

Location: Elihu Harris State Building, 1515 Clay Street, 2nd Floor, Room 2, Oakland, California

Reminder: Arrive early to pass through the Security Check-Point

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

Wednesday, August 28, 2013

9:00 am to 5:00 pm

Location: 1000 Broadway, 5th floor, Room 5000A
Oakland, CA

Thursday, August 29, 2013

Location: Elihu Harris State Building
1515 Clay Street, Room 2
Oakland, CA

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Overview

In accordance with the Ryan White Part "A" Planning Council Primer, the Planning Council sets both service categories and population 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 must follow 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. The Planning Council may direct the Grantee to fund services in particular parts of the TGA, (such as outlying counties, 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). The Planning Council 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 qualify. The Planning Council cannot be involved in any aspect of contractor selection (procurement) or in managing or monitoring Part A contracts.

As stated in the Comprehensive Plan, the goals are 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 the Oakland 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

Priority setting and the allocations process 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
- Comprehensive Plan report
- Public Comment Data
- Various other data reports

Other factors to consider include:

- 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
- EIHAA Early Identification of HIV/AIDS Act
- Healthy People 2020

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 access to 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 August 2012 to fund MSM Youth of Color. 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.

Please find listed below are the 13 Core Medical Service Categories and the 18 Support Service Categories that are fundable with Ryan White Program Part "A" and MAI. **Those funded by the OAA in 2013-2014 are in bold.** All funded agencies are contractually obligated to engage in activities, which help to engage and/or retain clients in care. Page numbers are listed for the definition of each service.

CORE medical services, including:

1. **Early Intervention Services (EIS)** (See page 8)
2. **Home and Community Based Health Services** (See page 10)
3. **Medical Case Management (Both Part A and MAI)** (See page 12)
4. **Mental Health Services (Both Part A and MAI)** (See page 14)
5. **Oral Health (Dental) Care** (See page 14)
6. **Outpatient/Ambulatory Medical Care (Both Part A and MAI)** (See page 15)
7. **Substance Abuse Services (Outpatient) (Both Part A and MAI)** (See page 18)
8. AIDS Drug Assistance Program (ADAP) (See page 19)
9. AIDS Pharmaceutical Assistance (Local) (See page 19)
10. Health Insurance Premium & Cost-sharing Assistance (See page 20)
11. Home Health Care (See page 20)
12. Hospice Services (See page 21)
13. Medical Nutrition Therapy (See page 21)

SUPPORT services, including:

1. **Child Care Services** (See page 8)
2. **Emergency Financial Assistance** (See page 9)
3. **Food Bank / Home-Delivered Meals** (See page 9)
4. **Housing Services (Both Part A and MAI)** (See page 11)
5. **Legal Services** (See page 11)
6. **Linguistics Services (Interpretation and Translation)** (See page 12)
7. **Medical Transportation Services** (See page 13)
8. **Outreach Services (Only MAI)** (See page 16)
9. **Psychosocial Support Services** (See page 17)
10. **Treatment Adherence Counseling** (See page 18)
11. Case Management (Non-Medical) (See page 20)
12. Health Education / Risk Reduction (See page 20)
13. Pediatric Development Assessment & Early Intervention Services (See page 21)
14. Permanency Planning (See page 22)
15. Referral for Health Care / Supportive Services (See page 22)
16. Rehabilitation Services (See page 22)
17. Respite Care (See page 22)
18. Substance Abuse Services (Residential) (See page 23)

FUNDED SERVICE CATEGORIES FOR 2013-2014

CHILD CARE SERVICES

HRSA Definition:
The provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending Ryan White HIV/AIDS Program-related meetings, groups, or training. This does not include childcare while the client is at work.

Activities:

- In home site based and out of home child care services

Unit of service:

- Child care, licensed, 1 hour
- Child care, non-licensed, 1 hour

EARLY INTERVENTION SERVICES

HRSA Definition:
Include counseling individuals with respect for HIV/AIDS, testing, including test to confirm the presence of the disease, test to diagnose to the extent of the immune deficiency, and test to provide information on appropriate therapeutic measures.

Activities:

- § Testing for diagnosis and evaluation of HIV/AIDS infection.
- § Assessments of newly diagnosed provider need to identify and address potential barriers and provide appropriate referrals for HIV care.
- § Referrals of newly diagnosed clients into primary care or case management services.
- § Maintain contact with client to assure client keeps appointments and treatment adherence.
- § Develop relationships with public and private HIV testing agencies for the referral of newly positive clients
- § Develop relationships with public and private agencies and entities that provide HIV primary care and case management to facilitate referrals into those services.

- § Develop relationships with other agencies/entities that may come in contact with clients aware of their positive HIV status but not engaged in care.
- § Follow up with agencies and clients to assure clients continue to access care services.

Unit of service:

- § 15 minute face-to-face encounter with client
- § 15 minute non-face-to-face encounter with client
- § Client assessment

EMERGENCY FINANCIAL ASSISTANCE

HRSA Definition:
The provision of short-term payments to agencies, or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Activities:

Food/Utilities:

- Nutrition education
- Food referrals
- Access to pantry
- Budget counseling

Unit of service:

- 1 food voucher- ($10 Units)
- 1 utility payment (1 payment = one unit of service; enter amount of payment)
- 1 grocery bag = one unit of service

FOOD BANK/HOME DELIVERED MEALS

HRSA Definition:
This includes the provision of actual food, meals or nutritional supplements. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household-cleaning supplies should be included in this item.

Activities:

- Food bank
- Prepared Meals: Delivered to the clients home
- Disseminate written nutrition education
- Assure linkage to care
- Hot & frozen daily meals delivered
- Nutritious grocery bags available for pick up

Unit of service:

- 1 grocery bag
- 1 home delivered meal (meal delivered to client's address)

HOME AND COMMUNITY BASED HEALTH SERVICES

HRSA Definition:
Includes skilled health services furnished to the individual in the individual's home, based on a written plan of care, established by a case management team that includes appropriate health care professionals. Services include durable medical equipment, home health aide services, and personal care services in the home, treatment, or other partial hospitalization services. Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy), routine diagnostic testing administered in the home, and appropriate mental health, developmental and rehabilitation services. In-patient hospital services, nursing home and other long-term care facilities are not included.

Activities:

- Home health aide services
- Personal in-home care
- Development of plan of treatment
- Medication adherence
- Education for the family and client

Units of Service:

- Home-based health, professional: 15 min unit
- Home-based health, Para-professional: 15 min unit

HOUSING SERVICES

HRSA Definition:
The provision of short-term assistance to support emergency, temporary or transitional housing to enable the individual or family to gain or maintain medical care. Housing related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Activities:

Emergency Housing Assistance

- Hotel vouchers
- Eviction prevention
- Emergency short term rental assistance
- Emergency payment of security deposits, first and last month's rent and rental application fees

Unit of service:

- Housing emergency (1 payment = 1unit of service; enter amount of payment)

LEGAL SERVICES

HRSA Definition:
The provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does NOT include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Activities:

- Comprehensive legal services
- Advice, assistance and representation with the following HIV related civic legal counsel, such as, housing, immigration and family law, and provider trainings

Unit of service:

- 15 minutes = one unit of service

LINGUISTIC SERVICES

HRSA Definition:

Include the provision of interpretation and translation services.

Activities:

- Telephone calls, connected to telephone interpreters, between English-speaking HIV Service Providers and PLW HIV/AIDS who speak limited or no English.
- Translation of HIV care and treatment service documents for PLW HIV/AIDS who read limited or no English.

Unit of service:

- 15 minutes of telephone translation services
- 1 translated document

MEDICAL CASE MANAGEMENT

HRSA Definition:
A range of client-centered services that links clients with health care, psychosocial and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Also includes inpatient medical case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility.

Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) treatment adherence counseling, (4) coordination of services required to implement the plan, (5) client monitoring to assess the efficacy of the plan, and (6) periodic re-evaluation and adaptation of the plan as necessary over the life of the plan, as necessary over the life of the client. It may include client –specific advocacy and/or review of utilization of services.
Activities:

- Benefits counseling
- Health education and risk reduction assessment and counseling
- Medication and treatment adherence
- Facilitate connection and retention in care
- Substance abuse and mental health screening and referral
- Referrals
- Prevention with Positives Activities
- Case conferencing

Unit of service:

- Face-to-Face client contact (15 min units)
- Non Face-to-Face client Services (15 min units)
- Care plan developed/updates
- Initial assessment (completed on all NEW clients)
- Reassessment (completed every 6 months for continuing clients)

MEDICAL TRANSPORTATION SERVICES

HRSA Definition:

Include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

Activities:

- Purchase, disseminate, manage, and monitor transportation voucher program
- Van transportation

Unit of service:

- One-way van trip
- Alameda County Transit: ticket pack - 20 one way, 1 one way, transfer pack - 20 transfer, 1 transfer, and disabled bus pass
- Taxi voucher, gas voucher
- Para transit book, Para transit voucher
- Disabled BART and regular BART ticket

MENTAL HEALTH SERVICE

HRSA Definition:
Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such service. This typically includes psychologists, psychiatrist and licensed clinical social workers.

Activities:

- Individual, group, couple, family counseling and therapy
- Treatment plan development
- Treatment and medication adherence
- Care coordination
- Risk reduction counseling

Unit of Service:

- Therapy/Counseling Session – Group of three (3) or more (15 min = one unit of service)
- Therapy/Counseling Session – Individual (15 min = one unit of service)
- Clinical assessment
- Reassessment (completed every 6 months for continuing clients)

ORAL HEALTH CARE

HRSA Definition:

Diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialist, dental hygienists and auxiliaries, and other trained primary care providers.

Activities:

- Emergency Services: treatment for pain or infection
- Diagnostic services: exams, x-rays, basic cleaning
- Preventative services: dental prophylaxis, home care instructions, occlusal sealants, drug therapies (fluoride, chlorhexidine mouth rinses.)
- Restorative services: fillings
- Fixed prosthetics: crown and bridges
- Removable prosthetics: partials or dentures
- Periodontal treatment: (gum) scaling, root planning, gingivectomy, crown lengthening
- Endodontics (root canal therapy): posts and build ups

Unit of service:

- 1 routine dental visit
- 1 specialty dental visit
- 1 laboratory (indicates 1 UOS regardless of amount of payment)

OUTPATIENT/AMBULATORY MEDICAL CARE

HRSA Definition:
The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. This includes diagnostic testing, early interventions and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary Medical Care* for the Treatment of HIV Infection includes the provision of care that is consistent with the Public Health Service's Treatment Guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Activities:

- Medical Visits
- Dental Referrals
- Medication Adherence
- Risk Reduction Assessment
- Mental health and substance abuse screening
- Vision screening and care
- Diagnostic (laboratory) testing

Unit of service:

- New Patient Visit (15 minutes = one unit of service)
- Patient Visit, on-going (15 minutes = one unit of service)
- Interdisciplinary Case Conference (one unit = one activity)
- Medical Coordination and/or follow-up (one unit = one activity)
- Diagnostic (laboratory) test (one unit = one test)

OUTREACH SERVICES

HRSA Definition:

Includes programs which have as their principal purpose identification of people with unknown HIV disease so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding); not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with state and local HIV-prevention outreach programs to avid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and be designed with quantified program reporting with will accommodate local effectiveness evaluation.

Activities:

- Identifying HIV + persons who are aware of their HIV status and have not entered care
- Identifying HIV+ persons who have been lost to care and addressing the barriers which keep them from accessing care
- Provide treatment education, (i.e., anti-viral medications, medication side effects, ADAP, care services, etc.) to HIV+ persons as a means to address the barriers which keep them from accessing care

Unit of Service:

- Face-to-face client contact (15 minutes = one unit of service)
- Non face-to-face client services (15 minutes = one unit of service)

PSYCHOSOCIAL SUPPORT

HRSA Definition:

The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes nutritional counseling provided by a non-registered dietitian but excludes the provision of nutrition supplements.

Activities:

- Peer led support groups
- Treatment and care adherence
- Information & referral
- Emotional support
- HIV education
- Risk reduction
- Group social activities

Unit of service:

- ***Counseling session – group of 3 or more (15 minutes = one unit of service)***
- Counseling session – individual (15 minutes = one unit of service)
- Peer group activities (one unit = one activity)
- Interdisciplinary case conference (one unit = one activity)

SUBSTANCE ABUSE SERVICES

HRSA Definition:

The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Activities:

- 12 Step programs
- Individual & group counseling
- Psychiatry referral
- Couples & Family counseling
- Therapy and treatment
- Harm reduction counseling

Unit of service:

- Counseling session – group of 3 or more (15 minutes = one unit of service)
- Counseling session – individual (15 minutes = one unit of service)
- Addiction assessment (completed assessment = one unit of service)
- Reassessment (completed every 6 months for continuing clients)
- Interdisciplinary case conference

TREATMENT ADHERENCE COUNSELING

HRSA Definition:

The provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatment by non-medical personnel outside of the medical case management and clinical setting.

Activities:

- Peer led support groups
- Treatment and care adherence
- Information & referral
- Emotional support
- HIV education
- Risk reduction
- Group social activities

Unit of service:

- ***Counseling session – group of 3 or more (15 minutes = one unit of service)***
- Counseling session – individual (15 minutes = one unit of service)
- Peer group activities (one unit = one activity)

Service Categories Unfunded by Parts "A" and MAI during 2013-2014

AIDS DRUG ASSISTANCE PROGRAM

HRSA Definition:

The AIDS Drug Assistance Program (ADAP) treatment is a State administered program authorized under Part B of the Ryan White program that provides FDA approved medications to low income individuals with HIV disease who have limited or no coverage insurance, Medicaid or Medicare.

AIDS PHARMACEUTICAL ASSISTANCE (Local)

HRSA Definition:

Includes local pharmacy assistance program implemented by Part A or B Grantees that provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B based award funds. Local Pharmacy Assistance programs are not funded with ADAP earmark funding.

CASE MANAGEMENT (Non-Medical)

HRSA Definition:

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatment, as medical case management does.

HEALTH EDUCATION/RISK REDUCTION

HRSA Definition:
This includes the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

HEALTH INSURANCE PREMIUM & COST-SHARING ASSISTANCE

HRSA Definition:
A program of financial assistance for eligible individuals with HIV to maintain a continuity of health insurance, or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

HOME HEALTH CARE

HRSA Definition: The provision of service in the home by licensed home care workers, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feedings, diagnostic testing and other medical therapies.

HOSPICE SERVICE

HRSA Definition:
Hospice services includes room, board, nursing care, counseling, physician services, palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including non-acute care section of a hospital that has been designated and staff to provide hospice services for terminal patients.

MEDICAL NUTRITION THERAPY

HRSA Definition:

Is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical Nutrition Therapy provided by someone other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

PEDIATRIC DEVELOPMENTAL ASSESSMENT AND EARLY INTERVENTION SERVICES

HRSA Definition:

The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infants or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools.

PERMANENCY PLANNING

HRSA Definition:

The provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased, or are no longer able to care for them.

REFERRALS FOR HEALTH CARE/SUPPORTIVE SERVICE

HRSA Definition:

The act of directing a client to service in person or through telephone, written or other type of communication. Referrals may be made within the non-medical case management system, by professional case managers, informally through support staff, or as part of an outreach program.

REHABILITATION SERVICE

HRSA Definition:

Services provided by a licensed or authorized professional, in accordance with individualized plan of care intended to improve or maintain the clients' quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology and low vision training.

RESPITE CARE SERVICE

HRSA Definition:

Provision of community or home based, non-medical assistance designed to relieve the primary care giver responsible for providing day-to-day care of a client with HIV/AIDS.

SUBSTANCE ABUSE SERVICE (RESIDENTIAL)

HRSA Definition:

The provision of drug and/or alcohol treatment in a residential treatment service that is separately licensed for that purpose. The provision of detoxification services in a separately licensed facility.

Timeline for Priority Setting & Resource Allocations

DATE	TASK	ACTION ITEM
April 15, 2013 1pm-3pm Quality Data --------- **CCPC Planning Council Meeting** **April 24, 2013** **10am-2pm** **1000 Broadway** **5th Floor** **Oakland, CA**	§ Quality Data & Services Committee will review the following presentations prior to CCPC listed below: • Service Utilization Data • Service Category "Gap Analysis" • Comprehensive Plan Report • Patient Satisfaction Survey/Chart Review • Feedback from Priority Setting & Allocations Evaluation survey • Epidemiology Data • Fiscal Report • 2013 Needs Assessment • Service Category Definitions **Comprehensive Plan Quarterly Report**	Informational Vote to Approve
May 20, 2013 1pm-3pm Quality Data -------- **CCPC** **May 22-23, 2013** **Training (HRSA)** **8:30am-4pm** **Elihu Harris State Office Bldg.** **Oakland, CA** **9am-5pm**	Review the Service Category definitions, Priority Setting Guidelines and Timeline, and Orientation of the resource allocation process. § **Service Utilization Data** OAA will provide a detailed report of the service categories with the number of Unduplicated Clients (UDC) served and the number of Units of Service (UOS). § **Service Category "Gap Analysis"** of Target & Actual Unduplicated Clients (UDC) and Units of Service (UOS)	Review the Service Category Definitions, Priority Setting & Resource Allocations Guidelines & Timeline

DATE	TASK	ACTION ITEM
June 17, 2013 1pm-3pm Quality Data --------- **CCPC** **June 25, 2013** **9:00 am** **To 5:00 pm** **Hayward City Hall, 777 "B" Street, Hayward, CA** **Town Hall Meeting** **12:00 am to 2:00 pm**	§ **Patient Satisfaction Survey/chart review report** § **Feedback from the Priority Setting & Resource Allocations process evaluations.** § **HIV Prevention Plan** § **Needs Assessment Update** § **Comprehensive Plan Quarterly Report**	Informational
July 15, 2013 1 pm-3pm Quality Data **CCPC** **July 24, 2013** **9am-5pm** **Elihu Harris State Building** **1515 Clay Street, 2nd Flr, Room 2** **Oakland, CA** **Town Hall Meeting** **12:00 am** **to 2:00 pm**	§ Lois Lindsay Oral Health Report § **Epidemiology (full report)** § **Priority Populations:** The CCPC will select the Fiscal Year 2014-15 Priority Populations for Ryan White Part "A" – **Vote** § **HOPWA Report-Written** § **Medi-Cal Update** § **MAI Update (to be presented Sept 25, 2013 CCPC mtg.)**	Vote to Approve: **Priority Populations** for Fiscal Year 2014-2015 for Ryan White Part "A"

Timeline for Priority Setting & Allocations

DATE	TASK	ACTION ITEM
August 19, 2013 1pm-3pm Quality Data **CCPC** **August 28, 2013** **9:00 am** **To 4:00 pm** 1000 Broadway, 5th Floor Oakland, CA	§ **Content Analysis of all public comments January 2013 through July 2013** § **The CCPC will hear the Standing Committees' recommendations for Core & Support Priority Setting Ranking and OAA recommendations** • People Living with HIV/AIDS (PLWH/A) Committee • Quality Data & Services Planning Committee • Policy Education & Review (PERC) Committee • Membership & Community Involvement Committee § **Fiscal Report will be presented by OAA** § **Individual Planning Council Member's Core & Support services ranking** § **Contra Costa County Priority Setting & Resource Allocations presentation** § **Ranking, Core and Support Service Priority Setting**: **Vote** to approve the Core and Support Services Priority Setting Ranking for Ryan White Part "A" § **Allocation Percentage**: Recommend percentages and **Vote** to approve Core and Support Services percentage. § **Contingency Planning:** The Planning Council will vote to increase and/or decrease allocation funding based on the actual funding award.	**Vote to Approve:** Ranking of Categories, Allocation **Vote to Approve:** Ranking and Percentage of Core and Support Services, and Contingency Planning.
August 29, 2013 **If necessary** **9:00 am** **To 4:00 pm** Elihu Harris State Building	§ **Evaluation**: The CCPC will evaluate the Priority Setting and Resource Allocation process using the Evaluation Tool enclosed within this manual date to be determined once process is completed.	All CCPC members to complete the evaluation tool.

1515 Clay Street, 2nd Floor, Room 2 Oakland, Ca		

Priority Setting Policy and Resource Allocation Procedures

PURPOSE

This **Priority Setting and Resource Allocation Process** is designed to engage all Planning Council members in Priority Setting and Resource 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 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 Resource 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 Resource 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 Resource 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.

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. **Resource 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. Core Services & Support Services will be grouped separately into blocks and the blocks are voted on separately.
iii. At the beginning of the discussion for each service category's funding, the Grantee and Planning Council Support Staff may provide Resource Allocation 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. 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	7/2013	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	5/23/2013	Y
√	**OAA Fiscal report presentation**	8/2013	Y
√	**Needs Assessment Data** with a focus on six Priority Populations for Care & Treatment services. § 2010 Community Needs Assessment § 2011 Community Needs Assessment	06/2013	Y

Check if Used	Presentations	Current As of (Mo/Yr)	Used by Full Planning Council
√	**Public Comment Data** § Content Analysis Compilation, January – July 2012 § Town Hall Meetings	8/2013	**Y**
√	**Comprehensive HIV Services Plan** with a focus on the Priority Populations for Care & Treatment services: 1. African American with special focus on Women and MSM 2. Latino with a special focus on MSM and Women 3. Transgender of all Races 4. Formerly Incarcerated 5. Injection Drug Users (IDU) 6. Youth	7/2013	**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	2013	**Y**

Evaluation Tool completed in 2013

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 Member	CCPC Committee Member	Service Provider
OAA Staff	Community # of meetings (1-2) (3 or more)	Other

Design of the Priority Setting and Resource Allocations Process

Objective 1

Involves all CCPC and interested members of the community in the resource allocations 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:	1	2	3	4	5	6
Please check the box that best describe your answer as indicated by number: **Strongly Agree (1) Agree (2) Strongly Disagree (3)** Disagree (4) Not Applicable (5) I Don't Know (6)						
1. I believe there was adequate opportunity for all CCPC members to participate in the priority setting and resource allocations discussions.						
2. I believe there was adequate opportunity for interested community members to participate.						
3. I believe during priority setting and resource allocations the point of view of PLWH/A was represented by CCPC members.						
4. I believe that the conflict of interest guidelines or policies were explained in advance.						
5. I believe the conflict of interest policy was followed during the priority setting and resource allocations process.						
6. I believe that in cases where there was a conflict of interest, the conflict was handled according to the written procedures.						
7. I believe that efforts were made to provide training or assistance to CCPC members and others who might not understand the process.						

Comments:

Objective 2
Establish a written priority setting and resource allocations 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 allocations process included participation by PLWH/A throughout the process. • A priority setting and resource allocations 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 allocations process was approved in advance by the CCPC.

Questions	1	2	3	4	5	6
1. I believe PLWH/A participated in all stages of the priority setting and resource allocations process.						
2. I believe the CCPC approved the principles to guide their decisions before beginning the process. (**Examples of principles**: CARE Act will be the last resort of funding or CARE Act will not be able to meet all needs).						
3. I believe the CCPC approved the principles used to guide decision-making.						
4. I believe the CCPC established clear criteria for setting priorities and allocating resources before beginning the process.						
5. I believe the CCPC approved the criteria to be used for setting priorities and allocating resources.						
6. I believe the CCPC decided what process to use before beginning the priority setting and resource allocations process.						

Comments:

Implementation of the Priority Setting & Resource Allocations 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 allocations 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	1	2	3	4	5	6
1. I believe the priority setting and resource allocations process included a review of priorities and allocations from the previous year.						
2. I believe the resource allocations process included a specific formula for allocating resources.						
3. I believe the resource allocations process included a review of the availability of other resources including funds from government or other sources.						
4. I believe the priority setting and resource allocations process included a review of the services needed by PLWH/A.						
5. I believe the CCPC approved the process for priority setting and resource allocations.						
6. I understood the process.						
7. I believe efforts were made to provide training or assistance to members who might not understand the process.						
8. I believe the priority setting and resource allocations process was effective.						
9. I believe the binders provided were helpful during the priority setting and resource allocations process.						

Comments:

Results of the Priority Setting & Resource Allocations Process

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

Questions	1	2	3	4	5	6
1. I believe the ranked service priorities resulting from the priority setting process differ from those revealed by the Needs Assessment process.						
2. I believe the CCPC approved a list of service categories.						
3. I believe the allocation of resources ranked as priorities reflect the need for services.						
4. I believe the CCPC took into account other possible (or available) resources when allocating resources to the ranked priorities.						
5. I believe the priority setting and resource allocations process was clearly documented in writing.						
6. I believe the areas of need that lacked funding were identified in the Needs Assessment and priority setting process.						
7. I believe these areas of need were taken into account during this priority setting and resource allocations process.						
8. I believe the priority setting and allocation of resources support the goals of the TGA Comprehensive Plan.						

Comments:

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	1	2	3	4	5	6
1. I believe the priority setting and resource allocations were approved by the CCPC.						
2. I believe the priority setting and resource allocations were presented in an easy to understand format such as a chart or table.						
3. I believe the summary of priority setting and resource allocations were made public.						
4. I believe the summary of priority setting and resource allocations were made available to stakeholders.						

Comments:

Please complete and return to:

Sweetwine Consultant Services by fax: (510) 433-0986

Or email patriciasweetwine@comcast.net