

Seattle HIV/AIDS Planning Council

Monday, September 14, 2009-- 4:00 p.m.–6:30 p.m.
2100 Building: 2100 - 24th Avenue South

AGENDA

- | | | | |
|-------|---|-----------------------------|-------------|
| I. | Welcome, Introductions & Announcements | | 4:00 |
| II. | Meeting Agenda (2 min) | | |
| | ➤ Action: Review and approve | | |
| III. | Minutes: (3 min) | 📁 Attachment: white | |
| | ➤ Action: Review and approve | | |
| IV. | Ryan White Grant 2009 Letter of Assurance (Jeff) | 📁 Attachment: yellow | 4:10 |
| | ➤ Action: Review and approve letter for co-chair signature | | |
| V. | 2010 Care Mini Prioritization Orientation (Jeff, Jesse) | 📁 Attachments: pink, salmon | 4:20 |
| | • What will happen today, what will happen next month (Jess) | | |
| | • Ryan White 101-a reminder of the purpose of RW funds and rules (Jeff) | | |
| VI. | Break | | 5:20 |
| VII. | 2010 Care Mini Prioritization Orientation (Jeff Jesse) | 📁 Attachment: blue | 5:35 |
| | • The current allocations and how we got there (Jess) | | |
| | • Adjustments for 2010 to make full-year funding (Jeff) | | |
| | • How much money are we going to be planning for? (Jeff) | | |
| | • Categories where we could apply more funding | | |
| | • What about a “special program”? (Jess) | | |
| | • What data do you need in order to do your work? (Jess) | | |
| VIII. | HIV/STD Program Integration (Matt Golden) | | 6:10 |
| IX. | Adjourn | | 6:30 |

Barrier-free location
Reasonable accommodation for persons with disabilities
available upon advance request.

Seattle HIV/AIDS Planning Council

Minutes ☿ Monday, September 14, 2009

4:00pm - 6:30pm

2100 24th Avenue South Seattle, WA 98144

Council Members Present: *Amy Bauer, Sergio Cueva Flores, Shireesha Dhanireddy, Brandie Flood, Melinda Giovengo, Joseph Grant, Sarah Kent, Gerrie LaQuey, Darren Layman, Higinio Martinez, Andrew Murphy, Ruth Njoroge, Kris Nyrop, Ron Padgett, Arthur Padilla, Kevin Patz, Tony Radovich, Michael Raitt, James Redel, Germán Rodríguez, Bob Wood*

Council Members Absent: *Richard Aleshire, Ryan Ceurvorst, Philip Doles, Kate Elling, Doug Erhardt, Robin Langdale, David Lee, Marcos Martinez, Christine Oyaro, Jodie Pezzi, Erick Seelbach*

Planning Council Staff Present: Jesse Chipps, Courtney Speigner (minutes), Diane Ferrero

Public Health Staff Present: Barb Gamble, Matt Golden, Gary Johnson, Jeff Natter

Guests: Jen Berthiaume

Italics denote Planning Council Membership.

I. Welcome, Introductions and Announcements

Attendees introduced themselves and stated their affiliations.

II. Grantee Reports

Prevention

Barb reported on the following items:

- The proposal review panel met on Friday, September 11 to make recommendations for 2010-11 funding. The next step will be to get approval from the director of Public Health; then agencies will be notified of their awards via email; then the awards will be announced to the Council.
- The CDC has released a funding opportunity for community-based organizations to provide HIV prevention services. Anyone interested can speak with Barb.

Care

Jeff reported on the following items:

- HRSA has released the Part A application, due October 30. He will request a 5% increase.
- The House has released a reauthorization plan.
 - Currently, if areas underexpend by over 2% of the award, they risk losing the supplemental award for the following year. This plan asks that the limit be increased from 2% to 5%, which would be beneficial to us.
 - This plan unfortunately does not eliminate the 75% core services requirement.
 - The Government Accountability Office released a report that showed that making MAI funding a separate award (it was previously part of the general Ryan White Part A award) has doubled the burden on subcontractors and grantees, and has led to no positive changes. Unfortunately, this plan does not suggest rolling MAI funding back into the regular award.

III. Meeting Agenda

☑ *The agenda was approved as written by acclamation.*

IV. August Meeting Minutes

☑ *The August minutes were approved as written by acclamation.*

V. Ryan White Grant 2009 Letter of Assurance

With the Ryan White application, HRSA requests a letter signed by the Co-Chairs, assuring the following items:

- 2009 funds were expended in accordance with the Council's Care Prioritization plan – Jeff reviewed the 2009 funding recommendations and distributed a grid of these. The group agreed they were in accordance.

<Tony entered at 4:10pm>

- All conditions of award related to the Planning Council have been addressed – the one obligation was the Comprehensive Care Plan, and this was completed.
- 2009 priorities were determined by the Planning Council – this was completed in the 2009-10 Care Prioritization Plan.
- Ongoing Planning Council orientation and training – All members have gone through a four hour New Member Orientation; additionally, the Council receives other trainings, such as the Ryan White 101 on today's agenda.
- The Planning Council is representative of the epidemic – Currently the Planning Council does not have any gaps, and 33% of Council members are consumers.

MOTION: Michael moved to have the Co-Chairs sign the letter of assurance as written. Tony seconded. There was no discussion

☑ *The motion passed unanimously.*

<Gerrie entered at 4:15pm>

VI. 2010 Care Mini Prioritization Orientation

Jesse explained that the orientation will provide clarification and be an opportunity for members to give input on what data will be available for the mini-prioritization process. The group will not make any decisions today.

Ryan White 101

Jeff gave a Ryan White 101 presentation and distributed handouts of the presentation.

Members asked questions throughout the presentation and Jeff provided the following clarifications:

- Andrew asked the grand total of HRSA Ryan White funding nationally, and Jeff stated he did not know exactly, but it is over two billion dollars.
- It can be difficult to provide clinical outcomes for some services. Examples of clinical outcomes that are not medical would include, for example, mental health or substance use counseling.
- The act is set to sunset on September 30 (not September 31, as listed in the presentation).

<Melinda entered at 4:30pm>

- If the AIDSNet structure is eliminated, the pooled parity will likely be calculated on cases in the TGA, versus cases in the rest of the state.

- Parity is calculated based on where PLWH were diagnosed; however client level data may make it possible to calculate based on PLWH's current place of residence. It cannot be based on where clients get their care because clients may have several care providers in different areas, change care providers, etc.
- The process for determining the formula award for EMAs and TGAs is similar. When HRSA reclassified several EMAs as TGAs, two TGAs sued HRSA for the right to again be classified as EMAs. They won the suit, but this did not increase their funding. Moving from TGA to EMA worked in our area's favor.
- The "service funding" (on page 4 of the presentation) is funding that actually goes to HIV services - \$6,300,000. The remainder of the anticipated \$7,300,000 award goes to administration and Quality Management.
- Pooled Parity is a state model, not mandated by HRSA.
- Washington state is unique in that its ADAP is also funded by the state. Many states' ADAP programs are funded only by Ryan White Part B and may have waiting lists for HAART as well as smaller formularies.

Review of the service definitions sheet included in the Council mailer (pink):

- Core services – must demonstrate there is need. This is based on data, most importantly the Care Needs Assessment. If need can be demonstrated, it's possible to spend all funds on these services. At least 75% of service funds must be spent on core services.
- Support services are defined as services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Medical outcomes are those outcomes affecting the HIV-related clinical status of an individual living with HIV/AIDS. Gerrie added that in theory, that a service would help achieve a medical outcome is not enough, but it must be documented that the service links to medical outcomes. There are many services listed for which it doesn't seem there's a way to document clinical outcomes. Specific clinical outcomes are not listed in the legislation, but can include adherence, appointments made, etc. For every service category there are agreed upon benchmarks. This information can be sent to the Council though it probably would not be used in this process. Not more than 25% of service funds can be spent on support services.
- Jesse went over some of the more confusing service definitions
 - *Outpatient/ambulatory medical care* – care in the clinic, not hospital care
 - *ADAP* – this is the only service for which there aren't multiple providers. There must be one ADAP in each state.
 - *Local AIDS Pharmaceutical Assistance* – we have never funded this. Some states' ADAPs may have a limited formulary, so Part A funds a local ADAP.
 - *Home health care, home and community-based health services, and hospice services* are often confused – read these definitions closely. None are currently funded.
 - *Substance abuse services (outpatient)* is a core service (e.g. methadone, one on one counseling); however *substance abuse services (residential)*, i.e. inpatient, is a support service.
 - In the past there was a service category called "other services," which made it possible to fund other services, for example, alternative therapies. However, this is no longer a category.
 - *Non-medical case management* – has not been funded recently. However, *medical case management* receives more funding than any other service.
 - *Housing* – The 2009 needs assessment asked about three types of housing: "help finding housing," "transitional housing" and "short term, emergency housing." Many people stated although they need these types of housing, they commented that what they need is permanent housing, but this cannot be funded. Jeff explained the HRSA mandate that a client can only be funded for 24 months of housing services in their lifetime. This will have major implications for existing program. Client-level data

reporting may be able to track this across the country, but as of yet, HRSA has not put out a policy asking providers to track clients moving in to a region.

🔴 **ACTION ITEM:** Anyone who has not yet read the service definitions should do so before the next meeting and call Jesse with any questions.

2010 Care Plan with increments

- The final funding column is the starting point for the mini prioritization. This totals to about \$5.7 million, and the Council will plan for about \$250,000 additional dollars in 2010. The group will also create an increment/decrement plan.
- The core services are bolded.
- The ranking of services in the left column is based on the 2007 needs assessment. Consumers and providers' responses were merged, with consumer responses receiving slightly more weight (55/45). In the final outcome, this weighting did not make a difference. Jesse listed a few discrepancies between consumer and provider responses:
 - Consumers are less likely to prioritize substance use and mental health. Consumers who have been impacted by these issues may be less likely to fill out the survey.
 - Providers are less likely to prioritize dental care.

<Joseph left at 5:15pm>

BREAK 5:15 – 5:30

Conflict of Interest (COI) Declaration

If a member has a conflict of interest, s/he cannot vote in *any* category and cannot suggest dollar amounts or caveats in his/her *specific* category. Jesse gave an example:

- Arthur has a conflict in housing, but not in case management.
- If there's a discussion in case management in which people cannot agree, Arthur cannot hold up consensus in this discussion (or a discussion about any other category).
- During the discussion of *housing services*, Arthur cannot suggest a dollar amount or caveat (nor can he hold up consensus).
- Bob, however, who does have a conflict in several categories as an employee of Public Health, but not in the housing category, could suggest a dollar amount or a caveat in housing (he cannot hold up consensus).
- Arthur could and should participate in the housing discussion, and other members may ask him questions about whether funding or caveats are appropriate.

Members should think of the "Front Page Test:" would their actions be seen as conflicted by someone viewing the actions of the Council from the outside? If members don't know whether their agency intends to apply for funds, they should ask. If a member does not list the COI and his/her agency does apply, it puts the process into question.

Grantee recommendations

At end of the second quarter, every agency is required to submit a report stating whether they intend to fully spend out their funds, to underexpend their funds and return a portion (which would be reallocated), or to spend out early and need more funds, if available. Jeff will have this information fully ready for the Council in early October. The information below is not based on the full information, rather they are initial recommendations.

- *Ambulatory/outpatient care* – no change
- *ADAP* – decrease. May have put in too much money in 2009 based on the pooled parity model.

- *Medical case management* – The 2009 increment was for an increase in staff for only three quarters of a year. To maintain this additional staff, the Council must put in some additional funds.
- *Housing* – decrease by \$224,000 dollars. Due to the 24 month life time limit, one of the current housing providers that provides assisted living will no longer be able to qualify for Ryan White funding for the majority of their clients. To maintain the current continuum, Jeff suggests the Council move these funds into *Home and community-based health services*.
- *Oral Health* – increase funding. They will spend out very early this year.
- *Mental health, psychosocial support, food bank/home-delivered meals, and substance abuse outpatient services* – no change.
- *Medical nutrition therapy* – appears that one of the programs may be spending out early.
- *Referral* – In March 2009, the only agency that provided referral services announced they would no longer be able to fund the program. The Council allocated \$30,000 in Part A funds for this service, and the agency received \$40,000 in Omnibus funds and \$30,000 in City of Seattle funds to maintain the service for the year, while other dollars were identified. Omnibus and City of Seattle funding will not be available for 2010, so if the Council would like to maintain this service, Jeff suggests the group allocate \$100,000 to this category, which would go out for bid and be available for an agency to pay for an entire program.

Data

Questions and requests for data should be given to Jesse, at the very latest, two weeks from today, so that answers may be included with the Council packet. Members asked the following questions:

- Kris stated that statewide funding for substance abuse outpatient is likely to disappear in 2010 and asked whether this would be factored in the group's planning. If members know about external funding changes, they should share them with the Council. Jeff will bring as much information as possible on changes in other funding systems.
- Tony asked how many people on the food and meals waiting list are Ryan White eligible.
- Kevin asked for information on how many people will be affected by DSHS cutting oral nutrition (supplements). At the next meeting, Richard will present on the impact to PLWH who are no longer Medicaid eligible. The oral nutrition cut applies to those PLWH still eligible for Medicaid.

Jesse explained that there was some contention in the steering committee over whether to give members the full Categorical Data Reports (CDR). Some felt it was important to give folks all available data. Others felt these data had already been used to set the current funding levels and to create the ranking, which cannot be changed, so it's not necessary for Council members to use them again. Jesse distributed the consumer (goldenrod) and provider (cherry) priorities and gaps lists, and asked the group whether they would like to receive the full CDRs. Shireesha pointed out that because the data has already been used to get to this point, it's not necessary for every one to read them, and the group agreed. Those who have participated in a Care Prioritization before already have these data and can review them if necessary; those who have not can request to see the CDRs if they choose. The CDRs will also be available for reference at the meeting. Additionally, those who haven't participated can talk to members who have participated before as resources: Michael, Gerrie, Shireesha, Sarah, Tony, Higinio or Ron.

Jeff noted that in a mini-prioritization, because Public Health has entered into contracts with agencies, it's dangerous to take money out of a category (unless there are under-expenditures in that category).

Jesse also distributed an annotated version of the 2009-10 Care Plan.

🌟 **ACTION ITEM:** Council members should send any questions or requests for data to Jesse by September 28, at the latest.

VI. HIV/STD Program Integration

Jesse introduced Matt Golden, the Disease Control Officer (DCO) of the STD program, and will be DCO for both STD and HIV after Bob retires. He has been the DCO of the STD program for five years, medical director of the program for nine years, and providing HIV care since 1991. He is also an associate professor of medicine at the University of Washington.

Matt explained that there is a national trend in combining STD and HIV programs and went over some reasons for merging the STD and HIV control programs and for choosing to have one DCO and two deputy DCOs.

- Currently, our STD clinic is the only clinic in state of Washington and the largest single diagnosing site in the Pacific Northwest. In order to staff this clinic, three medical doctors are needed. Three full-time equivalents (FTE) are not necessary; however, three people are needed to staff the clinic with staff going out of town, etc. In total, this will be 1.2FTE or less. This represents a decrease from 2.25 to 1.2 FTE for control of the HIV and STD programs over the last five to six years.
- New resources are needed to sustain the current programs, which will require a new model and new collaborators. To do this, Public Health will strengthen its relationship with the University of Washington. All of the physicians will be closely affiliated with the university (they will be receiving more than 50% of their salary from the university). Another goal will be to get the epidemiology staff increasingly more closely affiliated with the university as well. This will help Public Health to compete for National Institute of Health (NIH) grants, a rich funding source. There is \$1 billion in non-vaccine funding in HIV at NIH versus \$50 million available in CDC.
- Matt listed some challenges:
 - There is a growing population of people living longer with HIV.
 - There is more of an emphasis on merging treatment and prevention.
 - There is still a persistent epidemic, characterized by substantial disparities in racial, ethnic and sexual minorities.

He stated that to face these challenges, this must continue to be a community-driven and collaborative process, and Public Health aims to increase the pool of collaborators and allies.

Matt announced that Joanne Steckler has been chosen to be a deputy DCO. She works at Madison Clinic, is an assistant professor of medicine at the University of Washington, has worked with many CBOs, and has been very effective at getting grants, which is important to the position.

Members asked questions and Matt provided the following responses:

- Initially, Matt will be a member of the Council. Over the long term, Matt is not sure whether he or a deputy DCO would be the best person to be the Public Health representative to the Council.
- Joanne will be the deputy DCO for community work (the other deputy will be more focused on medical care). Matt will be in the clinic about half time. At this point, it's not yet decided exactly how staffing will work.
- Matt and the two deputies will all work on NIH prevention grants.
- Ron asked how the Planning Council will relate to the NIH prevention grants. Matt responded that they will have to go after whichever NIH grants that are available, some input from the Council where possible. The Planning Council will still plan for CDC, Omnibus and Ryan White dollars. Bob noted that NIH research grants often come with services, such as testing. Bob added that it's important for the Planning Council pay attention to House Bill 2360 which has proposed eliminating the AIDSNet administrative structure, possibly eliminating local prevention planning groups and replacing them with prevention planning at the State only. He stated Lifelong is in favor of that bill. There is a workgroup discussing recommendations for this, and there will be a community meeting sponsored by GACHA, where Planning Council members could have input. Jesse pointed out that the impact on care would be that the Planning Council would plan for King, Snohomish, and Island Counties (the TGA).

- Jesse noted that Matt and Joanne have brought in several NIH grants. Matt gave an example: Joanne is the principle investigator on a randomized trial which will compare different rapid tests, including one, they hope, which will detect many acute infections. About 13% of people that the STD clinic identifies with HIV don't have antibodies and would not test positive in regular, non-RNA testing. The downside of RNA testing is that it takes a long time to get results, so rapid tests would help. The staff the grant pays for is staff Public Health does not have to pay for at the STD and at Gay City. Another example is a community-level randomized trial for gonorrhea and chlamydia and that grant paid for the entire internet-based surveillance system for the entire state; the state used this to track all the gonorrhea and chlamydia cases in the state.
- Brandie commented that the Council is made up of many different kinds of people with different perspectives and different ways of understanding things, and she shared her hope that Matt will bring the spirit of willingness to listen to people and be able to translate the medical language to the community, so that there is an equal playing field.
- Kris asked whether there has been conversation about incorporating viral hepatitis into the HIV/STD program. Gary responded there had been some conversation, but it was decided to only incorporate two significant programs right now – HIV and STD, which they see as a large challenge already. Most of work on hepatitis is surveillance and there is less of focus on treatment for hepatitis than there is for HIV and STDs. Kris noted that the potential synchronicity with HIV prevention and hepatitis C prevention for IDU is so large. Matt responded he had recently seen two journal articles showing 70% effectiveness of treatment for hepatitis C, and agreed in the future, it will be important to plan how to get people into care to use these treatments. Right now, there is not enough staff to see the number of patients that would need the therapy, if they could be outreached, (there's currently a month waitlist for treatment for viral hepatitis). Bob added that the STD clinic has been very involved in hepatitis – they give vaccines for Hepatitis A and B to gay men and IDU, and they identify many hepatitis C cases as well. He stated there is not funding on the federal level for hepatitis C, and Kris stated that might change. Bob explained there are currently four disease control programs: HIV and STD (which will be integrated), TB, and all other communicable disease (including meningitis, H1N1, hepatitis, MRSA, etc.).

NEXT MEETING: Monday, October 19, at the **2100 Building – 2100 24th Ave. S. Seattle 98144**

- **Care Mini Prioritization Meeting:** 2:00pm – 5:15pm
- **Council Meeting:** 5:20pm – 6:00pm