



Seattle HIV/AIDS Planning Council

Monday, December 8, 2008-- 4:00 p.m.–6:30 p.m.
2100 Building – 2100 24th Avenue South

AGENDA

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|-------|--|--|
| I. | Welcome, Introductions & Announcements | 4:00 |
| II. | Meeting Agenda (2 min) <ul style="list-style-type: none">➤ Action: Review and Approve | |
| III. | Minutes: (3 min) <ul style="list-style-type: none">➤ Action: Review and Approve |  Attachment: White |
| IV. | Funded Prevention Programs Review (Barb) | 4:05 |
| V. | Care Grantee Report (Jeff) | 5:05 |
| VI. | EIP/ADAP Report (Richard) <ul style="list-style-type: none">•Changes in Medicare Spend Down•Current fiscal year budget challenges for the EIP program | 5:15 |
| VII. | Break | 5:30 |
| VIII. | Pooled Parity Model for 2009 (Gerrie, David) <ul style="list-style-type: none">•Review of how Parity works in Washington•Overview of changes from 2008 to 2009<ul style="list-style-type: none">➤ Action: Vote on parity plan |  Attachment: Salmon
5:45 |
| IX. | 2009-11 Comprehensive Care Plan (Jesse) <ul style="list-style-type: none">•Review Goals, Objectives and Activities (to be mailed out December 1st)<ul style="list-style-type: none">➤ Action: Review and Approve | 6:00 |
| X. | Committee Reports <ul style="list-style-type: none">•Prevention Prioritization (Erick, Bob)•AACT (Ron, Higinio)•Membership (Gerrie, Jodie) | 6:15 |
| XI. | Other Business/Next Meeting | 6:25 |

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

TTY: (206) 296-4843

Seattle HIV/AIDS Planning Council

Minutes ☒ December 18, 2008

4:00pm - 6:30pm

2100 24th Avenue South Seattle, WA 98144

Council Members Present: *Richard Aleshire, Amy Bauer, Shireesha Dhanireddy, Kate Elling, Brandie Flood, Melinda Giovengo, Bill Hall, Sarah Kent, Gerrie LaQuey, David Lee, Kris Nyrop, Ron Padgett, Arthur Padilla, Kevin Patz, Jodie Pezzi, Tony Radovich, Michael Raitt, David Richart, German Rodriguez, Pam Ryan, Erick Seelbach, Bob Wood*

Council Members Not Yet Appointed by the Executive Present: Joseph Grant, James Redel

Council Members Absent: *Charles Curvin, Philip Doles, Kieu-Anh King (emeritus), Higinio Martinez, Marcos Martinez, Eric Miles, Andrew Murphy, Ruth Njoroge*

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

Public Health Staff Present: Jeff Natter, Barb Gamble

Guests: Justin Hahn, Sergio Flores

Italics denote Planning Council Membership.

I. Welcome, Introductions and Announcements

Amy announced her engagement.

David R. announced this was his last Planning Council meeting (it is the end of his third term).

Gerrie confirmed that the Northwest Family Center is closing.

II. Meeting Agenda

The agenda was approved as written by acclamation.

III. November Meeting Minutes

The November minutes were approved as written by acclamation.

IV. Funded Prevention Programs Review

Prevention Grantee Update:

Barb reported that 2 proposals had been received for the 3MV program for Black MSM, and the review panel decided to award the funds to the Center for Multicultural Health. This process was different because it included an interview with the applicants, and the review panel felt this was valuable. Barb also reported that One to One, the currently funded Comprehensive Risk Counseling and Services (CRCS) program, will be funded again in 2009 because it is making good progress toward meeting its service unit goals. She will know more next week about the ACASI program at Madison Clinic. Barb also announced that Sharon Bogan is leaving her position with the HIV/AIDS program and will be working with the King County Communications Team and Emergency

Preparedness. Sharon's position in the HIV/AIDS Program was temporary, so now it has been eliminated.

Funded Prevention Programs Review:

Barb explained there are four different types of evaluations that Public Health requires:

- Contractual goals (called service units): these can be quarterly reports, provider meetings, agency visits, etc. If agencies aren't performing as expected, Public Health staff meets with them more frequently and helps brainstorm ideas to meet their goals.
- Programs are also evaluated on whether they're reaching the population they said they would reach, for example that a program is reaching not just Young MSM, but *high risk* Young MSM.
- Also measured is agencies' progress toward meeting Public Health goals such as decreasing the interval of testing, increasing condom use, etc. It's difficult to give a concrete evaluation; the best available data is from the CRCS program which measures differences in self-reported behavior, but it's not possible to prove that the program itself changed the behavior of those participants.
- Agencies also do process evaluation, sometimes as part of their formal evaluation plan and often more informally.

Barb reported on the programs individually and stated she would avoid using the agencies' names where possible, but in some cases the agency would be obvious:

- *Innovative program for MSM* – Last Prioritization, funding was set aside for an innovative program across all MSM populations. The program could not be an EBI or a DEBI, and had to be conducted by a community-based agency. The funded program is called Gay City TV, which is a community-level intervention that attempts to use digital media to talk about HIV prevention issues and have an impact on the community's HIV prevention perceptions. The program began by interviewing gay men at different events on different topics. They ask them 4-5 questions, tape the interview and put together the clips with the help of professional film makers from Three Dollar Bill Cinema. The films are posted on YouTube and presented at community forums. The program has faced the following successes and challenges:
 - The technology is new for the agency.
 - They found that people didn't have honest conversations with 4-5 questions, so they moved to hour-long interviews.
 - They have produced two documentary films which are available on their website, gaycity.com.
 - Learning to mark and retrieve the large amount of video has been challenging.
 - They have not got the audience they had hoped for on the internet and are facing the challenge of how to get more people to watch the videos.
 - They're trying to get more attendance at the community forums and working on getting the discussion to a deeper level.
- *Outreach to Injection Drug-Users (IDU)* – The program is called SCORE (South County Outreach, Referral and Exchange) and targets non-MSM meth and opiate injectors in South King County. The idea of this program was to go into an area where there aren't existing services. They provide field-based services, train peer educators to assist them, and recruit pharmacies to sell syringes to IDU. They have experienced the following successes and challenges:
 - The program started on April 15 and began with an assessment where they interviewed police officers, chemical dependency providers, etc.
 - They have put together a peer educator curriculum and have held 2 of the 5 sessions.
 - They're finding that people do call them to exchange syringes.
 - They have had success in providing outreach to heroin users and getting referrals for Needle Exchange.
 - They also work with providers in King County to spread the word about their service.
 - It's challenging to find meth users because they are often paranoid, awake during later hours, and in denial about drug use.

- *Community-level Intervention (CLI) for Foreign-born Blacks* – A CLI attempts to change the norms of the community about a particular issue and typically has several components. The currently funded program is a DEBI, follows the Community PROMISE model and develops role model stories.

<Brandie entered at 4:30.>

The role models are at different levels of change in an effort to acknowledge the difficulties of change. The program has four Prevention Councils that mostly talk with participants about testing in four different communities:

- Ethiopian
- Swahili-Kenyan
- Eritrean
- Somali

Challenges have included:

- It took a lot of work to find people and that would talk authentically.
- The scope of work is large.
- Addressing stigma of testing has been challenging.

- *Community-based HIV Testing and Counseling*
 - The Center for Multicultural Health (CMCH) provides testing for Foreign-born Blacks. They just began their own testing serves in May 2008 (in the past they collaborated with Gay City). The program has had good luck testing at work sites (e.g. taxi cabs, etc.) as well as at health fairs. It has taken a lot of work in the community to build the trust necessary to successfully reach the population
 - Also funded is CMCH's African American Testing Project (AATP). The project focuses on testing African American men in venues where high-risk men are likely to gather. Through peer referral, the program focuses on MSM. The testing is offered in conjunction with other health screening services like glucose, blood pressure, and cholesterol screening to promote a wellness approach. The program has exceeded its testing goals. In their first few months they tested broadly among African Americans but have now been able to narrow their focus to African American men with a high proportion of MSM. They have also been testing a lot of homeless men. There is no follow up for those that test negative, however those who test positive are referred to the One on One program. Brandie added that sometimes those who test negative are referred to CMCH's tobacco prevention program. They have a 1% case finding rate (meaning 1% of people they test are HIV+), although the last four months they have been more successful. Because the testing offers an incentive and is anonymous, it's difficult to ensure those who have previously tested positive do not come back to test again to get the incentive.
 - Gay City provides community-based HIV testing for MSM, mainly through their wellness center, as well as syphilis screening. They have a case finding rate of about 2%. Money is the main limiting factor for Gay City's testing program.
- *Group-level Intervention for MSM – Many Men, Many Voices (3MV)* – This intervention is a “boxed intervention” by the CDC, so the staff are trained to deliver the intervention and can receive additional technical assistance. The idea of this intervention the cultural context within which risk behavior occurs, including values, perceived risk, cultural and social norms, and sexual relationship dynamics. It was originally developed for Black MSM, but is also adapted for Latino MSM. Currently, Public Health funds two 3MV programs – one for Black MSM and one for Latino MSM. The evaluation of this program has included whether the trainers were prepared, whether space was sufficient, if the materials were adequate, and whether people participated. The program also measures increased knowledge through a pre and post test as well as a six month follow up on reported behavior changes. For the Black MSM program, CMCH will provide on-site testing; the Latino MSM program is working with Gay City for testing.

- *CLI for Latino MSM (Atrévete)* – This program seeks to influence community norms to support consistent condom use and further reduction of unsafe sexual behaviors through a variety of strategies, including socio-cultural events, a weekly radio program, referrals to counseling and testing, community outreach and educational workshops and forums. A portion of the program focuses on Young Latino MSM. They have 12 different service units and have met their service unit goals. They also have a program for addiction recovery meetings and peer recovery meetings. They are currently experiencing a challenge meeting service unit objectives for their meetings.
- *Comprehensive Risk Counseling Services (CRCS)* – CRCS used to be known as Prevention Case Management. Currently four CRCS programs are funded focusing on the following populations:
 - HIV positive MSM
 - HIV positive Latinos
 - HIV negative MSM
 - HIV negative Black MSM

CRCS provides intensive HIV prevention counseling and appropriate brokerage of services. The program uses an in-depth risk assessment tool and motivational interviewing to explore issues like condom use, drug use, etc. Through a series of feed-back sessions, the program aims to increase the client's sense of risk and decrease unprotected sex. A comprehensive risk assessment at the beginning and end makes this program easier to evaluate. However, it's difficult to know whether clients report that they change their behavior because of the program or because of other outside factors. The program is limited to 3 sessions with a client, but clients can re-enroll. In general, because of the intensity of the intervention, CRCS programs do not reach a lot of people in a year and have a high cost per client. Some of the challenges and successes the programs have experienced include:

- In general, the programs do reach high-risk clients.
 - Most of the programs are able to meet service units.
 - The programs have found it difficult for clients to be completely honest in the beginning of sessions, which has posed a problem because the programs only accept clients with a recent history of risk behavior. As a result they have loosened the screening criteria.
 - For HIV positive clients, the programs meet and exceed the requirements, but it is more difficult to reach HIV negative clients.
 - The One to One program for HIV negative Black MSM (which had been evaluated in order to receive continued funding) will get continued funding in 2009. The HIV negative Black MSM population is difficult to reach.
- *Community Outreach for MSM* – This program targets MSM who engage in high-risk behavior at public sex venues, bars and clubs. This program includes one-on-one outreach by peer-educators in baths, small media development and distribution, risk reduction material distribution, a high-volume distribution of condoms in bath houses and maintenance of the homohealth.org website. They also refer clients to counseling and testing at Public Health. The program is not required to prove they are working with the high-risk population, because it is assumed that clients in the bath houses are high risk. Their evaluation primarily consists of client satisfaction surveys on whether people believe the materials were relevant and helpful. Their challenges include that men are not picking up as many condoms in bars as in the past; lube is more popular but also expensive, so they have proposed some modifications to the program to address this.
 - *CLI for Young MSM* – This program is based on a DEBI developed in Eugene, OR, called MPowerment. The program focuses on street and community outreach and developing a core group of youth who create and implement all aspects of the project, including quarterly social/HIV prevention events, small media materials, one-on-one outreach, smaller group meetings, and maintenance of a project space. The Core group is Young MSM, but also includes young women who are opinion leaders in the community. Their greatest challenge is reaching the transient sex

worker population, and high-risk young MSM. The program has existed for a number of years and has made several adjustments. The model is less successful in King County, where there are other activities for young MSM, than in Eugene, which did not have those other activities. The age group is 15-24, which is also problematic because some participants are able to go to clubs, while others are not.

- *CLI for Crystal-Using MSM (injectors and non-injectors) – Project Neon* at Seattle Counseling Services (SCS) works with a continuum of “stage-matched services,” meaning they serve clients at different levels of change. They conduct a variety of activities including peer education, one to one counseling, assessments for drug treatment, one to one Needle Exchange, produce brochures, zines, etc. The program has been successful in recruiting peers to lead peer education, including 7 peers who outreach to injectors and 3 to non-injectors (the bulk of their funding is for injectors). Their challenges include that peers have a chaotic lifestyle and that injector and non-injector peers have separate issues and separate meetings. They also have a group for those in a mature stage of recovery and a relapse prevention group. They have also recently experienced a decrease in members, but those who do participate, seem to complete the whole series. SCS also collaborates with Gay City Health Project on Speed, Sex, and Sanity, a discussion series on crystal meth harm reduction and education. They produce one per quarter, and attendance has averaged about 30 participants.

V. Care Grantee Report

Jeff announced that the allocation review panel for care funding met last Friday, December 5 and made initial funding recommendations. Jeff has submitted the recommendations to Gary Johnson, the Prevention Division Manager and then they will go to the King County Procurement Office. Hopefully, agencies will receive their award letters in the next two weeks. A rebid has been put out for psychosocial support for women, and a panel is being put together to review the proposals. Jeff is also working on an RFP to be put out in January 2009 for Minority AIDS Initiative dollars.

VI. EIP/ADAP Report

Changes in Medicaid Spend-down

Richard explained the differences between *Medicaid* and *Medicare*:

- **Medicare** is a federal program for medical care for the elderly, blind, and disabled populations. Disabled persons qualify for Medicare after two years of being disabled. There is no spend-down. It's managed by the Center for Medicaid and Medicare Services (CMS). One aspect of the program is Part D medication coverage
- **Medicaid** is a state and federal combined program that provides medical care and other services to low-income individuals. At the State level it is overseen by DSHS. Spend-down can be a component of Medicaid.

Richard then explained spend-down. To be on federal Medicaid, one has to be at or below about 75% of the Federal Poverty Level (FPL). For state Medicaid, there are discretionary programs added to extenuate Medicaid and one of those is spend down. If someone makes over 75% of FPL, s/he is not eligible for Medicaid, however s/he can spend some of his/her own dollars on expenses related to medical care to spend-down to the income eligibility requirements. Medical care expenses include prescriptions, doctor's appointments, transportation to medical appointments, etc.

In the past, EIP was able to pay the spend-down to DSHS, as “anticipated expenses.” The CMS has said to DSHS that EIP cannot pay the spend-down upfront, and clients must incur the cost of the spend-down, beginning April 1, 2009. EIP has sent an email to all case managers and letter to the 600 EIP clients statewide that will be affected. The impact of this will be:

- For clients on **Medicaid only** (about 50 clients statewide), EIP can still help clients pay the expense of spend-down, for example (rather than paying for spend-down upfront) they can pay for a client's drugs, and the client will take the statement from EIP to DSHS to meet their spend-down, probably within the first month.
- For clients covered by **Medicaid and Medicare** (about 550 clients statewide):
 - Clients' medications are covered by Medicare, which would not count toward a spend-down.
 - EIP will be able to help clients with the cost of medical visits, labs, and prescriptions, but not other services clients have been receiving from Medicaid.
 - If clients are not able to meet the Medicaid spend-down, services they would lose (currently covered by Medicaid) would include transportation, mental health counseling, substance abuse counseling, co-pays, and dental services. However, dental services can be covered by Ryan White funds, and primary care and case management programs are required to address transportation needs as part of the Ryan White Part A grant.
- For **case management services**:
 - If clients are not on Medicaid, this will also impact case managers' ability to bill Title XIX for case management services.
 - A list is being developed of how case managers can help clients meet their spend-down.
- For **EIP** this is not a cost-saving measure; it may actually increase cost to EIP because they will pay full drug cost for some clients.

<Arthur left at 5:22.>

EIP program challenges for the next state fiscal year (beginning July 1)

Richard explained that the EIP Steering Committee meets quarterly and is advisory to the Department of Health. Ron and Shireesha are representing the Planning Council on the committee, and David L. is also on the committee. Richard distributed and presented on a hand out. The State has to find \$5.1 billion dollars to balance the budget for the next state fiscal year. This year, the Department of Health had to cut funds, and EIP is giving up \$805,000 in state dollars, which will come from not doing a CARE Event this year, and leaving two positions unfilled. Depending on the revenue forecast in March, EIP may have to take additional cuts. In November the committee brainstormed possible ideas to save money, in February they will prioritize the ideas and then finalize the plan in May. Richard explained the revenue and expenses outlook for 2010, which begins with a deficit of about \$3.2 million. He went over eligibility requirements, what EIP covers, and then they brainstormed list of where to save money (note the list of ideas are *just* brainstorming and are not necessarily going to be implemented). They did put in request for \$3 million additional dollars to the State Legislature, but the chances of getting this are very low. Additionally, there may be in 20-25% cut in funding from the State. From the \$8.4 million revenue from the State, this would mean an additional \$1.6 million cut, for a total of \$4 to 5 million in reduced funding for EIP.

Richard clarified some of the ideas listed on the hand out:

- One idea was a mandate that clients use the Washington State High risk Insurance Pool (WSHIP), a program for HIV positive people who are considered "high-risk" to most insurance companies. There used to be a cap on the number of people WSHIP would accept with AIDS, and if all 700 EIP clients without insurance were moved to WSHIP, they may ask to re-instate that cap.
- Currently clients that were on EIP in 2002 when the FPL eligibility was 370% have been grandfathered in, and one suggestion was to undo this, so all clients would have to be at or below 300% of FPL.
- Currently the formulary covers anti-anxiety medications, anti-depressants, etc., and one idea would be to reduce the formulary only anti-retroviral medications.

- Another ideas was to take a 10% cut across which would create a waitlist. Currently there are about 3300 clients on EIP, which would create a significant waitlist.

Principle 3 of the Pooled Parity model states that if the State is in need of money for EIP, EIP may propose a number which would affect the parity calculation, and then the parity work group would reconvene to consider the proposal. The principle is not new but has not been implemented for several years. In the past, the State has been able to pull funds from other regions but not from Region 4 because they it receives funding from Part A. Jeff clarified that Region 4 would be impacted by possibly having to make a more significant contribution to parity in Snohomish and Island Counties. The amount that the State receives from Part A is not through parity, but from the allocation plan created by the Council. Richard stated that the Governor's budget will be released next week, and the House and Senate will release their budgets in January, so there may be a community forum between March and July when more information is available. It was noted that switching State funding for medical care in Kitsap and Snohomish Counties to those Region's allocation of Part B funds from the Parity Pool was not on the list of recommendations.

<Sergio left.>

BREAK 5:45 – 5:55

VII. Pooled Parity Model for 2009

Richard explained that the State gets federal Part B dollars, and King (AIDSNet Region 4), Snohomish and Island Counties (Part of AIDSNet Region 3) get federal Part A dollars. The Pooled Parity Model pools that money together (pulling out a few things) and then allocates dollars out to the different regions, so that they receive a certain amount of money per person living with HIV (in the past this amount was about \$700 per person.) The allocation happens by the parity principles, which were presented to the Council for approval.

MOTION: Melinda moved to approve the Parity Principles. David R. seconded. There was no discussion.

☑ The motion passed unanimously.

VIII. 2009-11 Comprehensive Care Plan

Jesse presented on two suggestions for the Comprehensive Plan:

- Add additional Quality Management activities, which are currently being conducted by Becca Hutcheson.
- It was suggested to put the goals in the future tense, however others suggested that the present tense is a more active voice.

☑ The group agreed to add the Quality Management Activities to the Comprehensive Plan.

MOTION: Gerrie moved to approve the Comprehensive Care Plan and use the present tense. Michael seconded. There was no discussion

☑ The motion passed unanimously.

IX. Committee Reports

Prevention Prioritization

Erick reported that the Steering Committee has been going over the meeting-by-meeting schedule for Prioritization. The Interventions Committee has been meeting regularly and has scheduled one more meeting.

AACT

Ron reported that at the last AACT Committee meeting the group finished watching *Race: The Power of an Illusion*. At the next meeting the group will be discussing information from the National Advisory Committee on Cultural Competency. The next meeting is Wednesday, December 17, at the Bill Ford Conference Room.

Membership

Jodie reported that the Membership Committee currently has two applications to consider. One applicant has further questions about the time commitment. There was also an application that the committee decided not to forward to the Council. Kieu-Anh is being placed on emeritus status, and Brandie and Bill who had been on emeritus have returned. The Committee has received two resignations, from Lina Ali and Angela Williams, from three letters that were sent out to people who were out of compliance with membership. The Committee will do more recruiting focused on consumers; the Council specifically needs African American and Latino consumers.

Substance Abuse Prevention Needs Assessment

Jesse reported that the committee has met and will be able to conduct up to 200 interviews. They decided that in order to get a good sense of the population that they needed to narrow the focus, so the assessment will only interview MSM and focus on MSM who use stimulants and/or alcohol. For a control group, about 75 of the participants will not be stimulant users. According to Project Rewards, 60% of HIV+ meth-users started after they learned they were HIV+. If the assessment tried to represent other populations as well, there wouldn't be enough data on any one population.

X. Next Meeting

Next Meeting:* Monday, January 12, 4:00-6:30pm at the **2100 Building – 2100 24th Ave. S., Seattle 98144.*

The meeting adjourned.