Paterson-Passaic County-Bergen County
HIV Health Services Planning Council

Priority Setting Fiscal Year 2017
Report to the Recipient

Approved:
Planning & Development Committee – *January 11, 2017*
Steering Committee – *June 6, 2017*
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Bergen-Passaic Transitional Grant Area
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Department of Human Services, Ryan White Grants Division
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PATERSON-PASSAIC COUNTY – BERGEN COUNTY
HIV HEALTH SERVICES PLANNING COUNCIL

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REPORT TO THE RECIPIENT

I. INTRODUCTION, PARTICIPATION, ROLES AND RESPONSIBILITIES

Each year, the Planning Council engages in a comprehensive review of the priority ranking and resource allocations process. To prepare for FY 2017 deliberations, the Planning Council continued to strengthen the ability of Planning Council members to make informed decisions. Relevant data were provided both in summary and detail formats to reflect defined criteria and to enhance Planning Council's understanding of service need and use. Additionally, Planning Council members were offered technical assistance to enhance their understanding of the priority setting process and the use of data for decision-making. Finally, steps were taken to (1) assure absence of conflict of interest by Planning Council members, (2) avoid opportunities for impassioned plea, and (3) assume sole responsibility by the Planning Council for reviewing all data, establishing policy, priorities and allocations. As a result, a thorough and unbiased priority setting process was successfully implemented again for FY 2017.

The tasks of the Planning Council are articulated by the Planning Council in the approved Priority Setting Process, contained below.

To remove potential conflict of interest by aligned members of the Planning Council, each service category under consideration was voted separately, and members aligned with that service category were required to declare their status and not permitted to vote. Council members were permitted to offer their views and experiences during discussions to highlight the data. However, comments considered personal or self-serving in nature were not allowed.

The Planning & Development Committee accepted responsibility for assuring a smooth and effective priority setting process on behalf of the Planning Council by establishing and maintaining a year-round detailed month-by-month timeline for completing the required tasks of priority setting, resource allocations and directives. The Committee reviewed the priority setting timeline at each of its monthly meetings and then intensified its efforts in June through September of 2016. The committee's work included review of data and materials that would be brought to the Planning Council for review, guidance on procedural matters and formulating recommendations for consideration by the Council.

In 2015, a Planning Council task force was created to review data related materials and to recommend how these materials could be simplified and made more user friendly. The task force, consisting mostly of consumer members, worked with the Planning & Development Committee and the planning consultant to develop summary worksheets aimed at facilitating comprehension and decision making. The process was successful.

Persons living with HIV/AIDS (PLWH) and other community members participated in the priority setting and resource allocation process at multiple levels. Planning Council members and alternates with an interest in improving their understanding of the data and the process were invited to a special technical assistance program on May 26, 2016,. Participants used the environmental assessment, needs assessment presentation and data work book to discuss factors relating to priorities and allocations. They also reviewed the voting process that would be used. The orientation allowed PLWH to lay a strong foundation for the complete process. Eight Planning Council members, three of whom were consumers, participated. Finally, members of the public, many also PLWH, were invited to the Council's priority setting and resource allocations meetings and allowed to participate in discussions prior to the voting.

The Planning Council formally began priority setting deliberations on June 14, 2016 with the environmental assessment and results of the recently completed consumer survey. Data review and priority ranking took place on July 12, 2016, and resource allocations and contingency scenarios on August 2, 2016. Directives to the Recipient were discussed and voted upon September 13, 2016. Information and vital issues were discussed with motions and recommendations made from the floor. The overall process was successful and resulted in carefully considered priorities, allocations, and directives firmly grounded in the use of data for decision making. This report describes the process as well as the decisions of the Planning Council.

II. DATA

As part of the priority setting process and prior to the voting deliberations, the Planning Council received an environmental assessment of the status of HIV/AIDS in the Bergen-Passaic TGA with reference to state and national priorities. Under the guidance of the Planning & Development Committee, a complete data set in the form of two Priority Setting Data Work Books was assembled for the Planning Council with elements addressing the various criteria and variables considered crucial to decision making. The FY 2017 Priority Setting Data Work Books were intended to assist members of the Paterson-Passaic County – Bergen County HIV Health Services Planning Council as they determined priorities, allocations and directives. Data tables contained information requested by the Planning Council, supplemented by information and recommendations from the 2016 Needs Assessment and earlier studies describing specific characteristics of the population as well as service needs, access and barriers.

Data Work Book Part I was organized into two parts: (1) an introduction and summary tables; and (2) profiles for each funded service category pertaining to priority ranking. Data tables provided information from the Needs Assessment, the Gaps Analysis and other related studies. Data Work Book Part II presented each service category in the RWHAP Part A program that would be funded in FY 2017. The Work Book provided information about how the funds were utilized in previous fiscal years and availability of other sources of public funds, apart from Part A, to support the needs of PLWH.

To further facilitate the Council's review, two summary tables were developed by the special Data Task Force of the Planning Council. These tables succinctly summarized data related to the criteria identified by the Council. The summaries allowed for easy comparisons across service categories as well as succinct tables on service need, utilization and funding.

III. THE PROCESS

PROCESS COMPONENTS

1. Review of priority setting process
2. Review of priority setting criteria
3. Review of service category definitions
4. Environmental assessment to include the HIV Care Continuum, National HIV/AIDS Strategy, HRSA priorities, and status of the epidemic
5. Data reviews
6. Priority ranking of all service categories based on need/importance
7. Identification of which categories would be funded
8. Resource allocations (how dollars are to be spent)
9. Contingency scenarios (what if there is a significant increase or drop in funding)
10. Directives to the Recipient
11. Report to the Recipient
12. Process evaluation

PRIORITY RANKING CRITERIA

Priority Ranking defines the *importance* of each service category in maintaining engagement or providing access to HIV medical care. Priority Ranking does *not* relate to how much the service is used in Part A/MAI.

FY 2017 criteria, stated in priority order:

1. **In-Care PLWH (In-Care** means the individual is getting medical care for HIV): The service addresses their needs and maintains them in medical care, as indicated by:[1]
    - "Do you use this service?" from the needs assessment survey;
    - "If you do not use this service, do you need it?" from the needs assessment survey results;
    - Other available information from various sources.

2. **Out-of-Care PLWH** (**Out of Care** means the individual is not getting medical care for HIV) and **Unaware** (**Unaware** means the individual is HIV-positive but does not know his or her status)**:** The service addresses their needs, as indicated by:

[1] A person is determined to be in care if he/she receives an HIV-related medical visit, an HIV-related prescription, a CD4 test or viral load test within the past six months.

- "If you do not use this service, do you need it?" from the needs assessment survey;
- Other available information from various sources.

3. **Access:** The service addresses access issues ("ability to get the services you need") that get in the way of getting medical care, as indicated by:
    - "What keeps you from getting the service?" from the needs assessment survey;
    - Providers' capacity to increase access and remove barriers for needed services;
    - Comparison of provider locations to the epi-centers;
    - Other available information.

The priority ranking model uses the criteria identified above. Each service category is given a score from one to five points.

Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned.

PRIORITY RANKING SCORING TOOL

1 = Not Important		**5 = Very Important**
In-Care and Not-in-Care PLWH		
Need: For PLWH who are engaged in HIV primary medical care (in care), the service does NOT significantly contribute to maintenance in care.	**THIS SERVICE IS IMPORANT TO MEET IN-CARE AND NOT-IN-CARE NEED AND ACCESS TO SERVICES**	*Need:* For PLWH who are engaged in HIV primary medical care (in care), the service significantly contributes to maintenance in care.
Unmet Need: The service has NOT been identified by PLWH who are engaged in HIV primary medical care as an unmet need.		*Unmet Need:* The service has been identified by PLWH who are engaged in HIV primary medical care as an unmet need.
Gaps in Services: The service is NOT identified in the gaps analysis as significant to the network of services that enhance access to HIV primary medical care.		*Gaps in Services:* The service is identified in the gaps analysis as significant to the network of services that enhance access to HIV primary medical care.

Scoring Range:

1 = Not important
2 = Somewhat important
3 = Moderately important
4 = Important
5 = Very important

Planning Council members vote by assigning a score of 1 to 5 for each service category. Scores are averaged and then sorted from high to low to determine priority ranking. All HRSA defined service categories will be ranked. This year, the Planning Council voted to shorten the ranking process, as described below.

When all service categories are ranked and approved by the Planning Council, each will be reviewed to determine whether to fund the service in FY 2017. The Planning Council will decide by a Yes/No vote for each service category.

Public comment is allowed during discussion of each service category. Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned. Aligned members are officers, board members, employees, consultants, regularly scheduled volunteers[2] or anyone who may benefit financially from decisions made.

RESOURCE ALLOCATION CRITERIA

Resource allocation defines the way Ryan White funds will be distributed to specific service categories. The resource allocations criteria help to determine the level of funding for services that support engagement and retention in medical care.

FY 2017 criteria, stated in priority order:

1. *Utilization* of services provided by Ryan White Part A or MAI, as indicated by:
    - Percent of funds spent for the service category (provided by the Ryan White Recipient);
    - Cost per client to render the service (provided by the Ryan White Recipient);
2. *Capacity* for providers to render services, as indicated by:
    - Percent of expected clients versus actual clients served in the Part A system (provided by the Ryan White Recipient);
3. *Availability of other sources of funds* that may be used to serve PLWHs, as indicated by:
    - How much in other public funds are available to serve PLWH.

The resource allocation model uses the criteria identified above, each of which is given a score of one to five points.

[2] Regularly scheduled volunteers who can vote will be determined on a case-by-case basis.

RESOURCE ALLOCATION CRITERIA
SCORING TOOL

1 = Needs Less $		5 = Needs More $
Utilization: This service is NOT well utilized by PLWH to maintain engagement in HIV primary medical care.	**SERVICE UTILIZATION**	*Utilization:* This service is very well utilized by PLWH to maintain engagement in HIV primary medical care.
Capacity: Existing providers are able to provide enough services for PLWH.	**SERVICE CAPACITY**	*Capacity:* Existing providers are NOT able to provide enough services for PLWH.
Funding Resources: Adequate funding sources are available to provide the same or a similar service.	**OTHER SOURCES OF FUNDS**	*Funding Resources:* There are FEW (or NO) adequate funding sources that provide the same or a similar service.

Scoring Range:

1 = 20% less dollars
2 = 10% less dollars
3 = No change
4 = 10% more dollars
5 = 20% more dollars

For each service category, Planning Council members apply the resource allocation criteria by assigning a score of 1 to 5 to each of the three criteria. Scores are aggregated for each service category.

A decision model (or calculation) is constructed to determine the new allocations. The model assigns dollars to each service category and then adjusts each service category after the voting, as follows.

1. Allocations begin with an assumption of stable funding, i.e. no increase or decrease from fiscal year 2016.
2. A baseline, expressed in dollars allocated to each service category, establishes funding at one hundred percent of the prior year.
3. Each category is scored for utilization, capacity and other sources of available funds.
4. The scores are weighted and dollars adjusted for each service category. *The total of all service categories may be different from the baseline.*

Score	Weight	Meaning
1	0.80	Weight assigns 20% less dollars
2	0.90	Weight assigns 10% less dollars
3	1.00	Weight assigns no change in dollars
4	1.10	Weight assigns 10% more dollars
5	1.20	Weight assigns 20% more dollars

5. The difference is then allocated through deliberations by the Planning Council. Some service categories may receive more funds and some less, depending on the consensus of the Council.
6. When deliberations are completed, allocations are then converted into *percentages*.

The Planning Council is given responsibility for reviewing data pertaining to service utilization, capacity and other sources of funds.

Public comment is allowed during discussion of each service category. Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned.

CONTINGENCY SCENARIOS

Contingency scenarios define how the Planning Council will act if the grant award differs significantly from the prior year. The Planning Council determines a course of action based on discussion and consensus.

The process is as follows. FY 2016 contingency scenarios are reviewed by the Planning Council for their appropriateness in FY 2017. Current scenarios serve as the basis for the discussion process:

Example: In the event that FY 2017 funding levels significantly change from the prior fiscal year, the Planning Council determined the following course of action.

Scenario 1: If funding is up to 20% (+/-) of the FY 2016 award, the Recipient will distribute funds proportionately in accordance with percentages established by the Planning Council.

Scenario 2: If funding is increased or decreased by more than 20%, the Planning Council will convene to revise the previously established allocations.

DIRECTIVES

A directive advises the Recipient on the best use of funds. It goes beyond resource allocation and takes into consideration changes in the environment that could have an effect on services for PLWH. The Planning Council reviews the most recent information and recommendations from:

- Comprehensive HIV Health Services Plan
- Outcomes and Satisfaction Surveys
- Quality Measures
- Unit Cost and Cost per Case
- Needs Assessments, Special Population Studies, Epi-Profiles, Environmental Assessments, CARS data, etc.
- Statewide Coordinated Statement of Need (as available)

Directives may be offered as motions by members of the Planning Council or any of its committees. Discussion and voting occurs at the Planning Council by all members. Aligned members may not vote on behalf of the service category to which they are aligned.

REPORT TO THE RECIPIENT

Results of the Council's priority setting decisions, as reflected in the meeting minutes, are compiled into a report to the Recipient. The Planning & Development Committee reviews the drafts and forwards the final draft for further review to the Steering Committee. The report is forwarded to the Council for ratification. The Planning Council may edit the report for accuracy prior to final adoption.

PROCESS EVALUATION

A formal evaluation of the priority setting process is conducted in two phases: (1) an evaluation following each Planning Council meeting in which priority setting is an agenda item, and (2) a final evaluation of the entire process.

The first phase utilizes an online survey that each Planning Council member completes following each meeting via the internet. The Planning & Development Committee receives the results and forwards them to Steering Committee for discussion.

The second phase is completed by the Planning Council and includes (1) a review of the FY 2017 Priority Setting calendar for completed tasks during the fiscal year and (2) review of the Planning Council's survey responses following the completion of the entire process. Results are forwarded to Steering Committee by the Planning & Development Committee for further review along with recommendations for the next fiscal year. The Planning Council receives a report at its January 2017 meeting and determines appropriate improvements to be implemented for FY 2017.

IV. RESULTS

SERVICE CATEGORIES

The Planning Council reviewed 31 allowable service categories to determine which would be included in the FY 2017 plan. First, the Council reviewed each definition along with related need and access data from the environmental assessment and the recently completed consumer survey. This year, the Council decided to bypass scoring for each service category and instead adjust the FY 2016 rankings as appropriate. Members felt that rankings from FY 2016 were essentially reinforced from the available new data, and significant changes from last year were not indicated. Modifications were made as motions from the floor and followed by discussion and voting. Results are shown in Table 1. A record of the motions and votes are detailed in Exhibit B.

Table 1
RWHAP Prioritized Service Rankings FY 2016 and FY 2017

Service Category	FY 2016 Rank		FY 2017 Rank	
	Part A	**MAI**	**Part A**	**MAI**
a. Ambulatory/Outpatient Medical Care	**1**	**1**	**1**	**1**
b. AIDS Drug Assistance Program (ADAP)	**6**	**13**	**6**	**13**
c. AIDS Local Pharmaceutical Assistance (local)	**7**	**14**	**7**	**14**
d. Oral Health Care	**2**	**5**	**2**	**5**
e. Early Intervention Services	**8**	**6**	**8**	**6**
f. Health Insurance Premium & Cost Sharing Assistance	**18**	**20**	**18**	**20**
g. Home Health Care	**16**	**23**	**23**	**23**
h. Home and Community-based Health Services	**22**	**21**	**22**	**21**
i. Hospice Services	**19**	**27**	**24**	**27**
j. Mental Health Therapy and Counseling	**3**	**2**	**3**	**2**
k. Medical Nutrition Therapy	**24**	**19**	**19**	**19**
l. Medical Case Management	**4**	**4**	**4**	**4**
m. Substance Abuse Services Outpatient	**15**	**18**	**13**	**18**
n. Case Management - Non-medical	**5**	**3**	**5**	**3**
o. Child Care Services	**27**	**26**	**27**	**26**

Service Category	FY 2016 Rank		FY 2017 Rank	
p. Pediatric Development Assessment and Early Intervention Services	**N/R**	**N/R**	**31**	**31**
q. Emergency Financial Assistance	**12**	**8**	**12**	**8**
r. Food Bank/Home Delivered Meals	**23**	**17**	**16**	**17**
s. Health Education/Risk Reduction	**21**	**22**	**21**	**22**
t. Housing Services	**10**	**7**	**10**	**7**
u. Legal Services/Permanency Planning	**17**	**15**	**17**	**15**
v. Linguistic Services	**28**	**28**	**28**	**28**
w. Medical Transportation Services	**11**	**9**	**11**	**9**
x. Outreach Services	**9**	**10**	**9**	**10**
y. Permanency Planning	**N/A**	**N/A**	**30**	**30**
z. Psychosocial Support Services	**13**	**11**	**14**	**11**
aa. Referral for Health Care/Supportive Services	**20**	**12**	**20**	**12**
bb. Rehabilitation Services	**26**	**24**	**26**	**24**
cc. Respite Care	**29**	**29**	**29**	**29**
dd. Substance Abuse Services - Residential	**25**	**25**	**25**	**25**
ee. Treatment Adherence Counseling	**14**	**16**	**15**	**16**

N/R = Not ranked

The results of the priority ranking decisions reflect selective changes from FY 2016 in response to needs arising from the environment. In keeping with its historic importance, Ambulatory/Outpatient Medical Care was assigned the highest priority. Oral Health Care (ranked #2), Mental Health Therapy (ranked #3) and Medical Case Management (ranked #4) were also given the same high priority as in FY 2016. Other core services considered important included AIDS Drug Assistance (ADAP) and local pharmaceutical assistance, ranked #6 and #7, respectively, and Early Intervention Services (ranked #8). Importance ranking for Substance Abuse Counseling (ranked #13) was increased from the prior year (#15). Support services with the highest priority ranking were Non-Medical Case Management (ranked #5) and Outreach (ranked #9).

Priorities for MAI funded services differed slightly from those in Part A. Non-medical Case Management (ranked #3) received highest priority behind Ambulatory/Outpatient Medical Care (ranked #1) and Mental Health Therapy (ranked #2). Support services, in general, received higher importance rankings, reflecting the needs of minority PLWH. Housing Services (ranked #7), Emergency Financial Assistance (ranked #8) and Medical Transportation Services (ranked #9)

were among the most important services scored by the Planning Council. Outreach (ranked #10) also reflected needs of minority populations at risk for HIV infection.

Part Two of the priority ranking process involved decisions about which services would be funded in FY 2017. The Planning Council again reviewed need and access data as well as HRSA's HIV Continuum of Care (HCC) memorandum advising Planning Councils to link funded service categories with those that supported the HCC.

All service categories approved in FY 2016 were again approved in FY 2017. All service categories funded in FY 2016 were again funded in FY 2017. See Table 2.

Funding decisions reflect the strong preference by the Planning Council to maintain the network of Part A and MAI providers. Decisions also considered service needs implied by the HIV Care Continuum as recommended by HRSA in its memorandum of June 11, 2015. The Planning Council will fund nine of the twelve service categories identified by HRSA for Part A funding. The remaining three are available either from Part B funds (AIDS Pharmaceutical Assistance), government insurance programs (Home and Community-based Health Services, Home Health Care) or other Part A programs (Treatment Adherence Counseling).

Table 2
FY 2017 Funded Service Categories

FY 2017 Rank	Service Categories
	Part A Core Services
1	Ambulatory/Outpatient Medical Care
2	Oral Health Care
3	Mental Health Therapy and Counseling
4	Medical Case Management/Treatment Adherence
8	Early Intervention Services
13	Substance Abuse Services Outpatient
18	Health Insurance Premium & Cost Sharing Assistance

FY 2017 Rank	Service Categories
	Part A Support Services
5	Case Management - Non-medical/Non-medical incl. Treatment Adherence Counseling
9	Outreach Services
10	Housing Services
11	Medical Transportation Services
12	Emergency Financial Assistance
14	Psychosocial Support Services
16	Food Bank/Home Delivered Meals

17	Legal Services/Permanency Planning
	MAI
3	Non-Medical Case Management
10	Outreach Services
18	Substance Abuse Services/Outpatient
22	Health Education/Risk Reduction

HRSA approved service categories that will not be funded FY 2017 along with rationales for excluding these service categories were based on their availability through other programs in the TGA, either within or outside of RWHAP, and are summarized in Table 3.

Table 3
Services Not Funded in FY 2017

Service Category	Rationale
Core Services	
AIDS Drug Assistance Program (ADAP)	Available through NJ-DHSTS Part B.
AIDS Local Pharmaceutical Assistance	Funding from ADAP considered adequate.
Home Health Care	Alternative programs available in the TGA, Medicare and Medicaid
Home and Community-based Health Services	Available through home health programs and Medicaid
Hospice Services	Alternative programs available through Medicare and Medicaid
Medical Nutrition Therapy	Provided with outpatient medical care
Support Services	
Child Care Services	Alternative programs available; low importance ranking
Developmental Services for HIV-positive Children	Program available through Part C/D
Pediatric Developmental Assessment Services	Program available through Part C/D
Linguistic Services	Bi-lingual staff are required for all Part A programs as part of performance standards; other technology is available although future need will be monitored.
Referral for health care/supportive services	Provided with Medical and Non-medical Case Management
Rehabilitation Services	Alternative programs available, Medicare and Medicaid

Respite Care	Alternative programs available
Substance Abuse - Residential	Covered under most insurance programs; cost prohibitive for RWHAP
Treatment Adherence Counseling	Provided with Ambulatory/Outpatient Medical Care and funded under Medical Case Management

RESOURCE ALLOCATIONS

The RWHAP Part A and MAI resource allocations decisions for FY 2017 were determined by the Planning Council on August 2, 2016. Allocations are shown in Table 4 below. Resource allocations reflect local needs for PLWH as well as national priorities established by the National AIDS Strategy, HRSA directives and the ACA. The FY 2017 allocations comply with the legislative requirement to provide a minimum of 75% of Part A and MAI combined funds for core services. Rationales for the Planning Council's decisions are described beginning page 16. A record of the motions and votes by the Planning Council are detailed in Exhibit C.

Table 4
FY 2017 and FY 2016 Resource Allocations
RWHAP Part A and MAI Direct Services

FY 2017 Priority Rank	Service Category	FY 2017 Allocation In Percent Part A and MAI Combined	FY 2016 Allocation In Percent Part A and MAI Combined
	Part A Core		
1	Ambulatory/Outpatient Medical Care	24.04%	23.69%
2	Oral Health Care	16.26%	15.52%
3	Mental Health Therapy and Counseling	4.32%	4.26%
4	Medical Case Management	15.98%	15.75%
8	Early Intervention Services	2.36%	2.41%
13	Substance Abuse Services Outpatient	7.22%	8.17%
18	Health Insurance Premium & Cost Sharing Assistance	0.55%	0.62%
	Total Part A Core	**70.73%**	**70.42%**

	MAI Core		
18	Substance Abuse Services Outpatient - MAI	4.50%	4.81%
	Total Part A + MAI Core	**75.23%**	**75.23%**
	Part A Support		
5	Case Management - Non-medical	10.41%	10.61%
9	Outreach Services*	3.51%	3.45%
10	Housing Services	0.23%	0.24%
11	Medical Transportation Services	3.49%	3.55%
12	Emergency Financial Assistance	0.23%	0.27%
14	Psychosocial Support Services	0.41%	0.40%
17	Legal Services/Permanency Planning	0.80%	1.83%
16	Food Bank/Home Delivered Meals	1.91%	0.81%
	Total Part A Support	**20.99%**	**21.16%**

FY 2017 Priority Rank	**Service Category**	**FY 2017 Allocation In Percent Part A and MAI Combined**	**FY 2016 Allocation In Percent Part A and MAI Combined**
	MAI Support		
3	Case Management - Non-medical	2.28%	2.28%
10	Outreach Services	1.13%	1.13%
	Substance Abuse (See MAI Core)		
22	Health Education/Risk Reduction	0.38%	0.38%
	Total MAI Support	**3.79%**	**3.79%**
	Total Part A + MAI Support	**24.78%**	**24.95%**
	Grand Total RWHAP Part A and MAI	**100.0%**	**100.0%**

MAI DETAIL

FY 2017 Priority Rank	Service Category	FY 2017 Allocation In Percent MAI Alone	FY 2016 Allocation In Percent MAI Alone
3	Case Management - Non-medical	37.76%	37.76%
10	Outreach Services	13.75%	13.75%
18	Substance Abuse	43.49%	43.49%
22	Health Education/Risk Reduction	5.00%	5.00%
	Grand Total MAI	**100.0%**	**100.00%**

The FY 2017 results reflect the consensus of the Planning Council to approve:

- Increases for three core and one support services in Part A;
- Decreases for four core and seven support services in Part A;
- No changes in MAI services.

Changes were less than one percent for all but two service categories. A reduction in Substance Abuse Treatment was considered justified due to availability of other funds from the Medicaid Expansion Program in New Jersey and new insurance options as well as evidence of reduced demand. Non-medical case management was reduced considering availability of Medical Case Management and MAI Non-Medical Case Management. Current utilization of that service category indicated sufficient capacity to meet demand.

In FY 2016, allocations were reduced for Ambulatory/Outpatient Medical Care in anticipation of increased funds from Medicaid Expansion. However, the Part A Program was able to assist the Part C/D provider by funding Ambulatory/Outpatient Medical Care for their undocumented patients. As a result, Part A allocations were increased from the original level and then increased again in FY 2017. In response to potential gaps the insurance coverages, funds for Health Insurance Premium & Cost Sharing was maintained but reduced slightly due to availability of state-sponsored programs. Early Intervention Services (EIS) was increased to support efforts for HIV testing in the TGA. Support services, while changing slightly, remained relatively stable. MAI allocations remained unchanged. See Table 5.

Table 5
Changes in Resource Allocations
FY 2017

Increased	No Change or Not Funded	Decreased
Part A Core Services		
Ambulatory/Outpatient Medical Care (from 23.69% to 24.04%) Oral Health Care (from 15.52% to 16.26%) Mental Health Counseling (from 4.26% to 4.32%) Medical Case Management (from 15.75% to 15.98%)	AIDS Drug Assistance Program (ADAP)/AIDS Pharmaceutical Assistance (local)/Home & Community-based Health Services - not funded	Early Intervention Services (from 2.41% to 2.36%) Substance Abuse Treatment (from 8.17% to 7.22%) Health Insurance Premium & Cost Sharing Assistance (from 0.62% to 0.55%)
Part A Support Services		
		Non-Medical Case Management (from 10.61% to 10.41%) Outreach Services (from 3.45% to 3.49%) Housing Services (from 0.24% to 0.23%) Medical Transportation Services (from 3.55% to 3.49%) Emergency Financial Assistance (0.27% to 0.23%) Psychosocial Support Services (from 0.40% to 0.41%) Food Bank/Home Delivered Meals (from to 1.83% to 1.91%) Legal Services/Permanency Planning (from 0.89% to 0.80%)
MAI		
	Non-Medical Case Management (37.76%) Substance Abuse Treatment (43.49%) Outreach Services (13.75%) Health Education/Risk Reduction (5.00%)	

At the conclusion of the voting process, it was clear to the Planning Council that results would be able to support the 75/25 requirement. To accommodate their decision to comply with the requirement rather than authorize a waiver application. The Planning Council believes the changes in FY 2017 percentages are not significant, and the monetary impact would be manageable.

V. DIRECTIVES TO THE RECIPIENT

Specific recommendations to the Recipient were developed for all service categories combined and for each individually. Directives focused on funding practices as well as steps to support the National AIDS Strategy, HRSA priorities, the ACA, the Comprehensive HIV Health Services Plan, the EIIHA Plan, the Quality Management Plan and administrative mechanism requirements.

FY 2017 DIRECTIVES TO THE RECIPIENT

Global Directives

1. Continue to correlate Part A services with requirements of the Affordable Care Act. Identify, monitor and track insurance access issues. Monitor strategies to address emerging gaps in services that may result from implementation of the Act. Provide feedback on how providers are negotiating services to match the Affordable Care Act.
2. Continue to direct sub-recipients to require new enrollees in Part A and MAI services to complete the needs assessment consumer survey, and tie this requirement to billing.
3. Provide technical assistance on implementing the newly revised standards and policies.
4. The Recipient shall provide an annual written and oral report on progress with implementation of the Comprehensive HIV Health Services Plan, the EIIHA Plan and the Quality Management Plan as pertains to Recipient's responsibilities. This report shall be undertaken in concert with quarterly progress reviews by the Planning & Development Committee, included in the annual report to the Planning Council, discussed at scheduled recipient meetings, and available to Steering Committee in advance of the Administrative Mechanism Review at the end of the fiscal year.
5. The Recipient shall submit a Semi-annual Report in January and July to the Steering Committee, the Planning & Development Committee and the Planning Council on the effectiveness and compliance of directives. This narrative report shall provide specific documented evidence of compliance with each of the bulleted directives. This report shall be incorporated into the Council's Priority Setting Process as well as the Administrative Mechanism Review.
6. Continue to support the HIV Care Continuum in the Bergen-Passaic TGA, moving toward achievement of sustainable viral suppression. The Recipient will disseminate information on progress made in concert with the Quality Management Team and Planning Council sponsored collaboratives. Work in partnership with the Planning Council to utilize the HIV Care Continuum for planning purposes.
7. Implement the Planning Council's health literacy plan.
8. Recipient shall advance Cultural Competency Recommendations along with Stigma Reduction activities.
9. Recipient shall implement the Bergen-Passaic TGA Integrated Plan with that of the New Jersey Department of Health Division of HIV, STD, TB Services. This shall include facilitating the integration of prevention at care sites.

Service Category Directives

Core Services	
Mental Health Therapy	• Explore gaps in mental health support groups targeted to HIV.
Medical Case Management	• Determine the need for evaluating the primary case management system as directed in the Comprehensive Plan (Goal II, Objective 4)
Support Services	
Outreach	• Continue to direct funding for outreach services within the EIIHA target populations and communities. • Continue to coordinate quarterly meetings to facilitate outreach to the EIIHA target populations.
Health Education and Risk Reduction	• Continue to direct funding for health education and risk reduction within the EIIHA target populations and communities. • Continue to coordinate quarterly meetings to facilitate HERR to the EIIHA target populations.
Housing Services	• Continue to provide housing assistance only to those persons who are not eligible for HOPWA assistance and/or when HOPWA funds are not available.
Medical Transportation Services	• Encourage sub-sub-recipients to dedicate up to 5% of the total medical transportation funds for needed off-hour services.
Emergency Financial Assistance	• Allocate funds to short-term rental assistance and specialty food/dietary assistance only.

VI. CONTINGENCY SCENARIOS

In the event that FY 2017 funding levels significantly change from the prior fiscal year, the Planning Council determined the following course of action. Motions and votes from the Planning Council are detailed in Exhibit C.

Scenario 1: If funding is up to 20% (+/-) of the FY 2013 award, the Recipient will distribute funds proportionately in accordance with percentages established by the Planning Council.

Scenario 2: If funding is increased or decreased by more than 20%, the Planning Council will convene to revise the previously established allocations.

EXHIBIT A
Abbreviations Used in This Report

ACA	Affordable Care Act
ACCAP	AIDS Community Care Alternatives Program
ADAP	AIDS Drug Assistance Program
CARS	Client Acuity Rating System
EIIHA	Early Identification of Individuals with HIV/AIDs
EIS	Early Intervention Services
FY	Fiscal Year
HERR	Health Education and Risk Reduction
HIP&CS	Health Insurance Premium and Cost Sharing
HIV	Human Immunodeficiency Virus
HOPWA	Housing for People with AIDS
HRSA	U.S. Department of Health & Human Services, Health Resources & Services Administration
MAI	Minority AIDS Initiative
MSM	Men who have sex with men
PLWH	Persons Living with HIV/AIDS
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Need
TGA	Transitional Grant Area

EXHIBIT B
Priority Ranking Motions from the Planning Council
July 12, 2016

Planning & Development (P&D) Committee Report by Chairwoman, Karen Walker **Priority Setting Process**	Today we begin the Priority Setting Process for the funding that will occur next year. o A slideshow presentation on the Priority Setting "Rule of Thumb" was done by Jerry Dillard. o Tthe service category definitions were read so that the Council may RANK them in order of PRIORITY. The Council also referred to the Workbook Part One at the same time. The Data Workbook shows responses from Consumer Survey about the need of services. o **Motion #2**: John Frederick made a motion to keep the same rankings as last year and the motion was seconded by Freddy Rodriguez. **Vote: 4-YES, 15–NO, 2-ABSTAIN** o There was a lengthy discussion and explanation about the separation of ranking and funding. The ranking does not determine the amount of funds a service category receives.
Priority Setting Process	o **MMotion #3**: Providencia Zeno-Martinez made a motion to only modify the existing rankings and the motion was seconded by Khalilah Daniels. **Vote: 21-YES, 2–NO** o EEach ranking will be looked at because it is the Council's obligation to be in tune with the needs of the community based on the current data available. Motions to Modify Existing Rankings o **MMotion #4**: Paula Tenebruso made a motion to move Food Bank/Home Delivered Meals to #16 and Home Health Care to #23 and the motion was seconded by Graziela Ferreria. **Vote: 20-YES, 0–NO** o **MMotion #5**: Paula Tenebruso made a motion to move Substance Abuse Services (Outpatient) to #13 and Treatment Adherence Counseling to #15 and the motion was seconded by Anjettica Boatwright. **Vote: 15-YES, 0–NO** o **MMotion #6:** Joey Wiscovich made a motion to move Early Intervention Services to #2 and Oral Health Care to #8 and the motion was seconded by Anjettica Boatwright. **Vote: 2-YES, 14–NO** o **MMotion #7**: Dora Robinson made a motion to keep the same MAI rankings, and the motion was seconded by John Frederick. **Vote: 17-YES, 0-NO**

	○ **MMotion #8**: John Frederick made a motion to rank for the first time, the unranked categories, and it was seconded by Kathleen DeMichele. **Vote: 17-YES, 0–NO** ○ **MMotion #9**: Mark Anderson made a motion to make Pediatric Dvlpmnt. #31 and Permanency Planning #30, the motion was seconded by Kathleen DeMichele. **Vote: 17-YES, 0–NO**

RANKING FINAL RESULTS

	PART A RANKING AS OF JULY 12, 2016	Votes to Accept New Ranking
CORE SERVICES		
Ambulatory/Outpatient Medical Care OB/GYN Care Specialty Care	1	20-YES
AIDS Drug Assistance Program (ADAP treatments)	6	20-YES
AIDS Pharmaceutical Assistance (local)	7	21-YES
Oral Health Care	2	21-YES
Early Intervention Services	8	19-YES
Health Insurance Premium & Cost Sharing Assist.	18	22-YES
Home Health Care	23	22-YES
Home and Community-based Health Services	22	23-YES
Hospice Services	24	23-YES
Mental Health Services	3	16-YES
Medical Nutrition Therapy	19	23-YES
Medical Case Management (including Treatment Adherence)	4	17-YES
Substance Abuse Services Outpatient	13	17-YES
SUPPORT SERVICES		
Case Management - Non-medical	5	15-YES
Child Care Services	27	22-YES
Pediatric Development Assessment and Early Intervention Services	31	23-YES
Emergency Financial Assistance	12	22-YES
Food Bank/Home Delivered Meals	16	19-YES, 1- NO
Health Education/Risk Reduction	21	19-YES
Housing Services Long Term Housing Services Short Term	10	18-YES
Legal Services	17	22-YES
Linguistic Services	28	22-YES
Medical Transportation Services	11	21-YES
Outreach Services	9	15-YES

Permanency Planning	30	21-YES
Psychosocial Support Services	14	16-YES
Referral for Health Care/Supportive Services	20	22-YES
Rehabilitation Services	26	23-YES
Respite Care for Children Respite Care for Adults	29	22-YES
Substance Abuse Services - Residential	25	16-YES
Treatment Adherence Counseling	15	19-YES

Priority Setting Process	**FUNDING VOTING RESULTS**	
	CORE	**VOTES**
	Ambulatory/Outpatient Medical Care OB/GYN Care Specialty Care	YES by 18
	AIDS Drug Assistance Program (ADAP treatments)	NO
	AIDS Pharmaceutical Assistance (local)	NO
	Oral Health Care	YES by 19
	Early Intervention Services	YES by 14
	Health Insurance Premium & Cost Sharing Assist.	YES by 18
	Home Health Care	NO
	Home and Community-based Health Services	NO
	Hospice Services	NO
	Mental Health Services	YES by 14
	Medical Nutrition Therapy	NO
	Medical Case Management (including Treatment Adherence)	YES by 12
	Substance Abuse Services Outpatient	YES by 15
	SUPPORT	
	Case Management - Non-medical	YES by 11
	Child Care Services	NO
	Pediatric Development Assessment and Early Intervention Services	NO
	Emergency Financial Assistance	YES by 15, 6 nays
	Food Bank/Home Delivered Meals	YES by 19
	Health Education/Risk Reduction	NO
	Housing Services Long Term Housing Services Short Term	YES by 17
	Legal Services	YES by 20
	Linguistic Services	NO
	Medical Transportation Services	YES by 17

	Outreach Services	YES by 14
	Permanency Planning	NO
	Psychosocial Support Services	YES by 17
	Referral for Health Care/Supportive Services	NO
	Rehabilitation Services	NO
	Respite Care for Children Respite Care for Adults	NO
	Substance Abuse Services - Residential	NO
	Treatment Adherence Counseling	NO
MAI RESULTS	Ambulatory/Outpatient Medical Care OB/GYN Care Specialty Care	1
	AIDS Drug Assistance Program (ADAP treatments)	13
	AIDS Pharmaceutical Assistance (local)	14
	Oral Health Care	5
	Early Intervention Services	6
	Health Insurance Premium & Cost Sharing Assist.	20
	Home Health Care	23
	Home and Community-based Health Services	21
	Hospice Services	27
	Mental Health Services	2
	Medical Nutrition Therapy	19
	Medical Case Management (including Treatment Adherence)	4
	Substance Abuse Services Outpatient	18
	SUPPORT	
	Case Management - Non-medical	3
	Child Care Services	26
	Pediatric Development Assessment and Early Intervention Services	31
	Emergency Financial Assistance	8
	Food Bank/Home Delivered Meals	17
	Health Education/Risk Reduction	22
	Housing Services Long Term Housing Services Short Term	7
	Legal Services	15
	Linguistic Services	28
	Medical Transportation Services	9
	Outreach Services	10
	Permanency Planning	30

	Psychosocial Support Services	11
	Referral for Health Care/Supportive Services	12
	Rehabilitation Services	24
	Respite Care for Children Respite Care for Adults	29
	Substance Abuse Services - Residential	25
	Treatment Adherence Counseling	16

EXHIBIT C
Resource Allocations Motions from the Planning Council
August 2, 2016

AGENDA ITEM	DESCRIPTION
Planning & Development (P&D) Committee Report by Chairwoman, Karen Walker	• The date of the monthly P&D Committee meeting was changed due to mandatory case management training. The committee will meet Aug. 3rd at the Paterson Library, at 9:30 a.m. • Today, the council will look at those categories to be funded and MAI. • She informed the council that not everything can get more money because there is a limited amount of dollars. This process is for next year and the assumption is that the grant award will be almost, if not exactly, the same as the current year. • Members are not allowed to make an impassioned plea, if they are in conflict with the topic being discussed.

Resource Allocation Process	• The members reviewed the worksheet titled FY2017 Resource Allocations Data Summary. Pat Virga provided instructions and described how to read the layout of the workbook. • All questions regarding utilizations and adjustments were directed to the Recipient. • Some members expressed their confusion about the numbers and/or percentages not providing a clear or concrete picture. Discussions took place about newly diagnosed patients, coverage for undocumented patients and the effects of the Affordable Care Act. • The members reviewed the slideshow named Rule of Thumb. • The Priority Setting Workbook FY2017 – Part Two, was used to begin the resource allocations. • Midway through the resource allocation process, as a result of the clicker system's response, members were not satisfied with the amount of time it took to complete one vote. • Motion #2: Khalilah Daniels made a motion, seconded by Anjettica Boatwright, to move on to the next vote, after three attempts AND if the final count of needed votes was only missing 1 vote. Vote: 21-YES and 0–NO

Results	2017 RANKING	SERVICE CATEGORY (CORE)	FY 2017	PERCENT
	1	Ambulatory/Outpatient Medical Care	21.71%	
	2	Oral Health Care	15.28%	
	3	Mental Health Therapy and Counseling	5.04%	
	4	Medical Case Management	16.15%	
	8	Early Intervention Services	3.50%	
	13 18	Substance Abuse Services Outpatient	8.76%	
		Health Insurance Premium & Cost	1.68%	4.50% = 75.23%
		Sharing Total Core	70.73%	
Results		SERVICE CATEGORY (SUPPORT)		
	5	Case Management - Non-medical	10.42%	
	9	Outreach Services	3.51%	
	10	Housing Services	0.23%	
	11	Medical Transportation Services	3.49%	
	12	Emergency Financial Assistance	0.23%	
	14	Psychosocial Support Services	0.41%	
	16	Food Bank/Home Delivered Meals	1.91%	
	17	Legal Services/Permanency Planning	0.80%	3.78% = 24.77%
		Total Support	20.99%	
Results		MAI		
	3	Case Management - Non-medical	2.28%	
	25	Substance Abuse	4.50%	
	10	Outreach Services	1.13%	
	22	Health Education and Risk Reduction	0.38%	
		Total MAI		
Results				

- Motion #3: Paula Tenebruso made a motion, seconded by Elaine Halstead, to accept the results as is.

  Vote: 20-YES and 0–NO

- The FY2016 Contingency Scenarios was reviewed and discussed.
- Motion #4: John Frederick made a motion, seconded by Eddie Johnson, to keep the contingency scenarios the same as last year (2016).

  Vote: 19-YES and 0–NO