

HIV Service Delivery Administration Workgroup Report  
& Governor's Advisory Council on HIV/AIDS  
Letter to Governor Gregoire

December 4, 2009



DOH150-041 December 2009

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**GACHA**  
**Governor's Advisory Council on HIV/AIDS**  
P.O. Box 47844  
Olympia, WA 98504-7844

December 4, 2009

The Honorable Christine O. Gregoire  
Governor of the State of Washington  
P.O. Box 40002  
Olympia, WA 98504-0002

Dear Governor Gregoire:

On November 10, 2009, your Advisory Council on HIV/AIDS held a public forum in Seattle to discuss recommendations made by a workgroup and to obtain public input regarding the current HIV service delivery system in Washington State. Here are our recommendations.

- The Department of Health should be granted the flexibility to establish a planning and services delivery system to address HIV care and prevention needs. But the Department shall propose its changes to the administrative system for HIV services to the Governor's Advisory Council on HIV/AIDS (GACHA) for input and review. GACHA shall take steps to ensure full public participation in its review process. (While GACHA's role is limited to input and not approval, GACHA, as always, reserves its role to publicly advise the Governor on whether it agrees, or disagrees with any new delivery system.)
- In its review of the new delivery system, GACHA shall ensure the epicenter of the epidemic is recognized, but that the diverse needs of the entire state, including its rural counties and lower prevalence areas, are represented and protected.
- To the extent possible, any new delivery system shall use existing state prevention and care planning bodies with local and consumer input.
- Any new delivery system shall limit the impact and disruption on consumers.

### **Background**

In 2009, the Governor's Advisory Council on HIV/AIDS (GACHA) and the Department of Health established a workgroup to:

- Examine the administrative costs and benefits of continuing the current AIDSNET system compared to a Department administration.
- Identify other possible structures to assure the system is as efficient as possible in delivery of services.
- Develop final draft recommendations for GACHA. This information may be useful in responding to House Bill 2360 during the 2010 legislative session.

The workgroup conducted three teleconferences and one in-person meeting. The recommendations of the workgroup were the focus of a public forum conducted by GACHA in the Seattle area, with additional participation via teleconference from five other locations in the state.

## **Summary of Key Arguments and Findings**

### *From the Workgroup*

The six regional AIDSNETs were established by the legislature in 1988, with the boundaries reflecting existing regions established by the then Department of Social and Health Services. The regional structure was also seen as a way to ensure that state funds would be passed thru to local communities and to assure community input in the development and maintenance of HIV/AIDS care and prevention service decisions.

The administrative cost of the AIDSNETs system and the savings achieved by its elimination is in dispute. A DOH fiscal note (prepared in response to HB2360) projected reduced administrative costs of \$710,000 in FY10, with additional reduced costs in FY11 in comparison to legislative estimates. But the AIDSNETs Council takes issue with these figures, suggesting the legislature overestimates current administrative costs, and DOH underestimates the true costs to the DOH for centralized administration of HIV services, including the need to take responsibility from local health jurisdictions for mandated services such as planning and coordination. While agreeing that elimination of the AIDSNETs would yield savings, the AIDSNETs council asks: at what cost to local input and coordination?<sup>1</sup>

Seeking a comparison, the workgroup reviewed how HIV services are administered in four states (Colorado, Louisiana, Arizona, Michigan) with similar demographics to Washington (one large population center with other less-impacted and rural areas). This review found that while several of the states operated a regional delivery system at some point, none currently do. All are centrally administered with varying methods to maintain regional and consumer input – from statewide planning councils with mandated regional representation, to mandated consumer

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<sup>1</sup> *AIDS Services and Costs (attached)*

panels for each recipient of a state contract award. The review also found these centralized systems were not universally able to maintain satisfactory local input.<sup>2</sup>

The workgroup formulated a range of recommendations, from fewer AIDSNETs drawn either along geographic (eastern/western) lines, to new regions determined by the demographics and geographic foci of the epidemic. By consensus, the workgroup endorsed giving DOH maximum flexibility in the design of a new system with the caveat that certain values such as community input, transparency and results, be protected.<sup>3</sup>

*From the Public Forum*

The number of people living with HIV in Washington State has never been larger. Those with HIV are living longer while new infections continue to outnumber AIDS deaths and add to the caseload of both public and private providers.

State funding for HIV services – static for several years – was cut [by 14%] in 2009 [for the state fiscal year, 7/09 and 6/30/10] in response to the state's economic distress. Given the state's shrinking revenue forecasts, and recently estimated \$2.8B deficit, further reductions in funding for HIV services are expected in 2010.

With most care services funded through federal Ryan White allocations, elimination of the AIDSNETs would have relatively little impact on patient care, mostly outside King County. The majority of the impact will be felt in prevention planning and programs.

While elimination of the current AIDSNET structure will impact each region differently, there is consensus among AIDSNET administrators on these points:

- Flexibility, which has allowed each region to effectively develop and respond to the changing epidemic (often with innovative strategies), will be eliminated or at least greatly reduced.
- Some local health jurisdictions might abandon mandated services, such as anonymous HIV counseling and testing, and partner counseling and referral, because they would have too few cases to justify applying for DOH resources.
- The effective voice of AIDSNETs in achieving important public policy changes (like routine testing and opt-out testing for pregnant women) will be lost.
- Local monitoring of local programs will end.
- Local input in planning, accountability, policy development, coordination and collaboration could be lost [if DOH decided to abandon local prevention planning].

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<sup>2</sup> *State HIV/AIDS Systems Interview Results (attached)*

<sup>3</sup> *Values for Washington's HIV/AIDS Service Delivery Administration System (attached)*

- Critical technical assistance and support to local providers could no longer be accomplished by local public health and could become a DOH responsibility.

King County (Region IV), home to the majority (63%) of living HIV cases, prefers that in any reorganization, it be left “as is.” If it is not:

- King County HIV prevention planning would cease, with responsibility for prevention planning shifting to the statewide planning group where King County is currently greatly underrepresented, given it has nearly 2/3 of the state’s HIV cases (both existing and new.)
- Some county prevention planning would likely be defunded, and controversial but effective local prevention programs might not be possible with planning at the state level.
- King County will compete with community-based organizations for state DOH resources.
- King County might expect a larger share of CDC and state prevention dollars, as the current AIDSNET structure has provided fewer dollars for urban than for rural cases of HIV.

In fact, fear that King County will suck up all the state’s prevention dollars is a major concern of community-based organizations, AIDS service organizations and consumers not in King County.

Regions with lower prevalence rates worry that without access to funds provided by the current system, there will be less regional funding thus impacting their work, including the ability to reach important at-risk communities unique to their areas. (For example, Hispanic men who have sex with men and injection drug users.)

Local communities fear a centralized system (based in Olympia) will be less responsive to local needs. And that local voices and input will be lost—with this disenfranchisement leading to a loss of empowerment at the local level. Community activists are likely to become less involved, resulting in HIV disappearing from the radar screen of many communities.

There is worry by local communities that if the current AIDSNET structure is dismantled, a new system, designed by DOH will not offer the same security of a system prescribed by the legislature—that even if a new DOH-designed system protects regional interests in the short-term, those policies could be easily changed by a new administration in future years.

There is support for some refinements of the current AIDSNET structure, including opening service contracts to more competition beyond the local health jurisdictions—a change which community-based organizations—potential bidders for the contracts—suggest could offer potential savings. Communities outside of King County want equal access to funding protected.

Whatever changes are made to the current structure, there is universal support for a system which empowers and retains regional and local voices.

GACHA's structure has the flexibility to ensure all stakeholders are invited to the table in any future discussions evaluating a new HIV delivery system.

### **Complete Findings**

On costs of the current AIDSNET system, a legislative budget note estimates administrative costs of at least \$1,067,000 in FY10. The DOH estimates its new administrative costs would be \$357,000 for the same period, resulting in a net savings of \$710,000 for HIV prevention services. Complete details of the cost estimate of a centralized delivery structure are found in attachments to this report, as are counter arguments offered by the AIDSNETs.

A review of HIV delivery systems in four states found none with a regional system. See appendix 7 for complete information regarding each states system.

The discussions and product of the workgroup, beyond those summarized in the *Key Arguments and Findings* section of this report are attached.

Comments from the public forum (as recorded in GACHA's minutes):

Participants included those at the forum as well as other members of the public able to participate by conference call at the following sites:

- Evergreen AIDS Foundation
- Pierce County AIDS Foundation
- Public Health-Seattle and King County
- Skagit County Health
- Spokane AIDS Network
- Yakima County Health District
- Department of Health

#### **Overview of House Bill (HB) 2360 – Representative Jeannie Darneille, 27<sup>th</sup> District:**

Elected to the Legislature in 2000. Her background is as an activist and she's served in a number of positions prior to her election. Representative Darneille stated she was appointed as an ex-officio member to GACHA by Governor Locke. She currently serves on two fiscal committees: General Government Appropriations (Chair) and Ways and Means.

The 2009 legislative session was difficult. Before the session began, the shortfall was \$5B and by the end of session, the Legislature had to address a \$9B shortfall. More than 30 accounts were swept to cover half of the deficit.

The goal of HB 2360 was to look at the current administrative structure. Could funds be used more efficiently while service continued to be available? The Regional AIDSNETs receive a large amount of GFS dollars within the DOH. This crisis presented an opportunity to take a closer look at the structure.

The epidemic is changing stated Representative Darneille: there are more infections and people are living longer.

**Panel Discussion – John Peppert, Bob Wood, David Heal, Ed Wilhoite, Jill Dickey**

Bob Wood – HIV/Disease Control Officer, Public Health-Seattle and King County  
GACHA member and current Chair of the AIDSNETs Council

Impacts on King County and consensus concerns of the AIDSNETs Council

- King County (KC) wishes to remain a region as they are now.
- KC HIV prevention planning would cease and care planning would change slightly
- KC and other CBOs would receive their funds and support from the DOH.
- Public Health – Seattle and King County (PHSKC) would compete with CBOs for resources to perform public health mandated prevention and care services.
- DOH would coordinate prevention services in all regions.
- KC staff would be lost.
- KC would lose the flexibility of the current Omnibus funds to apply to shifting needs.
- The proportion of funds received by King County does not match the epidemic.

Ed Wilhoite, Evergreen AIDS Foundation, Executive Director

- Doesn't support HB 2360 as written; not prescriptive enough.
- Reorganization of the AIDSNETs is favored by his organization.
- Competing with the lead county for funds in his Region doesn't work well.
- Wants to know what the trade-offs for prevention would be with the proposed savings.
- Local input is important.
- Preferred the consortia system-natural geographic areas for planning.
- Review the mandated services to determine if still needed.

David Heal, Region 6 Coordinator, GACHA member  
Values of the AIDSNETs system

- Locals provide input in planning, accountability, policy development, coordination, and collaboration.
- Regional structure provides efficiency in bringing people together and creating programs.

- Voices of approximately 200 individuals would be lost statewide if current structure eliminated.
- Technical assistance and support can be provided to service providers by [?local] advisors and dedicated staff.
- Information flow is very efficient in the current system.
- Epidemiological information is quickly available when requested.
- Contract monitoring and oversight is readily available.
- Services offered are tailored as needed.

Jill Dickey, Blue Mountain Heart to Heart, Program Director

The agency covers Columbia and Walla Walla Counties and part of Asotin County. She has held her position for six months.

**(The AIDSNET structure) currently works**

- Prioritization of populations (works for rural area)
- Gas vouchers made available to clients

**Concerns**

- The loss of funding if AIDSNETs is eliminated.
- The possibility of being overlooked due to a low prevalence of cases.
- Access to meetings to provide input. Long distance to travel from rural area. Suggested using telephone conferencing, providing airline tickets to attend large state meetings.

Heart to Heart likes the idea of receiving funds from DOH for the services they provide.

**General Public Comment:**

- Local oversight is a must.
- Client representation, input needs to continue. Authority is not clear now and needs to be.
- Regional planning groups are important. Clarity is necessary for the planning body, what authority they have, and in the planning process.
- Smaller [and all?] regions would like to receive more funds.
- There was a lack of opportunity for public comment/participation around this process.
  - Meetings were closed.
  - Conflict of interest.
  - Minority groups were not represented.
  - Lack of transparency.
- Supports leaving King County as is.
- Voice of all at-risk need representation. Public input has decreased since the consortia system disbanded.
- Concerned about centralizing power with DOH. People, small organizations may be lost or ignored. No security is in place if changes occur.
- More fiscal analysis is needed regarding a shift in the service delivery system.

- Community involvement is important.
- Distribute funds equitably.
- Benefited from technical and moral support of regional coordinator.
- Some sort of grouping needed for critical mass around funds received, services provided.
- Keep HIV on the radar screen.
- Final recommendations of the workgroup have no teeth.
- Small programs or entities could be lost if an epicenter structure is set-up.
- Current delivery system is unsustainable. Need a new mechanism that delivers funds to local agencies.
- Make bidding process transparent-look for [and avoid?] any conflict of interest.
- Continue to use care planning bodies as possible.
- Have a mechanism in place so high-risk programs continue.
- Make sure changes are cost effective.

**GACHA Comments:**

- Mandates in law require administrative costs.
- Nothing in existing state law requires community input. The value of input is recognized at both the state and regional level.
- Look to current providers/systems in place should a bill pass.
- Problem identified with no articulated solutions outlined in the bill other than DOH will take care of the system.
- Evaluate case management for efficiencies.
- CBOs were asked if they have resources/structure in place to compete and respond to an RFP process. Some said they were able, others were not. All said they could maintain a consumer advisory panel, if required.
- Overhead taken provides for infrastructure.
- GACHA's structure has the flexibility to invite more stakeholders to the table to ensure all are represented when evaluating a new delivery system.

# HIV Service Delivery Administration Workgroup Report

## 2009



DOH150-041 December 2009

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## ***Background***

The Washington State Legislature established the AIDS Omnibus Bill in 1988. This legislation created a system to plan and deliver HIV services in Washington State. The Department of Health (Department) funds and supports services through this system known as the regional AIDSNETs. The lead agency for each region is the local health jurisdiction (LHJ) in the largest county. The lead agency is the head of finances and planning for the region.

### *Introduction of House Bill 2360 – Concerning consolidation of administrative services for AIDS grants in the Department of Health*

The 2009 Washington State Legislative Session was preceded by a significant national economic downturn that placed a large strain on state budgets across the United States. House Bill 2360 was one of many bills introduced during the session to achieve a cost savings and help fill a budget deficit of over \$8 billion for the 2009-2011 biennium. This bill would:

- Eliminate the AIDSNETs and regional HIV/AIDS planning activities
- Direct the Department to distribute grants directly to community service providers rather than through the AIDSNETs

The Department estimated a need for 2.0 FTE to manage approximately 50 new contracts and conduct planning activities at \$357,000 in fiscal year 2010 and \$337,000 in 2011.

House Bill 2360 did not pass. While Washington's economic experts believe that the worst of the down turn is behind us, consumer spending has not returned to normal levels and Washington is facing another tight budget year for 2010. State lawmakers are again expected to consider eliminating the AIDSNETS to reduce costs to the state.

## ***HIV/AIDS Service Delivery Administration Workgroup***

The Department formed the HIV Services Delivery Administration Workgroup in July 2009. The workgroup's purpose was to:

- 1) Examine the administrative costs and benefits of continuing the current AIDSNET system compared to a Department administration;
- 2) Identify other possible structures to assure the system is as efficient as possible in delivering services; and
- 3) Develop final draft recommendations for the Governor's Advisory Council on HIV/AIDS (GACHA).

GACHA will seek community input on proposed recommendations prior to finalizing and submitting to the Department, Governor Gregoire, and others for use in responding to House Bill 2360 during the 2010 legislative session.

This workgroup focused on how to efficiently and effectively administer funds. The workgroup's intent did not include evaluating what proportion of available funds are allocated to various locations or what services are funded.

The workgroup included 12 members representing a variety of HIV/AIDS service stakeholders across the state including:

- Non-profit AIDS service organizations
- Local Health Jurisdictions

- Regional AIDS Service Networks
- Governor’s Advisory Council on HIV/AIDS (GACHA)
- Early Intervention Steering Committee
- Department of Health

The workgroup held four scheduled two-hour conference calls between July 21 and September 21. The group met in-person on October 8 to develop final draft recommendations. Appendix 4 provides a brief summary of each of the conference calls.

HIV/AIDS Service Delivery Administration Workgroup members included: Al Brownell; Peter Browning; Frank Chaffee; Mark Garrett; David Heal; Tim Hillard; David Lee; Joel McCullough; Beverly Neher; John Peppert; David Richart; Erick Seelbach; Duane Wilkerson; and Bob Wood. Not all members were available for all of the conference calls or were present at the October 8, 2009 meeting.

John Peppert was the only Department staff member on the workgroup. Four other Department staff members provided meeting support (scheduled conference calls and meeting space, assisted in research and document preparation and attended conference calls and in-person meetings). Other Department staff were Richard Aleshire, Lynn Johnigk, Brown McDonald, and Tracy Mikesell

The workgroup reviewed or developed materials to help make final draft recommendations for the HIV/AIDS Service Delivery Administration System. The materials include:

- Comparison of House Bill 2360 to the current AIDSNET system
- Comparison of four states’ HIV/AIDS service delivery systems
- Summary of mandated HIV/AIDS related services for local public health and Department of Health “Office on AIDS”

All of the materials included in this review are in the appendices. A summary of these materials are on the final page of this report. Actual documents serve as Appendices 1 – 11.

## ***Proposed and Final Draft Recommendations and Values for Washington’s HIV/AIDS Service Delivery Administration System***

*(developed by members of the HIV/AIDS Service Delivery Administration Workgroup on October 8, 2009)*

### Proposed Recommendations for a New HIV/AIDS Administration System

1. Leave King County as is including current process to receive and distribute funds
2. Merge AIDSNET regions 4, and part of 3 and 5 where cases are concentrated including planning and coordination
  - Pierce
  - King
  - Snohomish
  - Possibly Island
3. Planning possibly aggregated at state level with appropriate representation
  - Services delivery may need local break down closer to communities (take an epicenter approach)

4. Eastern and Western Washington “entity” to represent those part of state for service coordination
5. Part A care planning to remain with King, Snohomish and Island counties and part B with rest of state
6. Use Early Intervention Program as state care plan lead and State Planning Group as prevention lead
  - Increase representation on both planning bodies
7. Mandated services should be funded before non-mandated services
8. DOH will provide service coordination for both Part B and prevention
9. Use separate parity for care and prevention (based on new infections)
10. Preserve consumer community input – all grant recipients maintain a consumer panel (Colorado example)
  - Maybe include consumer panel requirement in contract
11. Ensure areas without an organization currently receiving funding – get some type of organizational representation
12. Minimize number of times prevention and care priorities change – extend contracts beyond a two-year cycle

#### Final Recommendations for a New HIV/AIDS Service Delivery Administration System

The Department of Health shall establish a planning and service delivery system to address care and prevention needs.

- Department to review future changes in the system with some type of empowered advisory body (not Early Intervention Program Steering Committee or State Planning Group)
- Preserve and encourage consumer input
- Recognize epicenter between the Everett – Tacoma corridor
- Use existing state prevention and care planning bodies to the extent possible
- Include funding for mandated services
- Limit the impact and disruption on consumers

#### Values for Washington’s HIV/AIDS Service Delivery Administration System (values not in priority order)

- Community Input – empowered “clout”
- Parity – distribution of funds urban/rural, statewide inclusion and representation, demographics
- Efficiency – non-redundancy
- Transparency
- Results – effectiveness in output
- Evaluation – quality control of administration system and contractors
- Support prevention of new cases and result in more individuals care
- Are mandated HIV services current? Should they be “on the table?”

- Support effective services
- Limit impact/ disruption to consumers
- Clear and fair request for proposal (RFP) process. People/entities that can provide services have the opportunity
- Economy of scale
- Balance of consumer and provider in community input
- Disease management and management of community needs
- Promoting effective coordination and collaborations that are logical and appropriate vs. “forced” collaboration
- Flexibility – don’t get constricted by state law to manage programs with limited resources
- Community responsiveness in addition to evidence and science-based interventions
- Use existing systems that work
- Ability to create new capacity (flexibility)
- Support/ promote/ apply innovation and creativity in new system
- Support maximum use of resources for rapid response to emerging needs
- Use existing administrative structures across care and prevention
- Ellensburg Agreement – principles may continue to guide community input
- Make workloads manageable
- Link prevention and care – example: planning interventions
- Effectively respond to new/ emerging technologies

## List of Included Appendices

Appendix 1 – Map of Washington’s AIDSNET Regions

Appendix 2 – House Bill 2360 – Concerning consolidation of administrative services for AIDS grants in the Department of Health

Appendix 3 – Fiscal Note for House Bill 2360

Appendix 4 – Conference Call Notes Summary for HIV/AIDS Service Delivery System Workgroup July – September 2009

Appendix 5 – 2009 AIDSNETS Cuts Summary September 1, 2009

Appendix 6 – AIDS Services and Costs (Current AIDSNETS, DOH and HB 2360)

Appendix 7 – State HIV/AIDS System Interview Results (four state comparison of Louisiana, Colorado, Michigan, and Arizona)

Appendix 8 – Summary of Mandates for Local Public Health Officials and for the DOH “Office on AIDS” in RCW 70.24

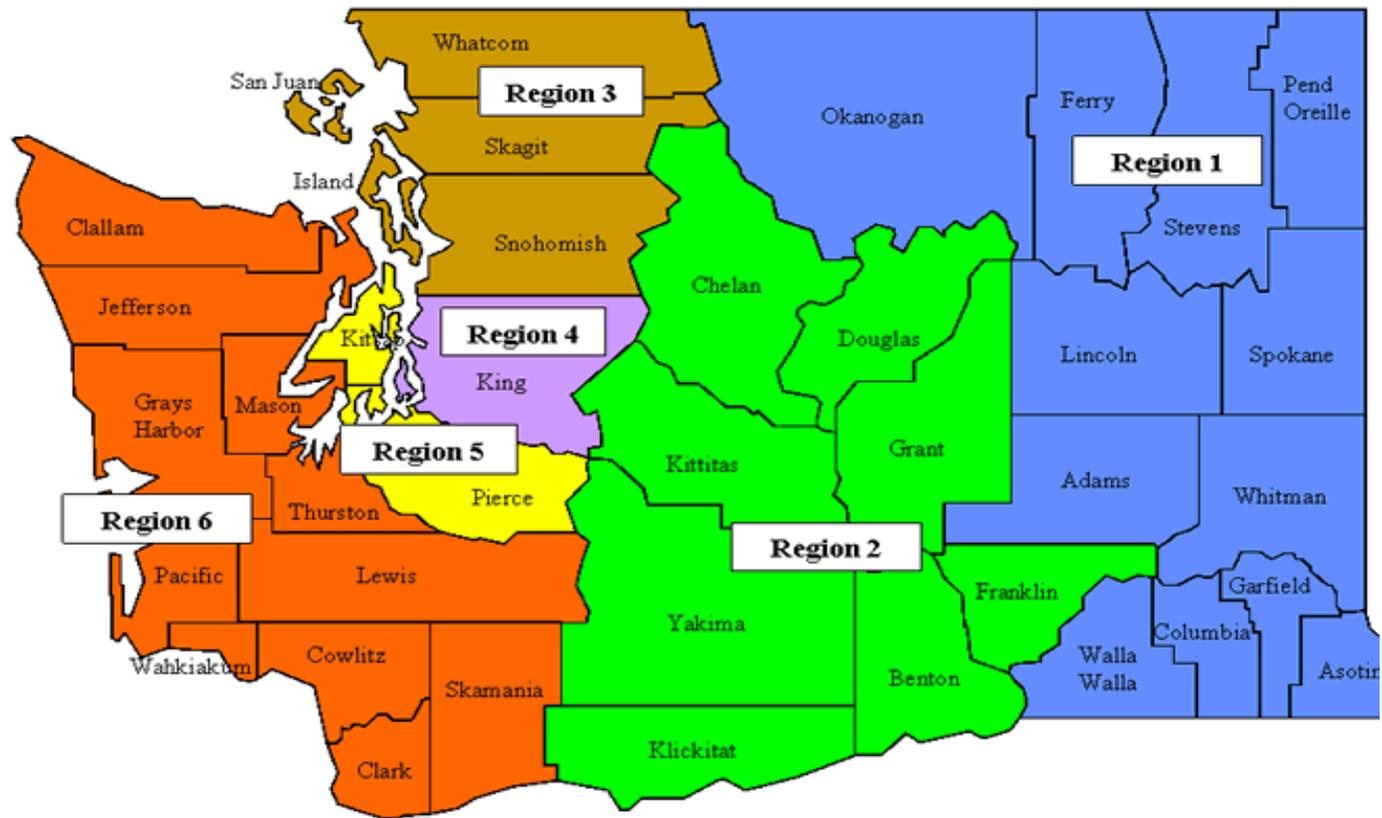
Appendix 9 – Current AIDSNETS System Value Added, With Examples

Appendix 10 - “Thoughts and Reflections on the Value of Money Redirected to CBOs for Prevention and Care Services”, Duane Wilkerson

Appendix 11 – Agenda for October 8, 2009 HIV/AIDS Service Delivery System Workgroup Meeting (Notes for this meeting are the final workgroup recommendations and values included in this report)

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## Washington State's Six AIDSNET Regions



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HOUSE BILL 2360

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State of Washington

61st Legislature

2009 Regular Session

By Representative Darneille

1 AN ACT Relating to consolidation of administrative services for  
2 AIDS grants in the department of health; amending RCW 70.24.400; and  
3 providing an effective date.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 70.24.400 and 1998 c 245 s 126 are each amended to  
6 read as follows:

7 ~~((The department shall establish a statewide system of regional  
8 acquired immunodeficiency syndrome (AIDS) service networks as  
9 follows:))~~

10 (1) The secretary of health shall direct that all state or federal  
11 funds, excluding those from federal Title XIX for services or other  
12 activities authorized in this chapter, shall be allocated to the office  
13 on AIDS established in RCW 70.24.250. The secretary shall further  
14 direct that all funds for services and activities specified in  
15 subsection ~~((3))~~ (4) of this section shall be provided ~~((to lead  
16 counties through contractual agreements based on plans developed as  
17 provided in subsection (2) of this section, unless direction of such  
18 funds is explicitly prohibited by federal law, federal regulation, or  
19 federal policy. The department shall deny funding allocations to lead~~

1 ~~counties only if the denial is based upon documented incidents of~~  
2 ~~nonfeasance, misfeasance, or malfeasance. However, the department~~  
3 ~~shall give written notice and thirty days for corrective action in~~  
4 ~~incidents of misfeasance or nonfeasance before funding may be denied.~~  
5 ~~The department shall designate six AIDS service network regions~~  
6 ~~encompassing the state. In doing so, the department shall use the~~  
7 ~~boundaries of the regional structures in place for the community~~  
8 ~~services administration on January 1, 1988.~~

9 ~~(2) The department shall request that a lead county within each~~  
10 ~~region, which shall be the county with the largest population, prepare,~~  
11 ~~through a cooperative effort of local health departments within the~~  
12 ~~region, a regional organizational and service plan, which meets the~~  
13 ~~requirements set forth in subsection (3) of this section. Efforts~~  
14 ~~should be made to use existing plans, where appropriate. The plan~~  
15 ~~should place emphasis on contracting with existing hospitals, major~~  
16 ~~voluntary organizations, or health care organizations within a region~~  
17 ~~that have in the past provided quality services similar to those~~  
18 ~~mentioned in subsection (3) of this section and that have demonstrated~~  
19 ~~an interest in providing any of the components listed in subsection (3)~~  
20 ~~of this section. If any of the counties within a region do not~~  
21 ~~participate, it shall be the lead county's responsibility to develop~~  
22 ~~the part of the plan for the nonparticipating county or counties. If~~  
23 ~~all of the counties within a region do not participate, the department~~  
24 ~~shall assume the responsibility.~~

25 ~~(3) The regional AIDS service network plan shall include the~~  
26 ~~following components:~~

- 27 ~~(a) A designated single administrative or coordinating agency;~~
- 28 ~~(b) A complement of services to include:~~
  - 29 ~~(i) Voluntary and anonymous counseling and testing;~~
  - 30 ~~(ii) Mandatory testing and/or counseling services for certain~~  
31 ~~individuals, as required by law;~~
  - 32 ~~(iii) Notification of sexual partners of infected persons, as~~  
33 ~~required by law;~~
  - 34 ~~(iv) Education for the general public, health professionals, and~~  
35 ~~high-risk groups;~~
  - 36 ~~(v) Intervention strategies to reduce the incidence of HIV~~  
37 ~~infection among high risk groups, possibly including needle~~  
38 ~~sterilization and methadone maintenance;~~

1 ~~(vi) Related community outreach services for runaway youth;~~  
2 ~~(vii) Case management;~~  
3 ~~(viii) Strategies for the development of volunteer networks;~~  
4 ~~(ix) Strategies for the coordination of related agencies within the~~  
5 ~~network; and~~  
6 ~~(x) Other necessary information, including needs particular to the~~  
7 ~~region;~~

8 ~~(c) A service delivery model that includes:~~  
9 ~~(i) Case management services; and~~  
10 ~~(ii) A community based continuum of care model encompassing both~~  
11 ~~medical, mental health, and social services with the goal of~~  
12 ~~maintaining persons with AIDS in a home like setting, to the extent~~  
13 ~~possible, in the least expensive manner; and~~

14 ~~(d) Budget, caseload, and staffing projections))~~ by the department  
15 directly to public and private providers in the communities.

16 ~~((+4))~~ (2) Efforts shall be made by both the counties and the  
17 department to use existing service delivery systems, where possible(~~(,~~  
18 ~~in developing the networks)~~).

19 ~~((+5))~~ (3) The University of Washington health science program, in  
20 cooperation with the office on AIDS, may, within available resources,  
21 establish a center for AIDS education(~~(,~~ ~~which shall be linked to the~~  
22 ~~networks)~~). The center for AIDS education is not intended to engage in  
23 state-funded research related to HIV infection, AIDS, or HIV-related  
24 conditions. Its duties shall include providing the office on AIDS with  
25 the appropriate educational materials necessary to carry out that  
26 office's duties.

27 ~~((+6) The department shall implement this section, consistent with~~  
28 ~~available funds, by October 1, 1988, by establishing six regional AIDS~~  
29 ~~service networks whose combined jurisdictions shall include the entire~~  
30 ~~state.~~

31 ~~(a) Until June 30, 1991, available funding for each regional AIDS~~  
32 ~~service network shall be allocated as follows:~~

33 ~~(i) Seventy five percent of the amount provided for regional AIDS~~  
34 ~~service networks shall be allocated per capita based on the number of~~  
35 ~~persons residing within each region, but in no case less than one~~  
36 ~~hundred fifty thousand dollars for each regional AIDS service network~~  
37 ~~per fiscal year. This amount shall be expended for))~~ (4) The  
38 department shall develop standards and criteria for awarding grants to

1 support testing, counseling, education, case management, notification  
2 of sexual partners of infected persons, planning, coordination, and  
3 other services required by law(~~(, except for those enumerated in~~  
4 ~~(a)(ii) of this subsection.~~

5 ~~(ii) Twenty five percent of the amount provided for regional AIDS~~  
6 ~~service networks)). In addition, funds shall be allocated for  
7 intervention strategies specifically addressing groups that are at a  
8 high risk of being infected with the human immunodeficiency virus.  
9 ~~((The allocation shall be made by the office on AIDS based on~~  
10 ~~documented need as specified in regional AIDS network plans.~~~~

11 ~~(b) After June 30, 1991, the funding shall be allocated as provided~~  
12 ~~by law.~~

13 ~~(7) The regional AIDS service networks shall be the official state~~  
14 ~~regional agencies for AIDS information education and coordination of~~  
15 ~~services. The state public health officer, as designated by the~~  
16 ~~secretary of health, shall make adequate efforts to publicize the~~  
17 ~~existence and functions of the networks.~~

18 ~~(8) If the department is not able to establish a network by an~~  
19 ~~agreement solely with counties, it may contract with nonprofit agencies~~  
20 ~~for any or all of the designated network responsibilities.~~

21 ~~(9) The department, in establishing the networks, shall study~~  
22 ~~mechanisms that could lead to reduced costs and/or increased access to~~  
23 ~~services. The methods shall include capitation.~~

24 ~~(10))~~ (5) The department shall reflect in its departmental  
25 biennial budget request the funds necessary to implement this section.

26 ~~((11))~~ (6) The use of appropriate materials may be authorized by  
27 ~~((regional AIDS service networks))~~ the department in the prevention or  
28 control of HIV infection.

29 NEW SECTION. Sec. 2. This act takes effect January 1, 2010.

--- END ---

# Individual State Agency Fiscal Note

<b>Bill Number:</b> 2360 HB	<b>Title:</b> Concerning consolidation of administrative services for AIDS grants.	<b>Agency:</b> 303-Department of Health
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## Part I: Estimates

No Fiscal Impact

### Estimated Cash Receipts to:

<b>FUND</b>					
<b>Total \$</b>					

### Estimated Expenditures from:

	FY 2010	FY 2011	2009-11	2011-13	2013-15
FTE Staff Years	2.4	2.4	2.4	2.4	2.4
<b>Fund</b>					
<b>Total \$</b>					

*The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.*

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

Legislative Contact: Chris Blake	Phone: 360-786-7392	Date: 04/15/2009
Agency Preparation: Stacy May	Phone: 360-236-3927	Date: 04/20/2009
Agency Approval: Jodine Sorrell	Phone: 360-236-4532	Date: 04/20/2009
OFM Review: Nick Lutes	Phone: 360-902-0570	Date: 04/23/2009

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## Part II: Narrative Explanation

### II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

*Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.*

Section 1: Directs the Department of Health (DOH) to distribute funds directly for services and activities specified in subsection 4.

DOH currently distributes the funding to six regional (AIDSNETS) lead agencies in Washington State. The AIDSNET regional lead agencies develop and implement each region's organizational and service plan for HIV prevention and HIV care.

Section 1(4): Directs DOH to develop standards and criteria for awarding grants to support services including: testing, counseling, education, case management, notification of sexual partners of infected persons, planning, coordination, and other services required by law. Additionally, funds are to be allocated for intervention strategies for individuals at risk for human immunodeficiency virus.

### II. B - Cash receipts Impact

*Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.*

### II. C - Expenditures

*Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.*

Section 1: DOH will no longer distribute funds through six regional (AIDSNETS) lead agencies in Washington State. The AIDSNET regional lead agencies will no longer develop and implement each region's organizational and service plan for HIV prevention and HIV care. The Statewide HIV Prevention Planning Group will take on new responsibilities for regional prevention planning, and the Early Intervention Program (EIP) Steering Committee will take on responsibility for care service planning. DOH will implement these plans through contract funds for services and activities to public and private providers in the communities. Total amount reduced from contracts is estimated to be \$259,000 pass through expenditures in fiscal year (FY) 2010 and \$239,000 in FY 2011 and ongoing to cover the DOH administrative costs listed below.

DOH will require 1.0 FTE Health Services Consultant (HSC) 4 and 1.0 FTE HSC 3 to coordinate development of statewide standards and criteria for prevention and care, coordinate a competitive contractual process, and set up and monitor approximately 50 new contracts, and conduct planning activities. Of the amount appropriated to DOH for this purpose, \$7,300,000 in FY 2010 and \$7,333,000 in FY 2011 and ongoing will be contracted directly to public and private providers in the communities. \$357,000 in FY 2010 and \$337,000 in FY 2011 will remain in DOH to cover administration and indirect costs. Therefore the net impact is zero.

Amounts listed above are based on 2007 – 2009 Biennium appropriation to DOH. The Governor, House and Senate proposed budgets include a reduction of approximately \$1,067,000 for the 2009 – 2011 biennium budget.

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FY 2010 and ongoing estimated expenditures include salary, benefit and related staff costs for 0.3 Fiscal Analyst 2 and 0.1 HSC 1 is needed for the agency's increased administrative workload.

### Part III: Expenditure Detail

#### III. A - Expenditures by Object Or Purpose

	FY 2010	FY 2011	2009-11	2011-13	2013-15
FTE Staff Years	2.4	2.4	2.4	2.4	2.4
A-Salaries and Wages	153,000	151,000	304,000	302,000	302,000
B-Employee Benefits	43,000	43,000	86,000	86,000	86,000
C-Personal Service Contracts	10,000	10,000	20,000	20,000	20,000
E-Goods and Services	29,000	29,000	58,000	58,000	58,000
G-Travel	3,000	3,000	6,000	6,000	6,000
J-Capital Outlays	18,000		18,000		
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services	(259,000)	(239,000)	(498,000)	(478,000)	(478,000)
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements	3,000	3,000	6,000	6,000	6,000
9-					
<b>Total:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

#### III. B - Detail: List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA

Job Classification	Salary	FY 2010	FY 2011	2009-11	2011-13	2013-15
Board Member FTE @ 250 per day						
Board Member FTE @ 50 per day						
Fiscal Analyst 2	44,928	0.3	0.3	0.3	0.3	0.3
Health Services Consultant 1	43,836	0.1	0.1	0.1	0.1	0.1
HEALTH SERVICES CONSULTANT	61,632	1.0	1.0	1.0	1.0	1.0
3						
HEALTH SERVICES CONSULTANT	68,016	1.0	1.0	1.0	1.0	1.0
4						
<b>Total FTE's</b>	<b>218,412</b>	<b>2.4</b>	<b>2.4</b>	<b>2.4</b>	<b>2.4</b>	<b>2.4</b>

### Part IV: Capital Budget Impact

### Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

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### **7/21/09 Meeting Summary:**

Review Purpose and Intended Outcome of Workgroup -

- Examine the administrative costs and benefits of continuing the current AIDSNET system versus Department administration
- Identify other possible structures to assure the system is as efficient as possible in delivering services
- Produce recommendations that the Department, Governor Gregoire's Office and others can use in responding to HB 2360 during the 2010 legislative session
  - workgroup not intended to address what proportion of available funds are allocated to various locales or what services are funded
  - focus on how funds can be most efficiently and effectively administered
- Information Needs – What information does the group need to proceed?
- Future Meetings – In-Person versus Conference Call
- Workgroup Conclusion Date

### **8/4/09 Meeting Summary:**

Group revisited work items from 7/21/09 -

- Information needs of the workgroup
  - Gather/ survey information from similar states about their HIV/AIDS Service delivery system.
  - Documents from AIDSNETs members
    - What would the delivery system look like if HB 2360 were enacted without changes?
    - What is the value added of the current AIDSNETs system? Provide examples.
    - Cost out what regions do now that DOH wouldn't do
    - AIDS prevention funding elements (Bob's spreadsheet)
  - Regional Coordinators provide information on how current \$1 million funding reductions were taken in each region
  - GACHA – Set date for public forum
- Discuss/set end date for workgroup meetings

### **8/20/09 Meeting Summary:**

- Review of draft spreadsheet presenting 7/09 – 12/09 regional funding reductions
- Review information gathered on other states experience –interview results from Louisiana, Colorado, Michigan, and Arizona. None of these states have/had a mandated regional service delivery system.
  - A savings of funds was realized by Michigan by doing away with their informal regional system. However, their system for gaining input isn't working well.
  - The DOH of Colorado contracts directly with AIDS service organizations. They also eliminated consortia and realized a savings.
  - Louisiana reduced the number of meeting held by the regional planning groups who are now only advisory to save money.
  - Arizona eliminated FTE that administered their regional planning and contracting process to save money. Work is now done by one state planning group.
- There has been no requirement for consortia in the Ryan White Act since 2000

- The workgroup would like community-based and AIDS service organizations in the same states contacted to get their perspective on the current system and how any changes have impacted them. Input from Washington organizations would also be helpful.
- Input from local health jurisdictions in Washington State is also needed.
- Review of DOH, AIDSNet and other cost estimates for administering HIV/AIDS service delivery system (community-based organizations)
  - These documents were briefly discussed with the group agreeing the full discussion of these and other position statements should await the in-person meeting.

**9/21/09 Meeting Summary:**

- Discussed new information from community-based and AIDS service organizations, and local health jurisdictions
  - Schedules of those responsible for this work item did not allow opportunity to interview community-based and AIDS service organizations
- Identify questions, topic areas to be addressed in the recommendations to be addressed in the Public Forum
  - October 8 – face-to-face full day meeting – 8:30/9:00 to 3:30/4:00
- Discussed Public Forum specifics - November 10 at SeaTac
  - Explore use of video and phone conference options (iLink, ESDs web conference, video access, conference phone) to ensure statewide participation

**Appendix 5 - 2009 Omnibus Spending Plan Reductions (as reported by the Regional AIDSNETs)**

Region	1	2	3	4	5	6	Total
<b>Category</b>							
<b>High Risk Interventions</b>	\$ 370,446	\$ 349,074	\$ 394,277	\$ 2,260,759	\$ 640,450	\$ 540,913	\$ 4,555,919
<b>Counseling, Testing, Referral &amp; Partner Notification</b>	\$ 100,368	\$ 81,865	\$ 482,697	\$ 418,390	\$ 303,723	\$ 150,417	\$ 1,537,460
<b>General Education</b>	\$ 54,496					\$ 4,745	\$ 59,241
<b>Case Management</b>		\$ 112,634		\$ 86,713		\$ 138,645	\$ 337,992
<b>Planning</b>	\$ 52,036		\$ 60,116	\$ 277,892		\$ 50,287	\$ 440,331
<b>Coordination</b>	\$ 87,615	\$ 79,019	\$ 23,634	\$ 217,623	\$ 133,240	\$ 86,689	\$ 627,820
<b>TOTAL</b>	\$ 664,961	\$ 622,592	\$ 960,724	\$ 3,261,377	\$ 1,077,413	\$ 971,696	\$ 7,558,763
<b>JULY-DEC 2009 REDUCTION</b>	<b>(\$46,324)</b>	<b>(\$43,371)</b>	<b>(\$66,927)</b>	<b>(\$227,197)</b>	<b>(\$75,056)</b>	<b>(\$67,691)</b>	<b>(\$526,566)</b>
% change from initial	-7%	-7%	-7%	-7%	-7%	-7%	-7%
	\$ 618,637	\$ 579,221	\$ 893,797	\$ 3,034,180	\$ 1,002,357	\$ 904,005	\$ 7,032,197

**REVISED 2009 Omnibus Spending Plan AFTER CUTS**

Region	1	2	3	4	5	6	Total
<b>Category</b>							
<b>High Risk Interventions</b>	\$ 370,446	\$ 349,074	\$ 394,277	\$ 2,113,759	\$ 598,684	\$ 487,897	\$ 4,314,137
% change from initial				-7%	-7%	-10%	-5%
<b>Counseling, Testing, Referral &amp; Partner Notification</b>	\$ 100,368	\$ 81,865	\$ 482,697	\$ 418,390	\$ 280,775	\$ 139,135	\$ 1,503,230
% change from initial					-8%	-8%	-2%
<b>General Education</b>	\$ 8,172					\$ 4,745	\$ 12,917
% change from initial	-85%						-78%
<b>Case Management</b>		\$ 112,634		\$ 86,713		\$ 145,312	\$ 344,659
% change from initial						5%	2%
<b>Planning</b>	\$ 52,036		\$ 60,116	\$ 237,695		\$ 42,895	\$ 392,742
% change from initial				-14%		-15%	-11%
<b>Coordination</b>	\$ 87,615	\$ 54,019	\$ 23,634	\$ 177,623	\$ 122,898	\$ 83,693	\$ 549,482
% change from initial		-32%		-18%	-8%	-3%	-12%
<b>Fund balance</b>		<b>(\$18,371)</b>	<b>(\$66,927)</b>				<b>(\$85,298)</b>
% change from initial							
<b>TOTAL</b>	\$ 618,637	\$ 579,221	\$ 893,797	\$ 3,034,180	\$ 1,002,357	\$ 903,677	\$ 7,031,869
% change from initial	-7%	-7%	-7%	-7%	-7%	-7%	-7%

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Appendix 6 - AIDS Services and Costs (prepared by Bob Wood)

AIDS Prevention Funding Elements:			Current AIDS Nets System		Darnielle's HB 2360		Comments Re HB 2360:	
	Service	Service value*	Cost Est.	Service	Service value*	Cost Est.	* Service value to whom (?local community, ?local public health, ???) and could be on Likert scale 1=little to 4=great	
<b>DOH Contracts AIDS \$\$ with whom? (DOH withholds a 1.3% indirect charge)</b>								
Six Lead Public Health regions	yes			no			Six lead regions would have no further authority	
Local County/Jurisdictional Public Health (LHD/LHJ)	no			probably all			counties or jurisdictions would apply to DOH for resources for Tier 1 & 2 activities	
Directly to eligible applicants	no		2 FTE+	yes				
AIDS Service Organizations	no			yes				
Other Organizations	no			maybe				
<b>AIDS Nets Contract with whom? (Regional Admin withholds XX% indirect, avg, range)</b>								
LHD/LHJ Public Health	yes			no			Six lead regions would have no further authority	
AIDS Service Organizaitons	yes			no			Six lead regions would have no further authority	
<b>LHD/LHJs Contract with whom? (LHD/LHJs withhold YY% indirect, avg, range)</b>								
AIDS Service Organizations	?yes			no			counties or jurisdictions would apply to DOH for resources for Tier 1 & 2 activities	
<b>Services RCW or Contract-Mandated of Public Health</b>								
Planning:								
DOH Responsibilities	yes			yes				
State Prevention Planning Group (SPG)	yes			yes			CDC only requires at state prevention planning body	
Six Regions' Planning Resonsibilities	yes			no				
Regional Planning Councils	yes			no			Six lead regions would have no further authority	
Prevention Plan preparation	yes			no			Six lead regions would have no further authority	
LHD/LHJ Responsibilities	no			probably all			counties or jurisdictions would apply to DOH for resources for Tier 1 & 2 activities (tier 1 = mandated prevention services; tier 2 = optimal services [needle exchg, e.g.]	
Coordination: [how do we define this?]								
State assurance	yes			yes				
DOH compiles Regional reports	yes			no				
DOH comprehensive summarization	no			yes			as monitor of more contractors DOH work would increase	
Six Regional Coordination Resonsibilities	yes			no			Six lead regions would have no further authority	
Contracting								
Issuing RFPs	yes			no			Six lead regions would have no further authority	
Application reviews	yes			no			Six lead regions would have no further authority	
Negotiating/awarding contracts	yes			no			Six lead regions would have no further authority	
Monitoring contracts	yes			no			Six lead regions would have no further authority	
billing	yes			no			Six lead regions would have no further authority	
Technical assistance (not mandated)	yes			no			Six lead regions would have no further authority	
Interagency collaboration/local synergy	yes			no			<b>Here may be a substantial loss to rural interagency coordination</b>	
Reporting/entering regional data	yes			no			Six lead regions would have no further authority	
SHARE, PEMS, CAREware, ?other	yes			no			Six lead regions would have no further authority	
Preparing DOH reports/plans	yes			no			Six lead regions would have no further authority	
Dealing with audits	yes			no			Six lead regions would have no further authority	
HIV Testing-related Services:								
State pays lab costs	yes			yes				
Access to anonymous and confidential VCT	yes			yes				
Testing itself	yes			yes				
Partner Counseling & Referral Svcs	yes			yes				
Mandated testing after sentencing	yes			yes				
LHD/LHJ Other RCW Responsibilities:								
Substantial Exposure Assistance	yes			yes				
Behaviors Endangering Investigations	yes			yes				
Volunteered, Not Required:								
AIDS Nets Council	yes			no			WASALPHO might organize an HIV/AIDS Policy/Coordination Interest group	
Coordination of state-wide regional plans	yes			no				
Identification and promotion of optimal policy	yes			no			WASALPHO might organize an HIV/AIDS Policy/Coordination Interest group	

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## **LOUISIANA**

The Louisiana Department of Health and Hospitals (LDHH) has a statewide system of public health units, hospitals, and clinics. There are no LHJs in the state. Louisiana (population 4.2 million) has two RWTMA Part A recipients (New Orleans and Baton Rouge) which are managed by the Office of Health Policy in N.O. and Community Services Office in B.R. Louisiana has \$1.5 million in state funds for HIV/AIDS prevention (2007).

There has always been only one statewide HIV Prevention Planning Group in the state. There used to be a system of informal regional planning groups that did not produce actual plans or letters of concurrence. Three years ago, in order to save money on coordination and administration, the groups have become strictly advisory, meet less frequently, and are organized and managed by LDHH (they sound more like “community forums or stakeholder meetings” than actual planning groups).

There are nine HIV care “consortia” in the state that determine the allocation of resources for service categories. LDHH conducts RFPs and manages contracts for all RWTMA Part B funded services, including some limited services in N.O and B.R. There is one statewide ADAP. There is no statewide care planning group. The RWTMA Part B planning/consortia structure will likely change next year.

## **COLORADO**

Colorado (population 5 million) has one RWTMA Part A TGA, Denver and about \$3 million in state funds for HIV/AIDS prevention (2007). Colorado eliminated RWTMA consortia a few years ago, and has realized significant savings in administrative costs which has allowed more funding for care services.

Legislation passed in the early 1990’s created the Colorado Advisory Council on HIV/AIDS to advise on care related issues. The council’s mandate expired in 2008. From 1994 to 2008, Coloradans Working Together handled the CDC prevention planning for the state. In 2008, the statewide Colorado HIV/AIDS Care and Prevention Coalition was created as a successor to these two former groups and handles both care and prevention planning, via two committees. There is no regional structure for input into the planning processes, however the Coalition bylaws call for representation from rural areas of the state, as well as representation from populations most at risk and other required stakeholders.

The DOH administers 22 RWTMA Part B contracts (7 for case management and 16 of other care services like dental) almost all of which are contracted directly with service providers. There are a few large contracts that include subcontracts with other agencies. CDC funding is contracted directly to about 24 LHJs and CBOs based on priorities established in the comprehensive HIV prevention plan developed by the Coalition. State funds are awarded through a separate competitive process to address priorities in the plan, or other outstanding gaps in prevention services. Currently, DOH administers 24 contracts for state funds.

DOH staff perform all HIV DIS functions in the state. DOH DIS staff are assigned regions of the state. Their duties have grown to also include contract monitoring as well.

## **MICHIGAN**

Michigan (population 10 million) has a legislative mandate to maintain a State Commission on HIV/AIDS to provide input into prevention and care services. The commission predates CDC and RWTMA requirements. Michigan has one RWTMA Part A recipient (Detroit). Michigan has \$3.3 million in state funds for HIV/AIDS prevention (2007).

In the 1990's Michigan established an "informal" (not mandated by rule or law) system of regional planning for care and prevention consisting of eight regions and sixteen planning groups, and also maintained a statewide prevention and a statewide care planning group, in addition to the State Commission on HIV/AIDS. That's a total of 19 groups. Lead LHJs in each region functioned as the lead agency for the region, contracted with the state DOH and managed subcontracts for HIV care and prevention with the other LHJs and CBOs within the region.

In 2000, the state held a Summit with the goal of reducing the administrative and "pass-through" costs, and reducing duplication of efforts in the HIV/AIDS system in Michigan. The result was elimination of the informal system of regional care and prevention planning and administration. The State Commission on HIV/AIDS was given responsibility for the statewide HIV prevention and care planning functions. Currently, the Michigan DOH contracts directly with LHJs and CBOs throughout the state for HIV prevention services including Detroit, and for care in all parts of the state except Detroit. Care service contracting is more complicated for Detroit due to Part A (I didn't ask for details).

Benefits of the new system include savings of \$1.2 million in administrative and pass-through funds that were not available for services. This is the primary selling point of the change.

Deficits of the new system include an inadequate system for gaining local input. Liisa Randall counsels us that mechanisms for adequate local input and bilateral flow of information back to communities be established prior to making any change.

## **ARIZONA**

Arizona (population 6.3 million) has one RWTMA Part A EMA and no state funding for HIV/AIDS. Arizona has two RWTMA Part B consortia, but they may need to be eliminated next year due to the requirements of RWTMA regarding "support services". The state administers a statewide ADAP that the Part A EMA contributes some funding to support. Part B no longer funds any care services in the Phoenix EMA.

Beginning in 1994 and until 2005, Arizona has 3 regional HIV prevention planning groups and a statewide group, all of which produced Letters of Concurrence. This was a policy decision by the DOH and not mandated by rule or law. Since 2005, the regional bodies are advisory only and DOH saved funding for prevention by eliminated three FTE that were directing and administering the regional planning and contracting processes. Arizona now has one state planning group and produces one Letter of Concurrence.

The DOH now contracts directly with four AIDS Service Organizations who in turn administer subcontracts for a range of HIV prevention services. It was late in the day, and I wasn't able to clarify how HIV CTR and DIS are performed, but I don't think those services are included in the contracts with ASOs.

## Appendix 8

### Summary of Mandates for Local Public Health Officials and for the DOH “Office on AIDS” in RCW 70.24

#### Mandates for Local Public Health Officials

**"Local public health officer"** means the officer directing the county health department or his or her designee who has been given the responsibility and authority to protect the health of the public within his or her jurisdiction.

#### Interviews, Examination, Counseling, Investigations

**State and local public health officers** and their authorized representatives may interview, or cause to be interviewed, all persons infected with a sexually transmitted disease and all persons who, in accordance with standards adopted by the board by rule, are reasonably believed to be infected with such diseases for the purpose of investigating the source and spread of the diseases and for the purpose of ordering a person to submit to examination, counseling, or treatment as necessary for the protection of the public health and safety, subject to RCW [70.24.024](#).

**State and local public health officers** or their authorized representatives shall investigate identified partners of persons infected with sexually transmitted diseases in accordance with procedures prescribed by the board.

**The state and local public health officers** or their authorized representatives may examine and counsel or cause to be examined and counseled persons reasonably believed to be infected with or to have been exposed to a sexually transmitted disease.

*The above three sections are followed by extensive, detailed procedures for counseling, restrictive measures, cease and desist orders and detention associated with behaviors endangering the public health.*

#### Counseling and Testing – Insurance Requirements

When an applicant does not identify a designated health care provider or health care agency and the applicant's test results are either positive or indeterminate, the insurer, the health care service contractor, or health maintenance organization shall provide the test results to **the local health department** for interpretation and post-test counseling.

#### Counseling and Testing

**Local health departments** authorized under this chapter shall conduct or cause to be conducted pretest counseling, HIV testing, and posttest counseling of all persons:

- (a) Convicted of a sexual offense under chapter [9A.44](#) RCW;
- (b) Convicted of prostitution or offenses relating to prostitution under chapter [9A.88](#) RCW; or
- (c) Convicted of drug offenses under chapter [69.50](#) RCW if the court determines at the time of conviction that the related drug offense is one associated with the use of hypodermic needles.

**Local health departments**, in cooperation with the regional AIDS services networks, shall make available voluntary testing and counseling services to all persons arrested for prostitution offenses under chapter [9A.88](#) RCW and drug offenses under chapter [69.50](#) RCW.

The **department** shall adopt rules requiring appropriate education and training of employees of state licensed or certified health care facilities. The education and training shall be on the prevention, transmission, and treatment of AIDS and shall not be required for employees who are covered by comparable rules adopted under other sections of this chapter. In adopting rules under this section, the **department** shall consider infection control standards and educational materials available from appropriate professional associations and professionally prepared publications.

#### **AIDS Education in Public Schools – requirements for “the Office on AIDS”**

The superintendent of public instruction shall adopt rules that require appropriate education and training, to be included as part of their present continuing education requirements, for public school employees on the prevention, transmission, and treatment of AIDS. The superintendent of public instruction shall work with the **office on AIDS** under RCW [70.24.250](#) to develop the educational and training material necessary for school employees.

Each district board of directors shall adopt an AIDS prevention education . . . so long as the curricula and materials developed for use in the AIDS education program either (a) are the model curricula and resources under subsection (3) of this section, or (b) are developed by the school district and approved for medical accuracy by the **office on AIDS** established in RCW [70.24.250](#). If a district elects to use curricula developed by the school district, the district shall submit to the **office on AIDS** a copy of its curricula and an affidavit of medical accuracy stating that the material in the district-developed curricula has been compared to the model curricula for medical accuracy and that in the opinion of the district the district-developed materials are medically accurate. Upon submission of the affidavit and curricula, the district may use these materials until the approval procedure to be conducted by the **office of AIDS** has been completed.

Model curricula and other resources available from the superintendent of public instruction may be reviewed by the school district board of directors, in addition to materials designed locally, in developing the district's AIDS education program. The model curricula shall be reviewed for medical accuracy by the **office on AIDS** established in RCW [70.24.250](#).

The office of the superintendent of public instruction with the assistance of the **office on AIDS** shall update AIDS education curriculum material as newly discovered medical facts make it necessary.

The **department** shall establish a statewide system of regional acquired immunodeficiency syndrome (AIDS) service networks. *Note: All other references to department responsibilities in RCW 70.24.400 are not included in this analysis.*

#### **Confidentiality – Reports – Unauthorized Disclosure**

In order to assure compliance with the protections under this chapter and the rules of the board, and to assure public confidence in the confidentiality of reported information, the **department** shall:

(a) Report annually to the board any incidents of unauthorized disclosure by the **department**, **local health departments**, or their employees of information protected under RCW [70.24.105](#). The report shall include recommendations for preventing future unauthorized disclosures and improving the system of confidentiality for reported information; and

(b) Assist health care providers, facilities that conduct tests, **local health departments**, and other persons involved in disease reporting to understand, implement, and comply with this chapter and the rules of the board related to disease reporting.

A law enforcement officer, firefighter, health care provider, health care facility staff person, department of corrections' staff person, jail staff person, or other categories of employment determined by the board in rule to be at risk of substantial exposure to HIV, who has experienced a substantial exposure to another person's bodily fluids in the course of his or her employment, may request a **state or local public health officer** to order pretest counseling, HIV testing, and posttest counseling for the person whose bodily fluids he or she has been exposed to. The person who is subject to the state or local public health officer's order to receive counseling and testing shall be given written notice of the order promptly, personally, and confidentially, stating the grounds and provisions of the order, including the factual basis therefor. If the person who is subject to the order refuses to comply, the **state or local public health officer** may petition the superior court for a hearing.

Jail administrators, with the approval of the **local public health officer**, may order pretest counseling, HIV testing, and posttest counseling for persons detained in the jail if the local public health officer determines that actual or threatened behavior presents a possible risk to the staff, general public, or other persons. Approval of the **local public health officer** shall be based on RCW [70.24.024](#)(3) and may be contested through RCW [70.24.024](#)(4).

### **Mandates for the Department of Health a.k.a. "Office on AIDS"**

"Department" means the department of health, or any successor department with jurisdiction over public health matters.

There is established in the **department an office on AIDS**. If a department of health is created, the **office on AIDS** shall be transferred to the department of health, and its chief shall report directly to the secretary of health. The **office on AIDS** shall have as its chief a physician licensed under chapter [18.57](#) or [18.71](#) RCW or a person experienced in public health who shall report directly to the assistant secretary for health. This **office** shall be the repository and clearinghouse for all education and training material related to the treatment, transmission, and prevention of AIDS. The **office on AIDS** shall have the responsibility for coordinating all publicly funded education and service activities related to AIDS. The University of Washington shall provide the **office on AIDS** with appropriate training and educational materials necessary to carry out its duties. The **office on AIDS** shall assist state agencies with information necessary to carry out the purposes of this chapter. The department shall work with state and county agencies and specific employee and professional groups to provide information appropriate to their needs, and shall make educational materials available to private employers and encourage them to distribute this information to their employees.

### **HIV/AIDS Training Requirements**

The **department** shall adopt rules that recommend appropriate education and training for licensed and certified emergency medical personnel under chapter [18.73](#) RCW on the prevention, transmission, and treatment of AIDS. The department shall require appropriate education or training as a condition of certification or license issuance or renewal.

The **department** shall adopt rules requiring appropriate education and training of employees of state licensed or certified health care facilities.

Each disciplining authority under chapter [18.130](#) RCW shall adopt rules that require appropriate education and training for licensees on the prevention, transmission, and treatment of AIDS. The disciplining authorities shall work with the **office on AIDS** under RCW [70.24.250](#) to develop the training and educational material necessary for health professionals.

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## CURRENT AIDSNETS SYSTEM “VALUE ADDED,” WITH EXAMPLES

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**Coordination within AIDSNet Regions by people in the regions:** This benefits local persons with HIV and those who are at risk of HIV. This should be seen as valuable to consumers and Community-based organizations (CBOs).

- The current system employs persons within Regions to tailor programs to the specific needs of the Regions.
- The dollars get to the people who need them.
- Regional people can facilitate local coordination, and solve problems quickly locally. Problems can be identified and solved through easier and quicker access to Regional public health folks.

Examples:

- Title XIX is coordinated at the local level, e.g., linking several CBOs’ efforts to get funding for long-term housing options.
- Important CBO providers who are actively engaged in planning and coordination for (both AIDS prevention and care services) indicate that they would be less likely to participate in statewide efforts and therefore AIDS as a program focus would drop in their agency priorities. More providers are interested in focusing on their local networks and communities.
- Region 3 has been able to modify contracts in exceptional circumstances in as little as <24 hours time.
- The summer 2008 death of Dr. Trucker in Wenatchee left all HIV clients at Wenatchee Valley without an HIV provider. Wendy Doescher was able to put together a contract (in just one week) between Wenatchee Valley Clinic and NEW HOPE Clinic to cover HIV care of clients for 8 months until a new provider could be found.
- This past spring Yakima’s only CBO for Care Services had to close due to misuse of funds. Wendy was able to find/put remaining programs within a couple weeks into a community agency so that the services would continue to clients in Region 2. It was not easy to find a local agency willing to provide services on a regional level.
- King County experienced a similar “crisis” when the CBO, Street Outreach Services (SOS) was not able to satisfy its contractual requirements, and Public Health Seattle-King County had to assume many of the services which SOS had been providing to injection drug users.

**Coordination of prevention & care.** Regional coordinators know of services which can be wrapped together to fund a position, create synergy and critical mass to make services available. This is especially important in a time of constrained funds.

Examples:

- One of Region 3’s CBO partner agencies has a staffer funded who provides both HIV medical case management services and Healthy Relationships for HIV+ prevention intervention sessions when a critical mass of clients needed for a group can be achieved.

- Provide for wrap-around funds meaning the use of all three HIV funding sources to provide enough funds to maintain a workable program in small rural counties. This has been a priority for Region 2.

**AIDS Nets structure pushes State Public Health.** The AIDSNET Council can hold the State Department of Health (DOH) accountable (“feet to the fire”) for key functions and actions, including new policy directions that may be politically unpopular.

Examples:

- In 1996 the AIDS Nets Council began pressuring DOH and the State Board of Health (SBOH) to make HIV a disease reportable in the standard way (by name), achieving a solution which made it possible, once the federal government began requiring HIV surveillance by name, for us to quickly comply. DOH wanted to play “neutral”.
- In 2007, the AIDS Nets Council pressed DOH and SBOH again to simplify the rules around HIV testing, so that 9/06 CDC recommendations designed to make HIV screening routine in medical care settings for persons age 13-64 and to remove the primary care provider as a gatekeeper for partner counseling & referral services. This should improve implementation of these CDC recommendations and should improve public health’s pursuit of partners of persons newly found to have HIV for their own education and HIV screening.

**AIDS Nets Council provides leadership on HIV/AIDS policy issues.** The AIDSNET Council has consistently provided leadership on key HIV & AIDS policy issues including the WAC changes identified above in the two examples.

- Public health directors in the jurisdictions with the largest population have stated that because they have so many other problems to address, they can barely devote any time to HIV/AIDS policy.
- The Washington State Association of Local Public Health Officers (WASALPHO) has not established a subcommittee to address HIV/AIDS policy and the Washington Medical Association abandoned such a subcommittee more than a decade ago.

**The AIDS Nets structure promotes funding and focus equity state-wide.** The secretary of DOH currently has the final say on how funds are distributed to the six AIDS Nets regions, although she has accepted the advice of the AIDS Nets Council in most instances, and that Council has developed rational models for fund distribution.

- There would be no mechanism to influence this otherwise. Under HB 2360, predictability in funding levels for CBOs and local public health jurisdictions could be lost, regional priority-setting could be lost, especially around difficult or controversial interventions and for controversial populations, and there would be no restrictions placed on the State government costs nor any required information to stakeholders about how the State would manage a statewide system.
- Focused public health and broad community advocacy for maintaining the already slowly shrinking level of categorical funding for AIDS would be lost among the Department’s competing uses for those funds other than for AIDS prevention.

**The AIDS Nets regional structure puts government-facilitated service design, delivery and problem-solving closer to the people being served and the agencies serving them.**

- Avoids the “one size fits all” approach that might more likely be applied by one state agency situated primarily in Olympia.
- Geographical distance will be an issue if DOH takes on these functions, as its resources will be further away from service delivery sites outside of Thurston County.
- Increased accountability may be had in dealing with Regional government officials rather than those at DOH in Olympia.

**Examples:**

- More timely solution of problems around issues such as provider availability, transportation costs (e.g., gas cards).
- Dental services were arranged by DOH for statewide coverage, but the number and geographical distribution of providers decreased.
- Multiple-county efforts around housing.

**AIDS Nets Regions’ work may be unsustainable under the DOH proposed staffing plan.**

- Data entry, TA for individual agencies in developing proposals that meet requirements, and regional level of program monitoring.

**Unanswered questions**

- The State’s plans and actual costs are unknown. Stakeholders are being asked to take it all “on faith.”
- HB 2360 offers no evidence of any actual or enduring cost savings or Value Added.

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## Appendix 10 – (Prepared by Duane Wilkerson)

### Thoughts and Reflections on the Value of Money Re-Directed to CBOS for Prevention and Care Services

#### Assumptions

1. I think the discussion about the complexity of the AIDSNETs funding obscures the simplicity of the reality: Monies spent on 6 individual bureaucracies to sustain six individual regional centers with staff and overhead costs), and six separate community planning and care group structures costs considerably more than having one state CPG and contracts serviced and monitored from one agency; DOH. How much is the only real question.
2. It costs CBOs/ASOs less in all areas to implement the same interventions that it costs local or regional health departments (staff salaries are less, fringe is less, overhead is less).
3. The role for local and regional HDs to provide counseling and testing, and partner notification should remain as is, unless there is clear evidence that it is not being utilized.

#### Access to High Risk Communities

The creation of Community Planning in 1994 was in large part an acknowledgement that the community agencies, consisting of and representing the communities in which the highest risk populations live, had the best opportunity of accessing these high-risk populations. They also represented the best chance of understanding the aspects of the behavioral and cultural determinants that both support behavior change and are barriers to behavior change within their own communities.

This is why the funding stream dramatically changed from most dollars going to state and local health departments, to a requirement that CBOs, specifically CBOs/ASOs be funded at a greater level. (Journal of Community Health, Vol 20, No. 2, April 1995, Valdesseri, Aultman, and Curran). The other primary shift with community planning was a shift from most dollars funding C&T to more risk-reduction, behavioral-based interventions being funded by those CBOs/ASOs.

Health Departments are seen, rightly or wrongly, as part of the “Government.” It is ironically most often the highest at-risk populations who are most wary, suspicious, and fearful of such a government entity; IDUs, African-Americans (who remember Tuskegee and believe to a degree that HIV/AIDS was a plot to kill off AA, much like the war on drugs is perceived), young MSMs of color, Latino/as, many whom are either undocumented, or treated suspiciously as possibly undocumented by many government agencies (ironically public health departments are probably the least likely to do this but get tainted with the broad “government” brush). (Journal of Comm Psych, 34, 601-616, Pinto & McKay, 2006)

It does not take a lot of research to understand why local CBOs/ASOs who look like them and talk like them, who live among them etc., are received better by these high-risk populations. Local health departments cannot change this reality, no matter how many minority-cultural people they hire.

#### Cost Effectiveness of CBOs

When one compares the average salary and fringe paid to a local health department staffer versus a comparable CBO/ASO staffer it is clear that CBOs/ASOs can do the same work for less. This is true even if a CBO/ASO is funded adequately (i.e. enough to actually cover all costs of doing an intervention). (Holtgrave and Pinkerton) There certainly has been a one-way door for years in Pierce County as staff from PCAF has moved over to TPCHD to take jobs because the pay and benefits are so much better.

The RAND Corporation recommends three strategies that are more cost effective than the four strategies that CDC has recommended in 2003. (See Rand News Release, July 12, 2005.) These three are:

- Community mobilization — targeting men who have sex with men — was predicted to prevent nearly 9,000 HIV infections per year.
- Needle exchange programs — most cost-effective when used for IV drug users in areas with a high HIV prevalence — was estimated to prevent close to 2,300 new cases of HIV infection.
- Mass-media campaigns containing messages to reduce risky sexual behavior and programs to distribute free condoms could prevent an estimated 1,100 and 1,900 new infections, respectively, among lower-prevalence populations.

CDC's "Advancing HIV Prevention" (AHP) has four approaches:

- Make HIV testing a routine part of medical care
- Implement new models for diagnosing HIV infections outside medical settings
- Prevent new infections by working with persons diagnosed with HIV and their partners
- Further decrease perinatal HIV transmission

Three of the four strategies advanced by CDC have little to nothing to do with CBOs/ASOs. Only the third one can be seen as an approach where CBOs/ASOs have a primary role (e.g., a prevention-for-positive behavioral intervention such as "Healthy Relationships" by Kalichman). The other three are primarily medical/clinical oriented.

By contract, CBOs/ASOs could have primary roles in all three approaches recommended by RAND that would benefit from their better access and experience with the high-risk communities who would be the targets of the recommended strategies.

#### Sustainability for Community Capacity/Empowerment Model

It can be argued that for long-term effective HIV and sexual risk-taking prevention efforts, CBOs/ASOs need a sustained, viable presence in the community over many years. The history of community and minority-specific CBOs/ASOs starting and then dying 2-3 years later (or sooner) arguably contributes to higher rates of HIV infections due to a lack of consistent culturally appropriate and effective programs within these communities.

CDC recognized this several years ago when they went from 1-2 year direct contracts to 5 year contracts, and added capacity-building services to raise the capacity levels of CBOs/ASOs for sustainability and effectiveness. Yet how many CBOs/ASOs outside of Seattle-King County are funded for more than 1-2 years at a time? How many are funded at a level that is sustainable (e.g., full program, staff and agency funding that actually pays for the entire cost of the program)? PCAF does not have one State- or AIDSNET-funded program that covers the full cost of implementing the program.

#### Public Health Department Dominance Versus Balanced Representation of Community

The value of having six regional health department agencies who meet regularly with DOH to determine strategy and direction for the State is not necessarily the best model. One could argue that an agency such as GACHA provides a much more representative, and therefore balanced, approach, bringing the knowledge, wisdom and experience of many different disciplines and communities to the table. The savings in dollars would be substantial as it is primarily a volunteer effort with some staff and travel time paid.

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Appendix 11

Administration of the HIV Service Delivery System  
October 8, 2009  
9:00 a.m. – 3:00 p.m.

Queen Anne Room  
Holiday Inn  
17338 International Boulevard  
Sea-Tac, Washington

**MEETING AGENDA**

<u>Time</u>	<u>Item</u>	<u>Lead/Facilitator</u>
9:00	Welcome, Self-introductions, and Agenda Review	All
9:15	Meeting Purpose – an agreement to develop recommendations	John Peppert
9:25	Review of Background Materials – Possible Update on CBO survey information	John Duane Wilkerson
9:40	Mandated Activities – Local mandates, Regional mandate(s), State Mandates	Brown McDonald
10:00	Attributes and Values – What are the attributes and values that are essential to a future AIDS Administration System?	John/ Tracy Mikesell
10:45	Break	
11:00	Application of the attributes and values to mandatory and essential services	John/ Tracy Mikesell
12:00	Lunch	
12:30	Developing Recommendations	John/ Tracy Mikesell
2:50	Closing and Next Steps	John

Materials Available

HB 2360 (bill and FN)

Review of HIV/AIDS Systems in five states - Brown McDonald

Current AIDSNET System Value Added - Bob Wood

Value of Money Re-directed to CBOs - Duane Wilkerson

2009 AIDSNETs Cuts Summary - Frank Chaffee

Comparison spreadsheet (both 8/4 and 8/17 versions)



DOH150-041 December 2009

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).