Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / www.BRHPC.org

MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, November 29, 2016, 12:30 p.m.
Location: Governmental Center Room A-337
Chair: Will Spencer **Vice Chair:** Rick Siclari

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 11/29/16 Agenda and 10/19/16 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   a. Monthly Expenditure/Utilization Report by Category of Service
4. **UNFINISHED BUSINESS**
   a. MAI Strategies- Discuss MAI strategies that will be included in the MAI Service Delivery Model (Handout A-B)
5. **MEETING ACTIVITIES**
   None.
6. **SUBCOMMITTEE REPORTS**
   None.
7. **GRANTEE REPORTS**
8. **PUBLIC COMMENT**
9. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** December 8, 2016 **Time:** 8:30 a.m. – 5 p.m. **Venue:** Secret Woods Nature Center

Goal/Work Plan Objective #:	*Accomplishments*
HIVPC and Committee Retreat	ACTION ITEM: All committee retreat

10. **ANNOUNCEMENTS**
11. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE PRINCIPLES IDEAS OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)

Date/Time: Wednesday, October 19, 2016, 12:30 p.m. **Location:** Governmental Center Room A-337

Chair: Will Spencer **Vice Chair:** Rick Siclari

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Bell, J.	**X**			Pietrogallo, T.
2	DeSantis, M.	**X**			Glincher, S.
3	Gammell, B.	**X**			
4	Grant, C.	**X**			**HIVPC Staff**
5	Hayes, M.	**X**			Johnson, B.
6	Katz, H. B.	**X**			Ewart, L.
7	Lopes, R.	**X**			Oratien, V.
8	Reed, Y.*	**X**			
9	Schickowski, K.	**X**			**Grantee Staff**
10	Shamer, D.	**X**			Drummond, K.
11	Siclari, R., *Vice Chair*	**X**			Card, W.
12	Spencer, W., *Chair*	**X**			Jones, L.
	Quorum = 7	**12**			On phone*

1. CALL TO ORDER:

The Chair called the meeting to order at 12:40 p.m. The Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

Motion #1: To approve today's meeting agenda.
Proposed by: Katz, H.B. **Seconded by:** Bell, J.
Action: Passed Unanimously

Motion #2: To approve meeting minutes of 8/17/16.
Proposed by: Grant, C. **Seconded by:** Katz, H.B.
Action: Passed Unanimously

3. PUBLIC COMMENT

a. Tom Pietrogallo from the Food Bank addressed the PSRA committee. He informed the members that he recently attended the Food is Medicine Coalition meeting. He informed the members that the Ryan White reauthorization in 2006 allowed for food to be provided as a core service. As a member of the public he would like everyone to know that this is a possibility under HRSA guidelines, and he has brought information back from the conference to share with the PSRA members.

b. Message from the PSRA Chair: The newly appointed PSRA Chair, Will Spencer, read a letter from Carla Taylor Bennett, the former PSRA Chair. The letter addressed the PSRA members, thanking them for their work on the committee, and informed the members of Carla's resignation from the committee as she does not wish to be a distraction to the work of the committee. The HIVPC Chair, Brad Gammell, stated that he has respect for Carla, that she will always be a leader in the HIVPC, and that the decision to remove her as the Chair was hard and not based on any of

her actions.

4. COMMITTEE LEADERSHIP DISCUSSION

a. The HIVPC Chair addressed the PSRA members about recent changes in the PSRA leadership. The longtime PSRA Chair, Carla Taylor-Bennett, has been removed with Will Spencer taking on the role of PSRA Chair. Brad recognized that all HIVPC members are community leaders, and those who are committee chairs devote a lot of time and effort to their committees. He stated that no chair has done anything wrong to provoke a change in leadership, but that it's about moving forward to bring in new leaders and members. He would also like to develop new leaders. He said that the PSRA Committee affects every life in Broward, and is a big responsibility, and at this time he has asked Will Spencer to serve as Chair with the purpose of looking for new leaders in the future. He thinks to decision was difficult but will help to build a stronger Planning Council.

A member stated that she has concerns about the diversity of the committee with the new leadership, which has been a problem in the past. She does not believe that the change will look good to the outside community. She urged that diversity play a key factor when looking for future leadership. Will Spencer stated that he has also made this point to the HIVPC Chair, and recognizes that two white males leading the PSRA may not be properly representative of the community or the epidemic.

Another member stated that she was very disappointed by the change. She stated that recognizes that the HIVPC Chair has the authority to make changes in committee chairs. However, she believes that Carla was a very good leader, and that Carla did not demonstrate that she was feeling overwhelmed or ready to give up her position as PSRA Chair. She spoke about the committee's work and the inconvenient timing of the HIVPC Chair's decision. She stated that the HIVPC Chair has implied that he is "seeking" new leadership, which to her means that there was no one ready or waiting, so there was no urgency to replace Carla. Carla had a good understanding of the committee, she has been on for more than 10 years and was a great Chair. The member does not think the decision to replace Carla was right or fair, and that the decision was premature. She believes that the HIVPC Chair could have waited for the end of the FY to make any leadership changes. The new PSRA Chair explained that he did not take this position to only serve as a place holder, but that he will stay to train a replacement and do his best to carry out the work of the committee.

5. STANDARD COMMITTEE ITEMS:

a. Reallocations ("Sweeps"): William Card, the Grantee's Fiscal Officer, presented the current FY2016 expenditures and proposed reallocations. Currently Outpatient Ambulatory Medical Care (OAMC) is 37% expended, which is under the target 50% for halfway through the FY. Minority AIDS Initiative (MAI) OAMC is 100% expended, as providers are encouraged to spend MAI funding before formula funds. Providers have both requests and returns, and the Grantee recommended that all requests are granted. A member asked if the return of funds were because of under-utilization, but the Grantee believes it because enrollment in ACA marketplace plans. The Grantee predicts that OAMC expenditures even off next year with integration of Behavioral Health screening with OAMC. Pharmaceuticals are 41% expended, and providers have requested $177,000 to Emergency Financial Assistance (EFA) for emergency medications due to an increase in utilization for new medications not covered by many insurance plans. A member asked about bulk purchases from FY2015: the bulk ARVs have been utilized and need to be restocked, and so far 6 people have been signed up for the Hepatitis C pilot program. Oral Health services are at 53%, with no provider requests. Case Management (CM) services are at 53%, with provider requests for both additions and returns. A member asked about extra funds for CM, and it was explained that one provider has had staffing issues while another provide has projected the need for more funds.

Disease Case Management (DCM) providers have requests for both additional funds and returns. Mental Health (MH) is 41% expended, with provider returns, and MAI MH is projected to be fully expended. There are 3 Mental Health providers. Substance Abuse is 50% expended with one request for return, and MAI Substance Abuse (SA) is on track to be fully expended. The Grantee's representative and PSRA Chair suggested waiting to vote on Health Insurance Continuation Program (HICP), EFA and Food Bank (FB) "sweeps" until their presentations later in the agenda.

#	Motion	Action
3	To reallocate $431,000 from OAMC	Passed Unanimously
4	To reallocate $29,272 from Case Management	Passed with 1 Objection
5	To reallocate $25,384 from Disease Case Management	Passed Unanimously
6	To reallocate $7,000 from Mental Health	Passed with 1 Objection
7	To reallocate $4,500 from Substance Abuse	Passed Unanimously
8	To reallocate $60,000 to CIED	Passed Unanimously

6. UNFINISHED BUSINESS:

a. MAI Strategies (Handouts A-B): The HIVPC Manager gave an overview/background of previous the previous PSRA meetings regarding MAI. The QMC looked at viral loads to identify priority populations that are least likely to be virally suppressed: 18-38 year old Black heterosexual males and females, and Black MSM. Staff presented a handout with the potential program to the PSRA members, detailing provided services, outcomes and programmatic components that the members previously identified. The members discussed the use of a Patient Care Team to coordinate each client's services, as well as the cost of implementing a patient centered medical home model. The group reviewed Handout B, a breakdown of potential clients served by the MAI program, and they decided to focus on unsuppressed 18-38 year old Black MSM, and Black heterosexual males and females. The members wanted to know how many of those unsuppressed clients received OAMC, and discussed how various components of the MAI model would greatly increase the average cost per client. The members discussed the integration of Behavioral Health into OAMC services, and how it may not be necessary to use MAI funds for MH or SA due to the fact that Behavioral Healthcare providers will already be on site to provide said services. The committee debated whether MAI clients receive the same services as regular Part A clients, and if the real impact of a new MAI model would come in the form of a Care Coordinator/MAI DCM to help guide each MAI client through the system of care. The PSRA Chair suggested that the new MAI model may act as a study to target specific populations to demonstrate the value of a DCM or Care Coordinator.

ACTION ITEM: For November PSRA meeting, provide total FY2017 MAI OAMC and MCM funds without MAI MH and SA allocations; viral load suppression rates for priority populations broken down by service category.

7. NEW BUSINESS

a. HICP Update: They Grantee explained that at the last meeting the members spoke about potential increase in ADAP coverage of ACA clients earning 400% FPL, and the changes' potential impact on Part A HICP. The state has agreed to support the local ADAP program in adding additional Full Time Employees (FTEs) in their contracts to offset Part A costs and reduce HICP transaction fees. Part A will pay client premiums until April, and then transition clients to the ADAP program and the stay as wraparound. The Grantee explained that the "sweeps" recommendation includes the cost of Part A premium coverage until April. He explained that ADAP cannot cover wraparound medical co-pays because of HRSA regulation on the service, and Part B do not have infrastructure to take over payments. A member stressed the need for a smooth transition so clients do not lose their coverage, and the Grantee stated that ADAP uses PE so the process should be an electronic

transfer. Part A will still cover wraparounds.

Motion #9: To reallocate $260,000 to HICP **Action:** Passed Unanimously **Motion #10:** To reallocate $177,156 to Emergency Financial Assistance **Action:** Passed with 1 Objection

b. Food Bank: The Grantee delivered a presentation based on data request about FB and changes in eligibility's effect on utilization. Food Voucher eligibility changes led to unprecedented increase in utilization and Food Bank service expenditures in FY2014-2015. The Grantee and Food Bank provider worked to develop cost containment strategies in FY15-16 to limit number of vouchers allotted for clients to preserve funding to last the remainder of the FY. The containment policy focused on foods groups to supported fruits, veggies and grains intake. The provider also had limited hours for voucher pick up, and clients needed to return both the voucher card and receipt when they were done. A member asked about the content of a food box; each box contains all of the food groups needed for one person, 3 meals/day, 7 days/week. A client can either receive 2 food boxes or a box and a voucher. The members discussed the need to find a balance in eligibility to allow for clients to access services throughout the year without over utilization. The new requirements for the vouchers include a list of recommended foods to buy, and clients must return the receipt but are not asked to reimburse for foods not recommended. The Grantee stated that they have no recommendations for FB/FV "sweeps" this quarter while they continue to review the impact of eligibility changes. A member asked about viral load suppression rates for clients who receive FB throughout the year, and it was stated that 85% were virally suppressed, although there is no direct evidence that VL suppression is tied to the service. Of those not virally suppressed, more than half were minorities.

8. GRANTEE REPORT

None.

9. AGENDA ITEMS/TASKS FOR NEXT MEETING: November 17, 2016 Venue: A-337

Goal/Work Plan Objective #:	*Accomplishments*
MAI Strategies	ACTION ITEM: Discuss MAI strategies that will be included in the MAI Service Delivery Model
Part B Bus Pass Update	ACTION ITEM: Follow-up with changes to Part B Bus Pass program

10. ANNOUNCEMENTS

None.

11. ADJOURNMENT

The meeting was adjourned at 2:50 p.m.

PSRA Attendance CY 2016

Consumer	PLWHA	Absences	Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date:	20	17	16	20	25	15	20	17	C	19			
			1	Bell, J.	N-		X	X	X	X	A	X		X			

Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

			2/17												
1		**2**	DeSantis, M.	X	A	X	X	X	X	X	X		X			
1		**3**	Gammell, B.	X	X	X	X	X	X	X	X		X			
		4	Grant, C.	X	X	X	X	X	X	X	X		X			
		5	Hayes, M.	X	X	X	X	X	X	X	A		X			
1	1	**6**	Katz, H.B.	X	X	X	A	X	X	X	X		X			
1			Lewis, L.	X	Z-2/1											
		7	Lopes, R.		X	X	X	X	X	A	X		X			N-1/20
	1		Proulx, D.	X	X	X	A	Z- 5/1								
1	2	**8**	Reed, Y.	X	X	A	E	X	X	A	X		X			
	1	**9**	Schickowski, K.	X	A	X	X	X	X	X	X		X			
1		**10**	Shamer, D.	X	X	X	X	A	A	X	X		X			
		11	Siclari, R., *V. Chair*	X	X	E	X	X	A	X	A		X			
		12	Spencer, W. *Chair*	N- 10/1									X			
			Taylor-Bennett, C., *Chair*	X	X	X	X	X	X	X	X	Z-10/1				
			Quorum = 8	12	10	11	10	11	10	9	10		12			

Legend:

X - present

A - absent

E - excused

NQA - no quorum absent

NQX - no quorum present

N - newly appointed

Z - removed

C - cancelled

W - warning letter

R - removal letter

HANDOUT A

MAI PROGRAM CLIENT OUTCOMES

The Broward Part A Program's MAI model is designed to improve rates of viral load suppression in Black MSM, and Black heterosexual males and females. The model will utilize evidence-informed strategies to increase engagement and retention in HIV care through specialized outpatient ambulatory medical care, medical case management, mental health and substance abuse services specifically designed for the Part A MAI populations. To improve access to and retention in care, the MAI program will utilize a patient centered medical home model. Intensive coordination and direct intervention will be provided by the care teams to improve HIV treatment adherence, medical education and the patient's ability to effectively navigate the healthcare system.

To enter the MAI program, unsuppressed clients in the priority populations will be screened for eligibility. If clients choose to enter the program they will have their care coordinated across providers so as to receive streamlined services. Each participant will receive a baseline needs assessment within the first month of entering the MAI program, and must be screened for both MH and SA. The client will be referred to the appropriate services, and referring provider will document their follow-up with confirmation by the receiving provider. Each MAI participant will have an MAI MCM, who will conduct quarterly evaluations of client progress based on the issues documented in the client's needs assessment and individualized treatment plan. The MAI MCM will develop and maintain a care plan that teaches the client where, when and how to access all health services to assist clients with attaining self-sufficiency. Updates on the client's needs assessment will be communicated and coordinated with shared outcomes between providers in the client's Patient Care Team.

Patient Care Team members will receive annual training to further educate on advancement of developmental, behavioral, medical, psychiatric and social service needs for the targeted MAI populations. Scheduling staff will maintain on-demand medical appointment slots to accommodate clients, including those who are employed or have other scheduling barriers. Based on preference of the client, providers will send at least two reminders within two weeks prior to the appointment via text message or email in addition to contact by phone. The model will utilize trained and certified peers to assist with linkage/referrals, engagement and retention in services.

Newly enrolled MAI clients will take a survey to assess their baseline needs, gaps and barriers to care. To ensure the implementation of high quality services, MAI clients will participate in an annual Part A MAI Needs Assessment activity (survey, focus group, community forum, etc.). The comprehensive Part A MAI Needs Assessment will at minimum include: clients' demographics, barriers to care, service gaps, and satisfaction with received services. Upon completion of the MAI program, clients will participate in a completion evaluation of the program.

HANDOUT A

MAI PROGRAM CLIENT OUTCOMES

In the first 18 months, the client should achieve the following outcomes in each enrolled service:

MAI OAMC

- Maintained medication adherence for >95%
- Maintained a suppressed viral load for at least nine consecutive months
- Demonstrated improvement with other clinical criteria (decreased hospitalization, other medical conditions stabilized, no new opportunistic infection diagnoses)
- Resolved 60% of major issues in the needs assessments
- Kept 85% of all scheduled medical appointments

MAI MCM

- Resolved 60% of major issues in the needs assessments
- Demonstrate the ability to navigate the health care system
- Developed a sense of self-sufficiency
    - Kept 85% of all scheduled medical and social services appointments
    - Established tools and resources to assist with being able to keep appointments in the future
    - Obtained and maintained needed services (housing, entitlements, benefits, medical, social, etc.)

MAI MH

- Documented improvement in client's symptoms associated with primary metal health diagnosis
- Kept 85% of all scheduled service appointments

MAI SA

- Documented improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis
- Kept 85% of all scheduled service appointments

HANDOUT B

TARGET POPULATION FOR BROWARD MAI PROGRAMS

Unsuppressed Black MSM				
Service Category	**All Ages** Unsuppressed VL	**All Ages** % of Total	**18-38 Year Old** Unsuppressed VL	**18-38 Year Old** % of Total
LAPA	68/374	18%	28/127	22%
OAMC	110/512	21%	47/188	25%
CIED	165/813	20%	61/232	26%
DCM	18/58	31%	3/12	25%
Food Bank	50/264	19%	12/52	23%
HICP	4/33	12%	1/10	10%
Legal	1/15	7%	0/5	0%
CM	57/351	16%	22/99	22%
MH	7/52	13%	2/19	11%
OHC	41/341	12%	18/98	18%
SA	3/21	14%	1/11	9%

Unsuppressed Black Heterosexual Males				
Service Category	**All Ages** Unsuppressed VL	**All Ages** % of Total	**18-38 Year Old** Unsuppressed VL	**18-38 Year Old** % of Total
LAPA	96/541	18%	8/46	17%
OAMC	122/624	20%	18/64	28%
CIED	217/1143	19%	26/84	31%
DCM	43/184	23%	5/14	36%
Food Bank	72/440	16%	4/20	20%
HICP	2/31	6%	0/1	0%
Legal	2/23	9%	0/1	0%
CM	90/550	16%	6/30	20%
MH	8/36	22%	1/3	33%
OHC	53/437	12%	2/24	8%
SA	3/20	15%	0/5	0%

Unsuppressed Black Heterosexual Females				
Service Category	**All Ages** Unsuppressed VL	**All Ages** % of Total	**18-38 Year Old** Unsuppressed VL	**18-38 Year Old** % of Total
LAPA	90/590	15%	10/55	18%
OAMC	130/685	19%	21/76	28%
CIED	255/1423	18%	41/143	29%
DCM	29/173	17%	1/8	13%
Food Bank	99/593	17%	11/36	31%
HICP	4/54	7%	2/5	40%
Legal	0/15	0%	0/1	0%
CM	92/555	17%	14/52	27%
MH	10/51	20%	1/7	14%
OHC	72/581	12%	8/43	19%
SA	7/17	41%	2/3	67%

HANDOUT C

Ft. Lauderdale/Broward EMA
Ryan White Part A and MAI
FY 2016-17 Expenditures

Service Category	Contracted or Allotted Amount	Expended Amount (7 Months)	Expended % (58%)	Unexpended Amount	Average Monthly Expenditures	FY 2016-17 Projected Expenditures
Ambulatory (5)	$4,924,047	$2,455,065	49.86%	$2,468,982	$350,724	$4,208,684
MAI Ambulatory (1)	$517,297	$286,422	55.37%	$230,875	$40,917	$491,010
Pharmaceuticals (3)	$677,165	$386,472	57.07%	$290,693	$55,210	$662,523
Emergency Financial Assistance	$177,156	$37,499	21.17%	$139,657	$5,357	$64,285
Dental (2)	$2,336,864	$1,528,681	65.42%	$808,183	$218,383	$2,620,596
Case Management (6)	$1,223,447	$784,280	64.10%	$439,167	$112,040	$1,344,479
MAI Medical Case Management (1)	$55,997	$29,417	52.53%	$26,580	$4,202	$50,429
Medical Case Management DM (4)	$312,616	$203,823	65.20%	$108,793	$29,118	$349,410
Mental Health (3)	$361,438	$163,422	45.21%	$198,016	$23,346	$280,152
MAI Mental Health (1)	$62,469	$31,854	50.99%	$30,615	$4,551	$54,607
Substance Abuse (2)	$208,009	$128,673	61.86%	$79,336	$18,382	$220,582
MAI Substance Abuse (1)	$400,000	$253,669	63.42%	$146,331	$36,238	$434,861
Food Bank (1)	$596,103	$251,619	42.21%	$344,485	$35,946	$431,346
Food Voucher (1)	$184,343	$27,421	14.87%	$156,922	$3,917	$47,007
Centralized Intake and Eligibility Determination (1)	$620,513	$321,020	51.73%	$299,493	$45,860	$550,319
MAI Centralized Intake and Eligibility Determination (1)	$290,957	$290,919	99.99%	$38	$41,560	$498,719
HICP (1)	$1,127,397	$648,498	57.52%	$478,899	$92,643	$1,111,711
Legal Assistance (1)	$121,426	$77,938	64.19%	$43,488	$11,134	$133,608
Total Part A Funds	**$12,870,524**	**$7,014,409**	**54.50%**	**$5,856,115**	**$1,002,058**	**$12,024,702**
Total MAI Funds	**$1,326,720**	**$892,282**	**67.25%**	**$434,438**	**$127,469**	**$1,529,626**
Total Funds	**$14,197,244**	**$7,906,691**	**55.69%**	**$6,290,553**	**$1,129,527**	**$13,554,328**
Bulk - Pharmaceutical (2)	$938,010	$504,152	53.75%	$433,858	$72,022	$864,261
Bulk - Voucher (1)	$169,380	$138,645	81.85%	$30,735	$19,806	$237,677
Bulk - Food Bank (1)	$123,055	$123,025	99.98%	$30	$17,575	$210,900

HANDOUT D

Service Category Allocations and Recommendations.				
Fiscal Year	**16-17**	**16-17**	**17-18**	**17-18**
Service Category	**Part A**	**MAI**	**Part A Recommended**	**MAI Recommended**
TRAUMA-INFORMED MENTAL HEALTH SERVICES:				
	$361,438.00	$62,469.00	$368,438.00	$26,534.00
SUBSTANCE ABUSE - OUTPATIENT:				
	$208,009.00	$400,000.00	$233,760.00	$400,000.00
INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES				
	$4,924,047.00	$517,297.00	$5,390,551.56	$291,669.00
CASE MANAGEMENT (MEDICAL CASE MANAGEMENT):				
	$312,616.00	$55,997.00	$507,000.00	$50,956.00
CASE MANAGEMENT SERVICES (Non-Medical Case Management):				
	$1,223,447.00		$1,353,263.09	
ORAL HEALTH CARE (Dental Services - Routine):				
	$2,336,864.00		$2,070,220.00	
ORAL HEALTH CARE (Dental Services - Specialty) :				
			$490,270.00	
AIDS PHARMACEUTICAL ASSISTANCE:				
	$677,165.00		$609,449.00	
LEGAL SERVICES:				
	$121,426.00		$121,426.00	
FOOD SERVICES (BANK):				
	$596,103.00		$596,103.00	
FOOD SERVICES (VOUCHER):				
	$184,343.00		$129,343.00	
HEALTH INSURANCE BENEFITS SUPPORT SERVICES:				
			$150,000.00	
HEALTH INSURANCE BENEFITS:				
	$1,127,397.00		$250,000.00	
CIED Part A:				
	$620,513.00	$290,957.00	$560,513.00	$290,957.00
Emergency Assistance				
	$177,156.00		$5,000.00	
Outreach (DIS)				
			$50,000.00	
	$12,870,524.00	**$1,326,720.00**	**$12,885,336.65**	**$1,060,116.00**