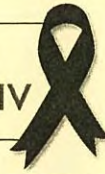




LOS ANGELES COUNTY
COMMISSION ON HIV



3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010
TEL. (213) 738-2816 · FAX (213) 637-4748
WEBSITE: <http://hiv.lacounty.gov> | EMAIL: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

**Thursday, April 11, 2019
9:00 AM – 1:00 PM**

**St. Anne's Conference Center, Foundation Room
155 North Occidental Blvd.
Los Angeles CA 90026**



Join the movement in ending the HIV/AIDS epidemic in Los Angeles County, once and for all.
Visit www.LACounty.HIV



LOS ANGELES COUNTY COMMISSION ON HIV



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HIVCOMM@LACHIV.ORG • <http://hiv.lacounty.gov>

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at-risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs) and Health Districts (HDs).



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GUIDELINES FOR CONDUCT

The Los Angeles County Commission on HIV has played an active role in shaping HIV services in this County and in the State for over a decade. The dedication to providing quality services to people with and at risk of HIV/AIDS by people who are members of this body, both past and present, is unparalleled.

In order to encourage the active participation of all members and to address the concerns of many Commissioners, consumers and other interested members of the community, it is important that meetings take place in a "safe" environment. A "safe" environment is one that recognizes differences, while striving for consensus and is characterized by consistent professional and respectful behavior. As a result, the Commission has adopted and is consistently committed to implementing the following Guidelines for Conduct for Commission, committee and associated meetings.

Similar meeting ground rules have been developed and successfully used in large group processes to tackle difficult issues. Their intent is not to discourage meaningful dialogue, but to recognize that differences and even conflict can result in highly creative solutions to problems when approached in a respectful and professional manner.

The following should be adhered to by all participants and stakeholders:

- 1) Be on Time for Meetings
- 2) Stay for the Entire Meeting
- 3) Show Respect to Invited Guests, Speakers and Presenters
- 4) Listen
- 5) Don't Interrupt
- 6) Focus on Issues, Not People
- 7) Don't just Disagree, Offer Alternatives
- 8) Give Respectful, Constructive Feedback
- 9) Don't Judge
- 10) Respect Others' Opinions
- 11) Keep an Open Mind to Others' Opinions
- 12) Allow Others to Speak
- 13) Respect Others' Time
- 14) Begin and End on Time
- 15) Have All the Issues on the Table and No "Hidden Agendas"
- 16) Minimize Side Conversations
- 17) Don't Monopolize the Discussion
- 18) Don't Repeat What Has Already Been Said
- 19) If Beepers or Cell Phones Must Be On, Keep Them on Silent or Vibrate

1. APPROVAL OF THE AGENDA:

- A. Agenda (**MOTION #1**)
- B. Membership Roster
- C. Committee Assignments
- D. Commission Member Conflict of Interest
- E. April - July 2019 Commission Meeting Calendar
- F. Geographic Maps



LOS ANGELES COUNTY COMMISSION ON HIV



AGENDA FOR THE **REGULAR** MEETING OF THE **LOS ANGELES COUNTY COMMISSION ON HIV (COH)**

(213) 738-2816 / FAX (213) 637-4748

EMAIL: hivcomm@lachiv.org WEBSITE: <http://hiv.lacounty.gov>

Thursday, April 11, 2019 | 9:00 AM – 1:00 PM

St. Anne's Conference Center
Foundation Room
155 N. Occidental Blvd., Los Angeles CA 90026

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616
Sacramento, CA 95814

AGENDA POSTED: April 5, 2019

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact Dina Jauregui at (213) 738-2816 or via email at djauregui@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dina Jauregui al (213) 738-2816 (teléfono), o por correo electrónico á djauregui@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: <http://hiv.lacounty.gov>. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order and Roll Call

9:00 A.M. – 9:02 A.M.

I. ADMINISTRATIVE MATTERS

- | | | | |
|----|-----------------------------|------------------|-----------------------|
| 1. | Approval of Agenda | MOTION #1 | 9:02 A.M. – 9:04 A.M. |
| 2. | Approval of Meeting Minutes | MOTION #2 | 9:04 A.M. – 9:06 A.M. |
| 3. | Consent Calendar | MOTION #3 | 9:06 A.M. – 9:08 A.M. |

II. REPORTS

- | | | | |
|----|--|------------------|-----------------------|
| 4. | Executive Director/Staff Report | | 9:08 A.M. – 9:12 A.M. |
| | A. Welcome and Introductions | | |
| | B. Ryan White HIV/AIDS Program Planning Council Primer | | |
| | C. Conflict of Interest Form 700 | | |
| 5. | Co-Chair Report | | 9:12 A.M. – 9:30 A.M. |
| | A. Meeting Management Reminders | | |
| | B. Executive At-Large Member Elections | MOTION #4 | |
| | C. Black/African American Community (BAAC) Task Force Formation | MOTION #5 | |
| | D. March 14, 2019 COH Meeting Follow-Up Items | | |
| | E. 2019 COH Membership Drive | | |
| | F. Community HIV/AIDS TA and Training for Planning (Planning CHATT):
Setting the Foundation for a Good Relationship Between PC/PB and Part A
Recipient Webinar Tuesday, April 16 @ 1 to 2:30 p.m. ET | | |
| | G. 2019 National HIV Prevention Conference Updates/Highlights | | |
| | H. 2019 Conference on Retroviruses and Opportunistic Infections (CROI)
Updates/Highlights | | |

III. DISCUSSION

- | | | |
|----|--|-------------------------|
| 6. | Colloquia Series: National Youth HIV/AIDS Awareness Day
(NYHAAD) Panel Discussion on the Impact of HIV/AIDS Among
Young People and their Efforts in Response to the Epidemic | 9:30 A.M. – 10:30 A.M. |
| 7. | Los Angeles County HIV/AIDS Strategy (LACHAS) | 10:30 A.M. – 11:00 A.M. |
| | A. Stigma Reduction Action Planning Series Summary | |

V. BREAK

11:00 A.M – 11:10 A.M.

IV. REPORTS

8. Housing Opportunities for People Living with AIDS (HOPWA) Report 11:10 A.M – 11:15 A.M.
9. Ryan White Program Parts C, D and F Report 11:15 A.M – 11:20 A.M.
10. California Office of AIDS (OA) Report 11:20 A.M – 11:30 A.M.
11. LA County Department of Public Health Report 11:30 A.M. – 11:45 A.M.
 - A. Division of HIV/STD Programs (DHSP) Report
12. Standing Committee Reports 11:45 A.M. – 12:30 P.M.
 - A. Planning, Priorities & Allocations (PP&A) Committee
 - (1) (Revised) 2019 RWP Service Category Rankings **MOTION #6**
 - (2) (Revised) 2019 RWP Allocations **MOTION #7**
 - B. Operations Committee
 - (1) Membership Management
 - (a) Membership Applications
 - (i) Susan Alvarado | City of Long Beach Representative **MOTION #8**
 - (ii) Maribel Ulloa | HOPWA Representative **MOTION #9**
 - (iii) Justin Valero | Representative, Board Office 4 **MOTION #10**
 - (2) Policies and Procedures
 - (a) (Revised) Code of Conduct **MOTION #11**
 - C. Standards and Best Practices (SBP) Committee
 - (1) Ryan White Program Allowable Use of Funds
 - (2) Standards of Care Review
 - D. Public Policy Committee
 - (1) County, State and Federal Legislation & Policy
 - (a) (Draft) 2019 Policies Priorities **MOTION #12**
 - (b) "End the Epidemics" Initiative
 - (2) County, State and Federal Budget
13. Caucus, Task Force and Work Group Reports 12:30 P.M. – 12:45 P.M.
 - A. Assessment of the Administrative Mechanism (AAM) Work Group
 - B. Aging Task Force
 - C. HIV Service Awards Work Group
 - D. Black/African American Community (BAAC) Task Force
 - E. Consumer Caucus
 - F. Women's Caucus
 - G. Transgender Caucus

VI. MISCELLANEOUS

14. Public Comment 12:45 P.M. – 12:51 P.M.
Opportunity for members of the public to address the Commission
On items of interest that are within the jurisdiction of the Commission.
15. Commission New Business Items 12:51 P.M. – 12:57 P.M.
Opportunity for Commission members to recommend new business
items for the full body or a committee level discussion on non-agendized
matters not posted on the agenda, to be discussed and (if requested)
placed on the agenda for action at a future meeting, or matters requiring
immediate action because of an emergency situation, or where the need
to take action arose subsequent to the posting of the agenda.
16. Announcements 12:57 P.M. – 1:00 P.M.
Opportunity for members of the public to announce community events,
workshops, trainings, and other related activities.
17. Adjournment and Roll Call 1:00 P.M.
Adjournment for the meeting of April 11, 2019.

PROPOSED MOTION(s)/ACTION(s):**PROCEDURAL MOTIONS**

MOTION #1:	Approve the Agenda order, as presented or revised.
MOTION #2:	Approve the Minutes, as presented or revised.
MOTION #3:	Approve the Consent Calendar, as presented or revised.
MOTION #4:	Approve Executive At-Large members, as elected.

CONSENT CALENDAR:

MOTION #5:	Approve formation of the Black/African American Community Task Force, as presented or revised.
MOTION #6:	Approve the (Revised) 2019 Ryan White Program Rankings, as presented or revised.
MOTION #7:	Approve the (Revised) 2019 Ryan White Program Allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.
MOTION #8:	Approve membership application for Susan Alvarado, City of Long Beach representative, as presented, and forward to Board of Supervisors (BOS) for final recommendation and appointment.
MOTION #9:	Approve membership application for Maribel Ulloa, HOPWA representative, as presented, and forward to BOS for final recommendation and appointment.
MOTION #10:	Approve membership application for Justin Valero, Board Office 4 representative, as presented, and forward to BOS for final recommendation and appointment.
MOTION #11:	Approve the (Revised) Code of Conduct, as presented or revised.
MOTION #12:	Approve (Draft) 2019 Policies Priorities, as presented or revised.

COMMISSION ON HIV MEMBERS:

Al Ballesteros, MBA, Co-Chair	Grissel Granados, MSW, Co-Chair	Traci Bivens-Davis	Jason Brown
Alasdair Burton (Alternate)	Joseph Cadden, MD	Danielle Campbell, MPH	Raquel Cataldo
Michele Daniels	Erika Davies	Susan Forrest (Alternate)	Aaron Fox, MPM
Alexander Luckie Fuller	Jerry D. Gates, PhD	Joseph Green	Terry Goddard II, MA
Felipe Gonzalez	Bridget Gordon	Karl Halfman, MA	Diamante Johnson
William King, MD, JD, AAHIVS	Lee Kochems, MA	Bradley Land	David P. Lee, MPH, LCSW
Eric Paul Leue	Abad Lopez	Eduardo Martinez (Alternate)	Miguel Martinez, MSW, MPH
Anthony Mills, MD	Carlos Moreno	Derek Murray	Katja Nelson, MPP
Jazielle Newsome	Frankie Darling-Palacios	Raphael Peña	Mario Pérez, MPH
Juan Preciado	Ricky Rosales	Martin Sattah, MD	LaShonda Spencer, MD
Kevin Stalter	Yolanda Sumpter	Greg Wilson	Russell Ybarra
MEMBERS:	43		
QUORUM:	22		



2019 MEMBERSHIP ROSTER | UPDATED 4/10/19

APPROVED BY COH ON 7/12/18

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative	1	SBP	Vacant		July 1, 2017	June 30, 2019	
2	City of Pasadena representative	1	SBP	Erica Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2020	
3	City of Long Beach representative	1	PP	Vacant		July 1, 2017	June 30, 2019	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2020	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2017	June 30, 2019	
6	Director, DHSP	1	EXC/PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2020	
7	Part B representative	1	PP&A	Karl Hallman	California Department of Public Health	July 1, 2018	June 30, 2020	
8	Part C representative	1	EXC/PP	Aaron Fox, MPH	Los Angeles LGBT Center	July 1, 2017	June 30, 2019	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2017	June 30, 2019	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2020	
11	Provider representative #1	1	EXC/ISBP	Joseph Cadden, MD	Rand Schrader Clinic (SPA1), LA County Department of Health Services	July 1, 2017	June 30, 2019	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2020	
13	Provider representative #3	1	EXC/PP&A	Miguel Martínez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2017	June 30, 2019	
14	Provider representative #4	1	EXC/OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2020	
15	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2017	June 30, 2019	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2020	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles LGBT Center	July 1, 2017	June 30, 2019	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Schrader Clinic (SPA1), LA County Department of Health Services	July 1, 2018	June 30, 2020	
19	Unaffiliated consumer, SPA 1	1	OPS	Michele Daniels	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
21	Unaffiliated consumer, SPA 3	1	EXC/PP&A	Jason Brown	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
22	Unaffiliated consumer, SPA 4	1	EXC/ISBP	Kevin Stalter	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
23	Unaffiliated consumer, SPA 5	1	PP&A	Yolanda Sumpter	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
24	Unaffiliated consumer, SPA 6	1	Vacant			July 1, 2018	June 30, 2020	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Pena	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
26	Unaffiliated consumer, SPA 8	1	OPS	Carlos Moreno	Unaffiliated Consumer	July 1, 2018	June 30, 2020	Susan Forrest (PP&A)
27	Unaffiliated consumer, Supervisorial District 1	1	OPS			July 1, 2017	June 30, 2019	
28	Unaffiliated consumer, Supervisorial District 2	1		Vacant		July 1, 2018	June 30, 2020	
29	Unaffiliated consumer, Supervisorial District 3	1		Vacant		July 1, 2017	June 30, 2019	
30	Unaffiliated consumer, Supervisorial District 4	1		Vacant		July 1, 2018	June 30, 2020	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
33	Unaffiliated consumer, at-large #2	1	EXC/OPS	Joseph Green	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
35	Unaffiliated consumer, at-large #4	1	OPS	Brigdet Gordon	Unaffiliated Consumer	July 1, 2017	June 30, 2019	
36	Representative, Board Office 1	1	EXC	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2020	
37	Representative, Board Office 2	1	EXC/OPS	Traci Bivens-Davis	N/A	July 1, 2017	June 30, 2019	
38	Representative, Board Office 3	1	EXC/PP	Karla Nelson, MPP	APLA	July 1, 2018	June 30, 2020	
39	Representative, Board Office 4	1	Vacant			July 1, 2017	June 30, 2019	
40	Representative, Board Office 5	1	SBP	Bradley Land	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
41	Representative, HOPWA	1	PP	Vacant		July 1, 2017	June 30, 2019	
42	Behavioral/social scientist	1	PP	Lee Kochems	Unaffiliated Consumer	July 1, 2018	June 30, 2020	
43	Local health/hospital planning agency representative	1	EXC	Vacant		July 1, 2017	June 30, 2019	
44	HIV stakeholder representative #1	1	PP	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2020	
45	HIV stakeholder representative #2	1	PP	Greg Wilson	In the Meantime Men's Group	July 1, 2017	June 30, 2019	
46	HIV stakeholder representative #3	1	EXC/OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2020	
47	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coalition	July 1, 2017	June 30, 2019	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2018	June 30, 2020	
49	HIV stakeholder representative #6	1	OPS	Alexander Luckie Fuller	N/A	July 1, 2017	June 30, 2019	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHVS	W. King Health Care Group	July 1, 2018	June 30, 2020	
51	HIV stakeholder representative #8	1	SBP	Jazelle Newsome	Unaffiliated Consumer	July 1, 2018	June 30, 2020	

TOTAL: 41

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM



LOS ANGELES COUNTY COMMISSION ON HIV



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COMMITTEE ASSIGNMENTS

(Updated: April 10, 2019)

Subject to Change

Committee Member Name/ Alternate	Member Category	Affiliation
<i>* = Primary Committee Assignment</i>		<i>** = Secondary Committee Assignment</i>
EXECUTIVE COMMITTEE		
Regular meeting day: 4 th Thursday of the month		Regular meeting time: 1:00pm–3:00pm
Number of Voting Members: 13		Number of Quorum: 7
Grissel Granados, MSW	Co-Chair, Comm./Exec.*	Commissioner
Al Ballesteros, MBA	Co-Chair, Comm./Exec.*	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Miguel Martinez	Co-Chair, PP&A	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Joseph Green	At-Large Member*	Commissioner
Katja Nelson	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Juan Preciado	Co-Chair, Operations	Commissioner
Kevin Stalter	Co-Chair, SBP	Commissioner

OPERATIONS COMMITTEE		
Regular meeting day: 4 th Thursday of the month		Regular meeting time: 10:00am-12:00pm
Number of Voting Members: 9		Number of Quorum: 5
Traci Bivens-Davis	Committee Co-Chair*	Commissioner
Juan Preciado	Committee Co-Chair*	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Susan Forrest	**	Alternate
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Carlos Moreno	*	Commissioner
Alexander Luckie Fuller	*	Commissioner

Committee Assignment List

Updated: April 10, 2019

Page 2 of 4

Committee Member Name	Member Category	Affiliation
* = <i>Primary Committee Assignment</i>	** = <i>Secondary Committee Assignment</i>	

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE		
Regular meeting day: 3 rd Tuesday of the month		Regular meeting time: 1:00-4:00 PM
<i>Number of Voting Members:</i> 14	<i>Number of Quorum:</i>	8
Jason Brown	Committee Co-Chair*	Commissioner
Miguel Martinez, MPH, MSW	Committee Co-Chair*	Commissioner
Susan Forrest	*	Alternate
Karl Halfman	*	Commissioner
William D. King, MD, JD, AAHIVS	*	Commissioner
Abad Lopez	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Diamante Johnson	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Pena	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE		
Regular meeting day: 1st Monday of the month		Regular meeting time: 1:00 pm-3:00pm
<i>Number of Voting Members:</i> 12	<i>Number of Quorum:</i>	7
Aaron Fox, MPM	Committee Co-Chair*	Commissioner
Katja Nelson	Committee Co-Chair*	Commissioner
Jerry Gates, PhD	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	*	Alternate
Terry Goddard, MA	*	Commissioner
Eric Paul Leue	*	Commissioner
Ricky Rosales	*	Commissioner
Martin Sattah, MD	*	Commissioner
Greg Wilson	*	Commissioner
Alasdair Burton	*	Alternate
Kyle Baker	DHSP staff	DHSP representative

Committee Assignment List

dated: April 10, 2019

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Committee Member Name	Member Category	Affiliation
* = <i>Primary Committee Assignment</i>	** = <i>Secondary Committee Assignment</i>	

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE		
Regular meeting day:	1 st Tuesday of the month	Regular meeting time: 10:00am-12:00pm
Number of Voting Members: 8		Number of Quorum: 5
Joseph Cadden, MD	Committee Co-Chair*	Commissioner
Kevin Stalter	Committee Co-Chair*	Commissioner
Erika Davies	*	Commissioner
Felipe Gonzalez	*	Commissioner
Bradley Land	*	Commissioner
David Lee, MPH, LCSW	*	Commissioner
Jazielle Newsome	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative

CONSUMER CAUCUS		
Regular meeting day:	Following Comm. mtg.	Regular meeting time: 1:00pm-3:00pm
<i>*Open membership to consumers of HIV prevention and care services*</i>		
Russell Ybarra	Co-Chair	Commissioner
Jorge Orellana-Merida (Geo)	Co-Chair	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Alasdair Burton	Member	Alternate
Michele Daniels	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Joseph Green	Member	Commissioner
Bridget Gordon	Member	Commissioner
Diamante Johnson	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
Carlos Moreno	Member	Commissioner
Raphael Pena	Member	Commissioner
Jazeille Newsome	Member	Commissioner
Kevin Stalter	Member	Commissioner
Yolanda Sumpter	Member	Commissioner

Committee Assignment List

Updated: April 10, 2019

Page 4 of 4

Committee Member Name	Member Category	Affiliation
* = <i>Primary Committee Assignment</i>	** = <i>Secondary Committee Assignment</i>	

AGING TASK FORCE (ATF)

Regular meeting day: 4 TH Thursday of the month		Regular meeting time: 10:00am-12:00pm
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Alasdair Burton	Member	Commissioner
Bradley Land	Member	Commissioner
Mark McGrath	Community Member	
Craig Pulsipher, MPP, MSW	Member	

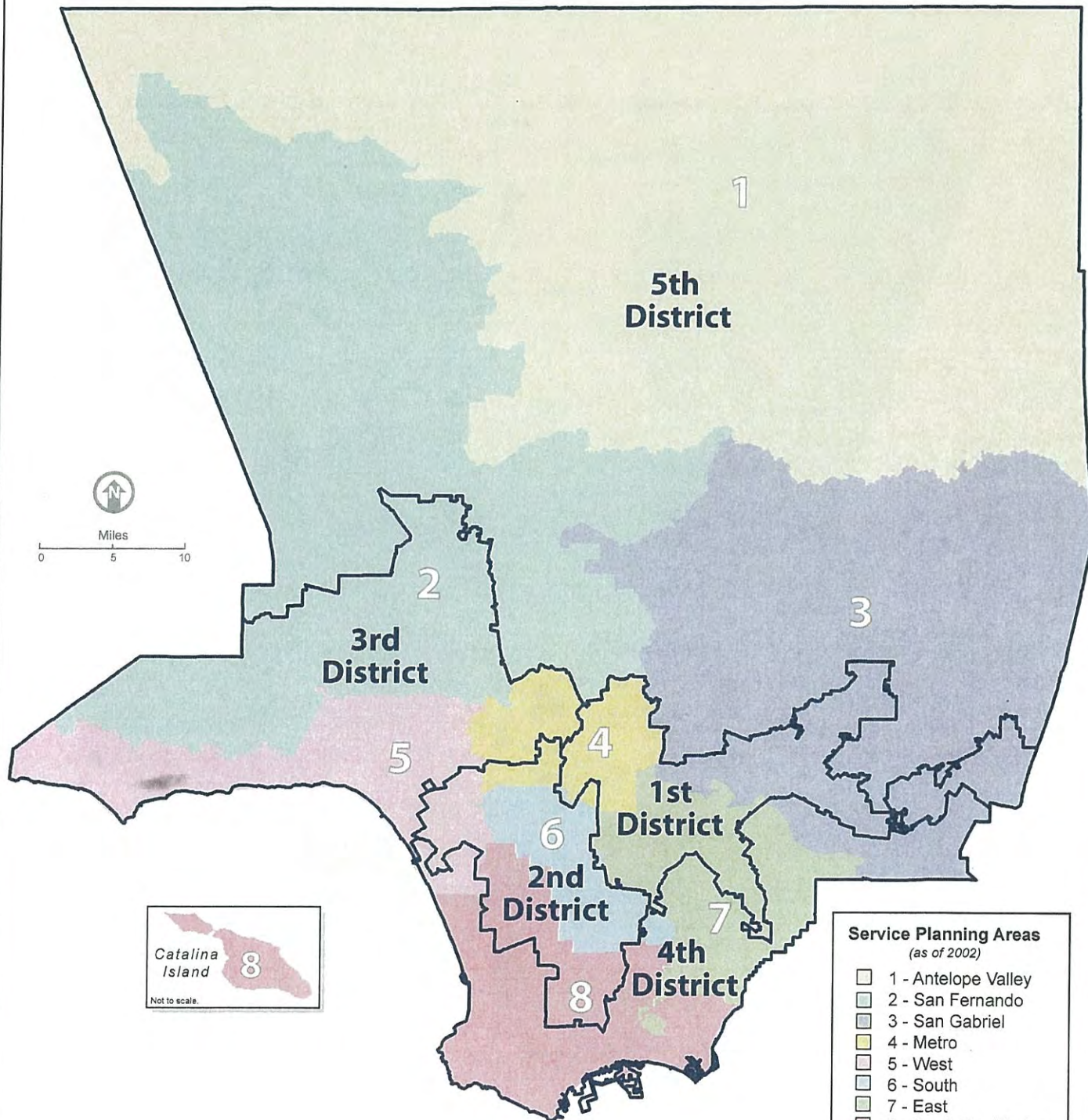
BLACK AFRICAN AMERICAN COMMUNITY TASK FORCE

Regular meeting time: TBD		
Luckie Fuller	Member	Commissioner
Traci Bivens-Davis	Member	Commissioner
Danielle Campbell, MPH	Member	Commissioner
Bridget Gordon	Member	Commissioner
Greg Wilson	Member	Commissioner
LaShonda Spencer, MD	Member	Commissioner
Yolanda Sumpter	Member	Commissioner
Jeffrey King	Member	Community

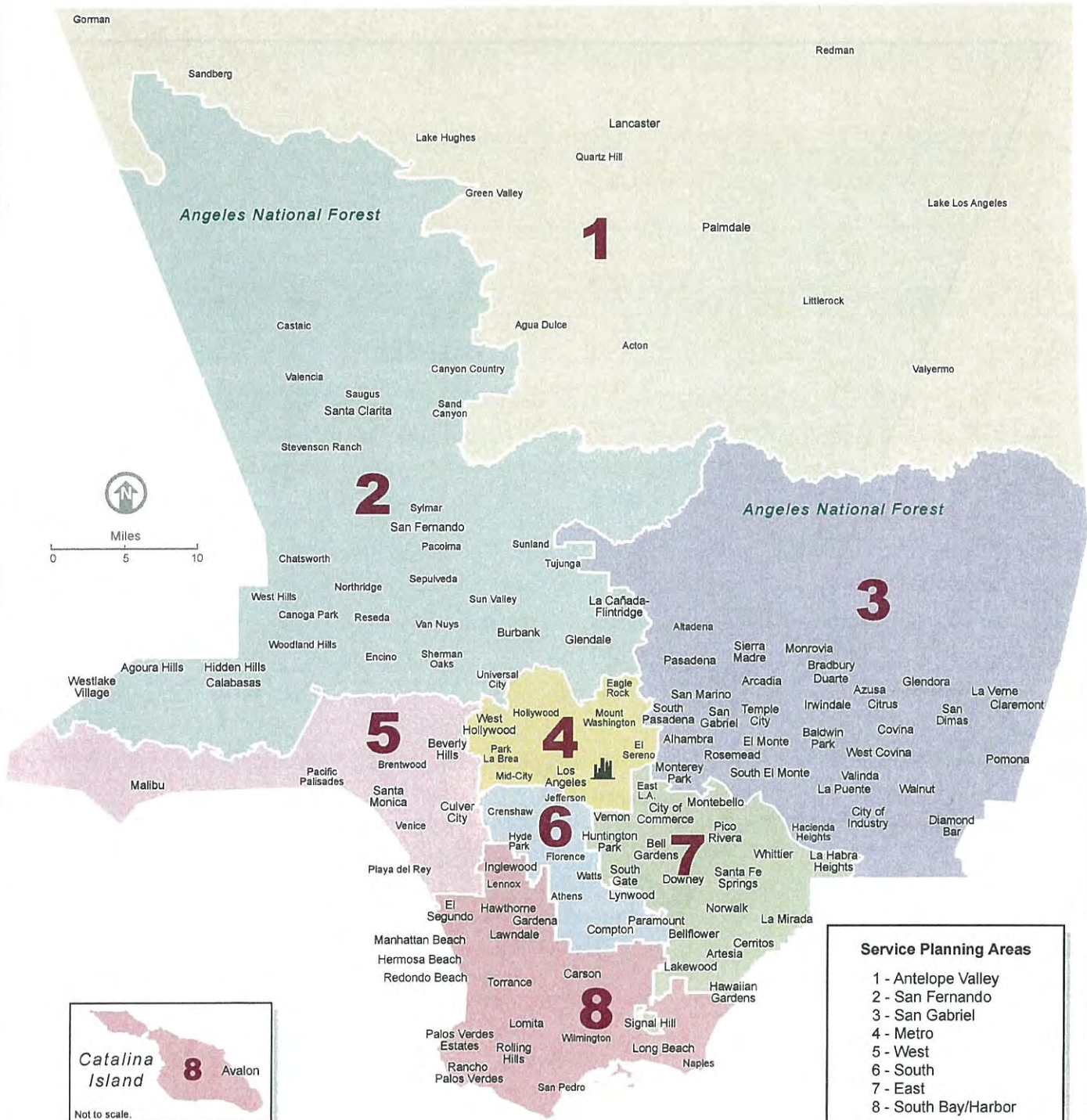
TRANSGENDER TASK FORCE*Meeting Day and Membership TBD***WOMEN'S CAUCUS**

Regular meeting day: 3 rd Wednesday of the month	Regular meeting time:	10:00am-12:00pm
Danielle Campbell	Member	Commissioner
Bridget Gordon	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Natalie Sanchez	Member	
LaShonda Spencer, MD	Member	Commissioner

Los Angeles County Service Planning Areas by Supervisorial District



Los Angeles County Service Planning Areas



Service Planning Areas

- 1 - Antelope Valley
- 2 - San Fernando
- 3 - San Gabriel
- 4 - Metro
- 5 - West
- 6 - South
- 7 - East
- 8 - South Bay/Harbor

American Indian Children's
Council covers all SPAs

Note: City names are shown in **BLACK**.
Communities are shown in **GRAY**.



August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

HIV Calendar

April 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
6 OK 14	1 10:00 AM - 12:00 PM LACHAS Policy Workgroup Meeting 1:00 PM - 3:00 PM Public Policy Committee	2 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3 9:30 AM - 11:30 AM BOS Agenda Review	4	5	6
7 Week 15	8	9 9:30 AM - 1:00 PM Board of Supervisors (BOS)	10 9:30 AM - 11:30 AM BOS Agenda Review	11 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	12	13
14 Week 16	15 10:00 AM - 12:00 PM Transgender Caucus	16 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	17 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Women's Caucus	18	19	20
21 Week 17	22	23 9:30 AM - 1:00 PM Board of Supervisors (BOS)	24 9:30 AM - 11:30 AM BOS Agenda Review	25 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	26	27
28 Week 18	29 12:00 PM - 2:00 PM Black/African-American Community (BAAC) Task Force Meeting	30 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Aging Task Force	1 9:30 AM - 11:30 AM BOS Agenda Review	2	3	4

HIV Calendar

May 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28 Week 18	29 12:00 PM - 2:00 PM Black/African-American Community (BAAC) Task Force Meeting	30 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Aging Task Force	1 9:30 AM - 11:30 AM BOS Agenda Review	2	3	4
5 Week 19	6 1:00 PM - 3:00 PM Public Policy Committee	7 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	8 9:30 AM - 11:30 AM BOS Agenda Review	9 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	10	11
12 Week 20	13	14 9:30 AM - 1:00 PM Board of Supervisors (BOS)	15 9:30 AM - 11:30 AM BOS Agenda Review	16	17	18
19 Week 21	20 10:00 AM - 12:00 PM Transgender Caucus	21 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	22 9:30 AM - 11:30 AM BOS Agenda Review	23 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	24	25
26 Week 22	27 HOLIDAY Memorial Day - COH Office Closed	28 9:30 AM - 1:00 PM Board of Supervisors (BOS)	29 9:30 AM - 11:30 AM BOS Agenda Review	30	31	1

HIV Calendar

June 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 22	27 HOLIDAY Memorial Day - COH Office Closed	28 9:30 AM - 1:00 PM Board of Supervisors (BOS)	29 9:30 AM - 11:30 AM BOS Agenda Review	30	31	1
2 Week 23	3 1:00 PM - 3:00 PM Public Policy Committee	4 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	5 9:30 AM - 11:30 AM BOS Agenda Review	6	7	8
9 Week 24	10	11 9:30 AM - 1:00 PM Board of Supervisors (BOS)	12 9:30 AM - 11:30 AM BOS Agenda Review	13 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	14	15
16 Week 25	17 10:00 AM - 12:00 PM Transgender Caucus	18 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	19 9:30 AM - 11:30 AM BOS Agenda Review	20	21	22
23 Week 26	24	25 9:30 AM - 1:00 PM Board of Supervisors (BOS)	26 9:30 AM - 11:30 AM BOS Agenda Review	27 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	28	29
30 Week 27	1 1:00 PM - 3:00 PM Public Policy Committee	2 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3 9:30 AM - 11:30 AM BOS Agenda Review	4 HOLIDAY Independence Day - COH Office Closed	5	6

HIV Calendar

July 2019

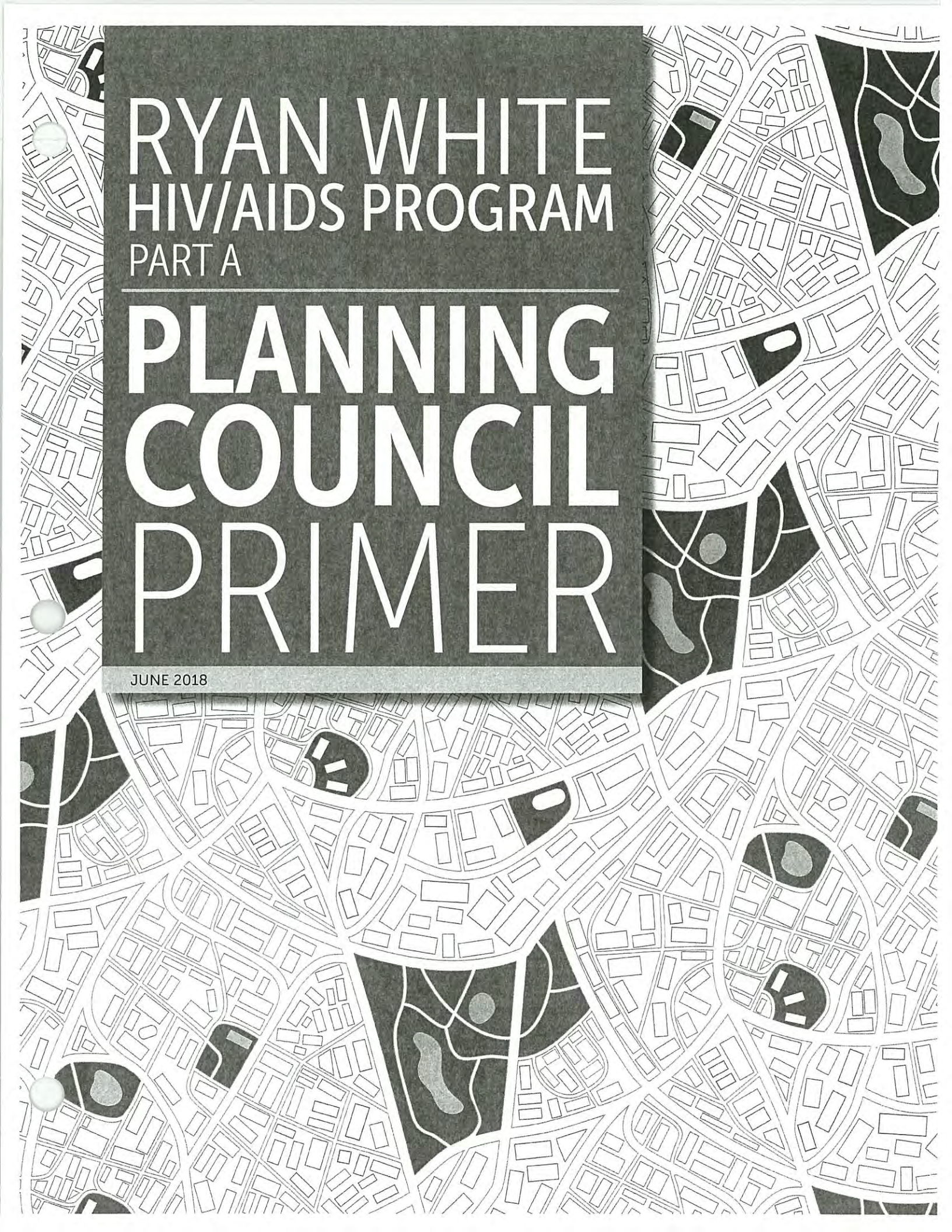
Sun	Mon	Tue	Wed	Thu	Fri	Sat
30 Week 27	1 1:00 PM - 3:00 PM Public Policy Committee	2 9:30 AM - 1:00 PM Board of Supervisors (BOS) 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	3 9:30 AM - 11:30 AM BOS Agenda Review	4 HOLIDAY Independence Day - COH Office Closed	5	6
7 Week 28	8	9 9:30 AM - 1:00 PM Board of Supervisors (BOS)	10 9:30 AM - 11:30 AM BOS Agenda Review	11 9:00 AM - 1:00 PM Commission Meeting 1:00 PM - 3:00 PM Consumer Caucus Meeting	12	13
14 Week 29	15 10:00 AM - 12:00 PM Transgender Caucus	16 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	17 9:30 AM - 11:30 AM BOS Agenda Review	18	19	20
21 Week 30	22	23 9:30 AM - 1:00 PM Board of Supervisors (BOS)	24 9:30 AM - 11:30 AM BOS Agenda Review	25 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	26	27
28 Week 31	29	30 9:30 AM - 1:00 PM Board of Supervisors (BOS)	31 9:30 AM - 11:30 AM BOS Agenda Review	1	2	3

2. APPROVAL OF THE MEETING MINUTES:

- A. March 14, 2019 COH Meeting Minutes (**MOTION #2**)

4. EXECUTIVE DIRECTOR'S REPORT:

B. Ryan White HIV/AIDS Program Planning Council Primer

The background of the entire page is a stylized, high-contrast map of a city. It features a dense grid of white lines representing streets and building footprints on a dark grey background. Interspersed within the grid are several irregular white shapes representing parks, green spaces, and bodies of water. The map is oriented horizontally, with the city grid running from left to right.

RYAN WHITE
HIV/AIDS PROGRAM
PART A

PLANNING COUNCIL PRIMER

JUNE 2018



PLANNING **CHATT**

Community HIV/AIDS
Technical Assistance & Training

This resource was prepared by JSI Research & Training Institute, Inc. in collaboration with EGM Consulting, LLC, and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30795: Ryan White HIV/AIDS Program Planning Council and Transitional Grant Area Planning Body Technical Assistance Cooperative Agreement. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



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Introduction

Uniqueness and Value of Planning Councils

One of the important aspects of the Ryan White HIV/AIDS Program (RWHAP) is its focus on community health planning for HIV care and treatment. Community health planning is a deliberate effort to involve diverse community members in “an open public process designed to improve the availability, accessibility, and quality of healthcare services in their community.”¹ The process involves “identifying community needs, assessing capacity to meet those needs, allocating resources, and resolving conflicts.” For RWHAP Part A, planning councils/planning bodies play that role.

RWHAP planning councils are unique. No other federal health or human services program has a legislatively required planning body that is the decision maker about how funds will be used, has such defined membership composition, and requires such a high level of consumer participation (at least 33 percent). When more than 100 recipients, planning council leaders, and planning council support staff were asked in a recent national assessment² about the greatest value of planning councils, they most often identified the following benefits:

- Community involvement in decision making about HIV services
- A consumer voice in decisions about services
- Collaboration among diverse stakeholders, including consumers and other people living with HIV, providers, the local health department, researchers, and other community members, with everyone sitting at the same table and working together to make the best decisions for the community
- Positive impact on the service system, including improvements in access to and quality of care, and contributions to positive client outcomes including viral suppression.

Individuals who serve as RWHAP planning council members make a vital contribution to their communities by helping to strengthen and improve the service system for people living with HIV.

1 Stern J. Community Planning, American Health Planning Association, 2008. available at http://www.ahpanet.org/files/community_health_planning_09.pdf

2 McKay E., et al. Engaging RWHAP Consumers in Planning and Needs Assessment, 2016 National Ryan White Conference on HIV Care & Treatment. available at <https://careacttarget.org/sites/default/files/supporting-files/6746McKay.pdf>

Purpose of the Primer

This Primer is designed to help Ryan White HIV/AIDS Program (RWHAP) Part A planning council members better understand the roles and functioning of planning councils.

The Primer explains what RWHAP does, and describes what planning councils do in helping make decisions about what RWHAP services to fund and deliver in their geographic areas. The Primer is intended to be a basic reference to help prepare planning council members to actively engage in planning council activities, and effectively carry out their legislatively defined community health planning duties.

While most RWHAP Part A jurisdictions have planning councils, a few smaller areas have planning bodies, which serve the same purpose but are not subject to the same legislative requirements as planning councils. This Primer describes the expectations for planning councils; there are no specific requirements for other types of planning bodies. However, Health Resources and Services Administration (HRSA) encourages such planning bodies to be as similar as possible to planning councils in their membership, and to carry out the same activities as planning councils³, as outlined in the legislation. Therefore this Primer should be useful to planning bodies as well as planning councils.

³ HRSA/HAB Letter to RWHAP Part A Grantees, 2013. Available at <https://hab.hrsa.gov/sites/default/files/hab/Global/transitionalgrantareasplanningcouncilsmoving-forward.pdf>

The Ryan White HIV/AIDS Program

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. The Program reaches over half of all people diagnosed with HIV in the United States.

The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training and the development of innovative models of care. The Program serves as an important source of ongoing access to HIV medications that can enable people living with HIV to live close to normal lifespans.

The RWHAP legislation is known as the Ryan White HIV/AIDS Treatment Extension Act of 2009, and is also Title XXVI of the Public Health Service Act. The legislation was first passed in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The 2009 law is the fourth reauthorization of RWHAP by Congress. The program helps people living with HIV get into care early, stay in care, and remain healthy.

Most RWHAP funds are used for grants to local and state areas to address the needs of people living with HIV. Many decisions about how to use the money are made by local planning councils/planning bodies and state planning groups, which work as partners with their governments.

RWHAP is administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care by strengthening the healthcare workforce, building healthy communities and achieving health equity.

The RWHAP legislation supports grants under the five sections of the Act: Parts A, B, C, D, and F. Below is a short description of each. The majority of the funding that goes to RWHAP Part A and Part B is awarded under a formula based on the number of living HIV and AIDS cases in these areas.

RYAN WHITE HIV/AIDS PROGRAM FUNDING

- **RWHAP Part A:** Grants to metropolitan areas hardest hit by the epidemic for HIV medical care and support services
- **RWHAP Part B:** Grants to states and territories for HIV medical care and support services, including HIV-related medications through the AIDS Drug Assistance Program (ADAP)
- **RWHAP Part C:** Community-based early intervention services grants for HIV medical care and support services
- **RWHAP Part D:** Community-based grants for family-centered primary and specialty medical care and support services for infants, children, youth, and women living with HIV
- **RWHAP Part F:** Support for five programs—Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), HIV Dental Programs, and the Minority AIDS Initiative (MAI)

RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas

RWHAP Part A funds go to local areas that have been hit hardest by the HIV epidemic. The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV to improve their health outcomes.

Almost three quarters of people living with HIV in the U.S. live in RWHAP Part A-funded areas. These areas are called eligible metropolitan areas (EMAs) or transitional grant areas (TGAs):

- EMAs are metropolitan areas with at least 2,000 new cases of AIDS reported in the past five years and at least 3,000 cumulative living cases of AIDS as reported by the Centers for Disease Control and Prevention (CDC) in the most recent calendar year for which data are available. As of early 2018, there were 24 EMAs.
- TGAs are metropolitan areas with between 1,000 and 1,999 new cases of AIDS reported in the past five years and at least 1,500 cumulative living cases of AIDS as reported by the CDC in the most recent calendar year for which data are available. As of early 2018, there were 28 TGAs.

RWHAP Part A funds go to the **chief elected official (CEO)** of the major city or county government in the EMA or TGA. The CEO is usually the mayor; however sometimes the CEO is the county executive, chair of the board of supervisors, or county judge. The CEO is legally the recipient of the grant, but usually chooses a lead agency such as a department of health or other entity to manage the grant. That entity is also called the **recipient**. The recipient manages the grant by making sure RWHAP funds are used according to the RWHAP legislation, program policy guidance, and grants policy. The recipient works with the **RWHAP Part A planning council/planning body**, which is responsible for making decisions about service priorities and resource allocation of RWHAP Part A funds.

RWHAP Part A funds are used to develop or enhance access to a comprehensive system of high quality, community-based care for low-income people living with HIV. RWHAP Part A recipients must provide comprehensive primary health care and support services throughout the entire geographic service area. RWHAP Part A funds may be used for HIV primary medical care and other medical-related services and for support services (like medical transportation) that are needed by people living with HIV in order to stay in care, and linked to positive medical outcomes.

At least 75 percent of service funds must be used for core medical-related services, and up to 25 percent may be used for approved support services, unless the EMA or TGA successfully

applies for a waiver. A limited amount of the money (up to 10 percent of the total grant) can be used for administrative costs, which include planning, managing, monitoring, and evaluating programs. Administrative funds are also used to support a comprehensive community planning process, through the work of a planning council or other planning body. In addition, some funds (up to 5 percent of the total grant or \$3 million, whichever is less) are set aside for clinical quality management, to ensure service quality.

RWHAP Part B: Grants to States and Territories

RWHAP Part B provides funds to improve the quality, availability, and organization of HIV health care and support services in states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the U.S. Pacific Territories and Associated Jurisdictions.

Like RWHAP Part A funds, RWHAP Part B funds are used for medical and support services. A major priority of RWHAP Part B is providing medications for people living with HIV. The RWHAP legislation gives states flexibility to deliver these services under several programs:

- Grants for medical and support services for people living with HIV
- The AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications through the purchase of medications and the purchase of health insurance
- Grants to states with emerging communities that have a growing rate of HIV/AIDS.

States can receive ADAP funds through three types of grants:

- Formula funding that goes to every state and territory based on the number of living HIV/AIDS cases reported by the CDC in the most recent calendar year
- Competitive ADAP supplemental funding, supported through a five percent set aside of the ADAP base award and provided to states and territories that meet RWHAP legislative eligibility criteria and apply for additional funds to address a severe need for medications
- Competitive ADAP Emergency Relief Funding (ERF), available to states and territories that can demonstrate the need for additional resources to prevent, reduce, or eliminate waiting lists, including through cost-containment measures.

ADAP funds are used to provide HIV antiretroviral medications to low-income people living with HIV. Funds may also be used to pay for health coverage, copays, and deductibles* for eligible clients and for services that enhance access and adherence to drug treatments, or monitor drug treatments.

ADAP FORMULARY REQUIREMENTS

Each ADAP must cover at least one drug from each class of HIV antiretroviral medications on its ADAP formulary. RWHAP funds may only be used to purchase FDA-approved medications. Within these requirements, each ADAP decides which medications to include on its formulary and how those medications will be distributed. ADAP eligibility criteria must be consistently applied across the state or territory, and all formulary medications and ADAP-funded services must be equally and consistently available to all eligible enrolled people throughout the state or territory.

As with RWHAP Part A, 75 percent of RWHAP Part B service dollars must be used for core medical-related services unless the state obtains a waiver. RWHAP Part B recipients can use no more than 10 percent of their grants for administration, including indirect costs. They can also use up to 10 percent for planning and evaluation, but the total for both types of activities must be no more than 15 percent of the RWHAP Part B grant. As with RWHAP Part A, recipients may also spend up to 5 percent of their grant or up to \$3 million, whichever is less, for the establishment and implementation of a clinical quality management program.

States are required to conduct a needs assessment to determine service needs of people living with HIV. Based upon needs assessment results, states must set priorities and allocate resources to meet these needs. States must also prepare an integrated HIV prevention and care plan, including a ***Statewide Coordinated Statement of Need (SCSN)***, which is a guide on how to meet these needs.

Planning is an essential part of determining how to use limited RWHAP Part B funds in providing a system of HIV/AIDS care. States are required to obtain community input as a component of planning for the use of RWHAP Part B resources, and many states do this through RWHAP Part B advisory groups. A state can choose to oversee planning itself through statewide or regional planning groups, or can assign the responsibility to consortia. Consortia are associations of public and nonprofit healthcare and support service providers and community-based organizations that the state contracts with to provide planning, resource allocation and contracting, program and fiscal monitoring, and required reporting. Some are statewide groups, while others cover specific local areas or regions. Some regional consortia also directly deliver medical and support services.

Some states also receive ***Emerging Communities*** grants to establish and support systems of care in metropolitan areas that are not eligible for RWHAP Part A funding but have a growing rate of HIV. To be eligible for these funds, a metropolitan area must have between 500 and 999 AIDS cases reported in the past five years. To stay eligible, it must have at least 750 cumulative living AIDS cases as of the most recent calendar year. Some Emerging Communities eventually become eligible for RWHAP Part A funding.

RWHAP Part C: Community-Based Early Intervention Services

RWHAP Part C funds local, community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people living with HIV.

RWHAP Part C funding is through **Early Intervention Services (EIS)** program grants. RWHAP Part C funds also help organizations more effectively deliver HIV care and services. Unlike RWHAP Part A and Part B, these funds are awarded competitively and go directly to community agencies like community health centers, rural health clinics, health departments, and hospitals. While RWHAP Part C funds many locations around the nation, a funding priority under the legislation is support for HIV-related primary care services in rural areas or for populations facing high barriers to access.

RWHAP Part C recipients must use at least 50 percent of the grant for EIS. They may use no more than 10 percent of their grants for administration, including indirect costs. In addition, RWHAP Part C recipients must use at least 75 percent of their grant funds for core medical services and up to 25 percent for support services. This is the same requirement that applies to Parts A and B.

RWHAP Part C also provides Capacity Development grants. **Capacity Development** grants help public and nonprofit entities strengthen their organizational infrastructure and improve their capacity to provide high-quality HIV primary care services.

RWHAP Part D: Services for Women, Infants, Children, and Youth

RWHAP Part D funds are used to provide family-centered primary medical care and support services to women, infants, children, and youth living with HIV. RWHAP Part D funds are competitive grants that go directly to local public or private healthcare organizations including hospitals, and to public agencies.

RWHAP Part D grants are used for medical services, clinical quality management, and support services, including services designed to engage youth living with HIV and retain them in care. Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth. RWHAP Part D recipients can use no more than 10 percent of their grants for administration, including indirect costs.

RWHAP PART C EARLY INTERVENTION REQUIRED SERVICES

EIS programs must include the following components:

- HIV counseling
- High-risk targeted HIV testing
- Referral and linkage of people living with HIV to comprehensive care, including outpatient/ambulatory health services, medical case management, substance abuse treatment, and other services
- Other HIV-related clinical and diagnostic services

RWHAP Part F: SPNS, AETC, Dental Programs, and MAI

RWHAP Part F provides grant funding that supports several research, technical assistance, and access-to-care programs.

- **Special Projects of National Significance (SPNS):** SPNS funds are awarded competitively to organizations that are developing new and better ways of serving people living with HIV and addressing emerging client needs. Projects include a strong evaluation component.
- **AIDS Education and Training Centers (AETCs):** AETC regional and national centers train health care providers treating people living with HIV. AETCs train clinicians and multidisciplinary HIV care team members. They help to increase the number of health care providers prepared and motivated to counsel, diagnose, treat, and medically manage people living with HIV.
- **HIV/AIDS Dental Reimbursement Program:** These funds go to dental schools and other dental programs to help pay for dental care for people living with HIV.
- **Community Based Dental Partnership Program:** These funds are used to deliver community-based dental care services for people living with HIV while providing education and clinical training for dental care providers, especially in community-based settings.
- **Minority AIDS Initiative (MAI):** MAI funds are used to improve access to health care and medical outcomes for racial and ethnic minorities— communities that are disproportionately affected by HIV. RWHAP Part A programs apply for MAI funds as part of their annual applications, and receive funds on a formula basis. They are expected to administer MAI activities as an integral part of their larger programs.

How RWHAP Part A Works

The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV residing in the EMA/TGA, in order to improve their health outcomes. This section of the Primer describes the people and entities that participate in RWHAP Part A and what they do.

Participants

Participants in the RWHAP Part A grant for the EMA or TGA include the following:

- The chief elected official (CEO), who receives the funds on behalf of the EMA or TGA
- The recipient, the entity chosen by the CEO to manage the grant and make sure funds are used appropriately
- The planning council (or planning body), which conducts planning, decides how to allocate resources, and works to ensure a system of care that provides equitable access to care and needed services to all eligible people living with HIV in the EMA or TGA
- The HRSA HIV/AIDS Bureau's Division of Metropolitan HIV/AIDS Programs (HAB/DMHAP), the federal government entity within HRSA that makes sure the RWHAP Part A program is implemented appropriately.

The Chief Elected Official (CEO)

The CEO is the person who officially receives the RWHAP Part A funds from HRSA. The CEO is the chief elected official of the major city or urban county in the EMA or TGA that provides HIV care to the largest number of people living with HIV. The CEO may be a mayor, chair of the county board of supervisors, county executive, or county judge. The CEO is responsible for making sure that all the rules and standards for using RWHAP Part A funds are followed. The CEO usually designates an agency to manage the RWHAP Part A grant—generally the county or city health department. The CEO establishes the planning council/planning body and appoints its members.

The Recipient

As the person who receives RWHAP Part A funds, the CEO is the recipient. However, in most EMAs and TGAs, the CEO delegates responsibility for administering the grant to a local government agency (such as a health department) that reports to the CEO. This agency is called the recipient. The word “recipient” means the person or organization that actually carries out RWHAP Part A tasks, whether that is the CEO, the public health department, or another agency that reports to the CEO.

THE RWHAP PART A AWARDS PROCESS

Each year Congress appropriates funds for the Ryan White HIV/AIDS Program, including RWHAP Part A. The money for RWHAP Part A is divided into formula and supplemental funds and Minority AIDS Initiative (MAI) funds.

- **Formula funds** are awarded to EMA or TGAs based on the number of persons living with HIV and AIDS in the EMA or TGA.
- **Supplemental funds** are awarded to the EMA or TGA based on increasing prevalence rates, documented demonstrated need and service gaps, and a demonstrated disproportionate impact on vulnerable populations.
- **RWHAP Part A MAI funds** are allocated based on each EMA's or TGA's percentage of all living HIV disease cases among racial and ethnic minorities.

EMAs or TGAs must submit a grant application to HRSA to receive RWHAP Part A formula, supplemental, and MAI funds.

The recipient should prepare the application with planning council/planning body input. The funding year begins on March 1.

The Planning Council

Before an EMA/TGA can receive RWHAP Part A funds, the CEO must appoint a planning council. The planning council must carry out many complex planning tasks to assess the service needs of people living with HIV living in the area, and specify the kinds and amounts of services required to meet those needs. The planning council is assisted in fulfilling these complex tasks by **planning council support (PCS) staff** whose salaries are paid by the grant.

The RWHAP legislation requires planning councils to have members from various types of groups and organizations, including people living with HIV who live in the EMA/TGA. A key function of the planning council is to provide the consumer and community voice in decision-making about medical and support services to be funded with the EMA/TGA's RWHAP Part A dollars.

TGAs do not have to follow the legislative requirements related to planning councils, but must provide a process for obtaining consumer and community input. TGAs that have currently operating planning councils are strongly encouraged by the HIV/AIDS Bureau to maintain that structure.

HRSA/HAB

The HRSA HIV/AIDS Bureau (HAB) is the office in the federal government that is responsible for administering RWHAP Part A throughout the country. The HRSA/HAB office is located in Rockville, Maryland. HRSA develops policies to help implement the legislation, and provides guidance to help recipients understand and implement legislative requirements. These include Policy Clarification Notices (PCNs), related Frequently Asked Questions (FAQs), and Program Letters.

Each EMA or TGA is assigned a **Project Officer** who works in HRSA/HAB. Project Officers help the recipient and planning council do their jobs and make sure that they are running the local RWHAP Part A program as the RWHAP legislation, National Monitoring Standards, and other federal regulations say they should. Project Officers make periodic site visits and hold monthly monitoring calls with the recipient. The planning council Chair is sometimes included on a part of these calls.

Planning Council and Recipient: Separate Roles and Mutual Goals

The RWHAP Part A planning council and the recipient have separate roles that are stated in the RWHAP legislation, but they also share some duties.

The planning council and the recipient work together on identifying the needs of people living with HIV (by conducting a needs assessment) and preparing a ***CDC and HRSA Integrated HIV Prevention and Care Plan***, formerly known as a comprehensive plan (which is a long-term guide on how to meet those needs).

Both also work together to make sure that other sources of funding work well with RWHAP funds and that RWHAP is the “payor of last resort.” This means that other available funding should be used for services before RWHAP dollars are used to pay for them.

The planning council decides what services are priorities for funding and how much funding should be provided for each service category, based upon the needs of people living with HIV in the EMA/TGA. The recipient is accountable for managing RWHAP Part A funds and awarding funds to agencies to provide services that are identified by the planning council as priorities, usually through a competitive “Request for Proposals” (RFP) process.

The planning council cannot do its job without the help of the recipient, and the recipient cannot do its job without the help of the planning council. Some of the responsibilities are identified clearly in the RWHAP legislation. Others must be decided locally. It is important that the planning council and the recipient work together and come to an agreement about their duties. This agreement should be written in planning council bylaws and in a memorandum of understanding (MOU) between the recipient and the planning council.

How RWHAP Part A Improves Access and Services for People Living with HIV



The table below shows which RWHAP Part A participant has responsibility for specific roles and duties. Each of these roles/duties is described in detail in the following sections of the Primer.

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	<i>Optional</i>
Development of Service Standards		✓	✓
Clinical Quality Management		✓	<i>Contributes but not responsible</i>
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

Planning Council Duties

The planning council (and its staff) must carry out many complex tasks, summarized in the box and described below.

The first step is to set up rules and structures to help the planning council to operate smoothly and fairly (**planning council operations**). This includes bylaws, grievance procedures, conflict of interest policies and procedures, procedures that ensure open meetings, and an open nominations process to identify nominees for the planning council. It also includes a committee structure. Planning councils must be trained in planning, and new members must receive orientation to their roles and responsibilities and those of the recipient.

The planning council must find out about what services are needed and by which populations, as well as the barriers faced by people living with HIV in the EMA or TGA (**needs assessment**). Next—based on needs assessment, utilization, and epidemiologic data—it decides what services are most needed by people living with HIV in the EMA or TGA (**priority setting**) and decides how much RWHAP Part A money should be used for each of these service categories (**resource allocations**).

The planning council may also provide guidance to the recipient on service models, targeting of populations or service areas, and other ways to best meet the identified priorities (**directives**). The planning council works with the recipient to develop a long-term plan on how to provide these services (**integrated/comprehensive planning**, formerly called comprehensive planning). The planning council reviews service needs and ways that RWHAP Part A services work to fill gaps in care with other RWHAP Parts through the Statewide Coordinated Statement of Need (SCSN) as well as with other programs like Medicaid and Medicare (**coordination**).

The planning council also evaluates how providers are selected and paid, so that funds are made available efficiently where they are most needed (**assessment of the efficiency of the administrative mechanism**). All of these roles are described below.

Planning Council Operations

Planning councils must have procedures to guide their activities. Planning council operations are usually outlined in their bylaws and described in greater detail in policies and procedures covering the following areas:

MEMBERSHIP

The planning council needs a membership committee and a clear and open nominations process to choose new planning council

PLANNING COUNCIL ROLES AND RESPONSIBILITIES

- Planning council operations: structure, policies, and procedures, and membership tasks
- Needs assessment
- Integrated/comprehensive planning
- Priority setting and resource allocations
- Directives: guidance to the recipient on how best to meet priorities
- Coordination with other RWHAP Parts and other HIV-related services
- Assessment of the efficiency of the administrative mechanism
- Development of service standards
- Evaluation of program effectiveness (optional)

members and to replace members when a member's term ends or the person resigns. This includes making sure that the planning council membership overall and the consumer membership meet the requirements of **reflectiveness**—having characteristics that reflect the local epidemic in such areas as race, ethnicity, gender, and age, and **representation**—filling the required membership categories as stated in the legislation (See page 17). Particular attention should be paid to including people from disproportionately affected and “historically underserved”⁴ groups and subpopulations. At least 33 percent of voting members must be consumers of RWHAP Part A services who are “unaffiliated” or “unaligned.” This means they do not have a conflict of interest, meaning they are not staff, paid consultants, or Board members of RWHAP Part A-funded agencies.

Open nominations require member vacancies and nomination criteria to be widely advertised. The announcement of an opening on the planning council should include the qualifications and other factors that are considered when choosing members. Nomination criteria must include a conflict of interest standard so that planning council members make decisions that are best for people living with HIV in the EMA or TGA, without considering personal or professional benefits for themselves or their families. The planning council reviews nominations against vacancies and recommends members to the CEO for appointment.

LEADERSHIP

Every planning council has a leader, usually called the Chair. This responsibility may be shared by two or more persons, called Co-Chairs, or there may be a Chair and Vice Chair(s). HRSA suggests that the Chair of the planning council be elected by its members. Sometimes a Chair or one Co-Chair is appointed by the recipient from the list of members recommended by the planning council. A person who works for the recipient may not be the only Chair of the council—in this case, there must be Co-Chairs.

COMMITTEES

Planning councils do much of their work in committees. Most planning councils require each member to participate actively on one committee and to attend full planning council meetings. Bylaws usually specify several permanent “standing committees,” and may permit special ad hoc temporary or time-limited committees or caucuses as well. Committee structures vary, but most planning councils have an executive or steering committee, a membership committee (sometimes also responsible for operations such as policies and procedures), and a people living with HIV or consumer committee or caucus. In addition, they usually have one or several committees responsible for carrying out major legislative responsibilities related

⁴ Ryan White HIV/AIDS Treatment Extension Act of 2009
www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf

Required Planning Council Membership Categories



PEOPLE LIVING WITH HIV & COMMUNITY

- Members of affected communities*
- Non-elected community leaders
- Representatives of recently incarcerated people living with HIV
- Unaffiliated consumers



PUBLIC HEALTH & HEALTH PLANNING

- Public health agencies
- Healthcare planning agencies
- State agencies**



HEALTH & SOCIAL SERVICE PROVIDERS

- Healthcare providers, including FQHCs
- Community-based organizations and AIDS service organizations
- Social service providers
- Mental health and substance abuse treatment providers



FEDERAL HIV PROGRAMS

- RWHAP Part B recipients
- RWHAP Part C recipients
- RWHAP Part D recipients†
- Recipients under other federal HIV programs‡

* Including people living with HIV, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and "historically underserved⁴ groups and subpopulations

**Including state Medicaid agency and agency administering the RWHAP Part B program

† If there is no RWHAP Part D recipient in the EMA or TGA, representatives of organizations with a history of serving children, youth, and families living with HIV

‡ Including HIV prevention services

PLANNING COUNCIL BYLAWS

Each planning council must have written rules, called bylaws, which explain how the planning council operates. Bylaws must be clear and exact. They should include at least the following:

- Mission of the planning council
- Member terms and how members are selected (open nominations process)
- Duties of members
- Officers and their duties
- How meetings are announced and run, including how decisions are made
- What committees the planning council has and how they operate
- Conflict of interest policy
- Grievance procedures
- Code of Conduct for members
- How the bylaws can be amended

to needs assessment, integrated/comprehensive planning, priority setting and resource allocations, and maintaining and improving the system of care. Committees typically discuss issues, develop plans or recommendations, and bring them to the executive/steering committee for review and possible revision. Then the recommendations go to the full planning council for final discussion and action.

TRAINING

Members need to learn how to participate in the many tasks involved in RWHAP planning. Planning councils must provide orientation for new members, covering topics such as the legislation and their roles and responsibilities in planning, as well as those of the recipient. All planning council members should receive periodic training to help them carry out their roles. HRSA requires planning councils to confirm in the annual RWHAP Part A application that training for all members occurred at least once during the year.⁵

GROUP PROCESS

This includes a Code of Conduct, as well as rules for committee and full planning council operations, meeting times, and locations. These decisions are usually summarized in the bylaws and detailed in official policies and procedures.

DECISION MAKING

The planning council needs to agree on how decisions will be made—for example, by voting or consensus—and how grievances related to funding decisions and conflict of interest will be managed (see Planning Council Bylaws). For example, the planning council needs to decide whether its meetings will follow *Robert's Rules of Order*. These rules and procedures are usually included in the bylaws and further described in separate policies and procedures.

CONFLICT OF INTEREST

The planning council must define **conflict of interest** and determine how it will be handled as the planning council carries out its duties. The planning council must develop procedures to assure that decisions concerning service priorities and funding allocations are based upon community and client needs and not on the financial interests of individual service providers or the personal or professional interests of individual planning council members. Conflict of interest procedures generally include a disclosure form completed by all members that states in writing any affiliations that could create a conflict of interest.

⁵ The FY 2018 Notice of Funding Opportunity (NOFO) for RWHAP Part A requires that the letter of assurance from the planning council or the letter of concurrence from the planning body leadership provide evidence that "ongoing, annual membership training occurred, including the date(s)" [p 15].

Usually, conflict of interest policies also apply to specified family members. Thus, planning councils must decide how planning council members may or may not participate in making decisions about specific services if they or close family members are staff, consultants, or Board members of agencies that are receiving RWHAP Part A funds for these specific services, or are competing for such funds. For example, if a planning council member works for a substance abuse treatment provider receiving RWHAP Part A funds, the member may not participate in decision making about priorities, allocations, or directives related to substance abuse treatment. However, members may freely share their insights and expertise at appropriate times in a non-voting context, such as during data presentations or community input sessions, since all members can benefit from hearing a variety of perspectives and expertise.

GRIEVANCE PROCEDURES

The planning council must develop ***grievance procedures*** to handle complaints about how it makes decisions about funding. The grievance procedures must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled. The recipient must also have its own grievance procedures, which focus on handling of complaints about the process used for funding of ***subrecipients*** who provide services. The two sets of grievance procedures should be written to be in alignment with each other so that they do not conflict.

PLANNING COUNCIL SUPPORT

Planning councils need personnel to assist them in their work, and money to pay for things like a needs assessment and meeting costs. This is called ***planning council support***. Planning council support should cover reasonable and necessary costs associated with carrying out legislatively mandated functions. The planning council's budget is a part of the recipient's administrative budget, so the planning council and recipient decide together what funds are needed. The planning council then works with its support staff to develop its own budget and monitor expenses, but must meet RWHAP and recipient rules regarding use of funds. In deciding how much planning council support to pay for, planning councils and recipients should balance the need for support in order to meet planning requirements with the need for other administrative activities and for direct services for people living with HIV.

HRSA encourages planning councils to use some planning council support funds to reimburse unaffiliated consumer members for their actual expenses related to participation in the planning council, such as travel or child/dependent care. However, RWHAP funds may not be used to provide stipends to members.

Needs Assessment

The planning council works with the recipient to identify service needs by conducting a needs assessment. This involves first finding out how many persons living with HIV (both HIV/non-AIDS and AIDS) are in the area through an **epidemiologic profile**. Usually, an epidemiologist from the local or state health department provides this information. Next the council determines the needs of populations living with HIV and the capacity of the service system to meet those needs. This assessment of needs is done through surveys, interviews, key informant sessions, focus groups, or other methods.

The needs assessment seeks to determine:

- Service needs and barriers for people living with HIV who are in care
- The number, characteristics, and service needs and barriers of people living with HIV who know their HIV status and are not in care
- The estimated number, probable characteristics, and barriers to testing for individuals who are HIV-infected but unaware of their status
- The number and location of agencies providing HIV-related services in the EMA or TGA—a resource inventory of the local “system of care”
- Local agencies’ capacity and capability to serve people living with HIV, including capacity development needs
- Service gaps for all people living with HIV and how they might be filled, including how RWHAP service providers need to work with other providers, like substance abuse treatment services and HIV prevention agencies.

The needs assessment must include direct input from people living with HIV. Needs assessment is usually a multi-year task, with different components updated each year.

The needs assessment should be a joint effort of the planning council and recipient, with the planning council having lead responsibility. It is sometimes implemented by an outside contractor under the supervision of the planning council. Usually the costs for needs assessment are part of the planning council support budget. Regardless of who does this work, it is important to obtain many perspectives, especially those of diverse groups of people living with HIV, and to consider the needs of people living with HIV in and out of care, including the need to identify those who do not know their status. Results should be carefully analyzed and compared with other data, such as information from the recipient on client characteristics and utilization of funded services. (See Appendix I for a description of the multiple data sources the planning council reviews in making its decisions.)

Priority Setting and Resource Allocations

The planning council uses needs assessment data as well as data from a number of other sources to set priorities and allocate resources. This means the members decide which services are most important to people living with HIV in the EMA or TGA (priority setting) and then agree on which service categories to fund and how much funding to provide (resource allocations). In setting priorities, the planning council should consider what service categories are needed to provide a comprehensive system of care for people living with HIV in the EMA or TGA, without regard to who funds those services.

The planning council must prioritize only service categories that are included in the RWHAP legislation as core medical services or support services. These are the same service categories that can be funded by RWHAP Part B and RWHAP Part C programs. (See page 22 for a list of service categories eligible for RWHAP Part A funding.)

After it sets priorities, the planning council must allocate resources, which means it decides how much RWHAP Part A funding will be used for each of these service priorities. For example, the planning council decides how much funding should go for outpatient/ambulatory health services, mental health services, etc. In allocating resources, planning councils need to focus on the legislative requirement that at least 75 percent of funds must go to cover medical services and not more than 25 percent to support services, unless the EMA or TGA has obtained a waiver of this requirement. Support services must contribute to positive medical outcomes for clients. Typically, the planning council makes resource allocations using three scenarios that assume unchanged, increased, and decreased funding in the coming program year.

The planning council makes decisions about priorities and resource allocations based on many factors, including:

- Needs assessment findings
- Information about the most successful and economical ways of providing services
- Actual service cost and utilization data (provided by the recipient)
- Priorities of people living with HIV who will use services
- Use of RWHAP Part A funds to work well with other services like HIV prevention and substance abuse treatment services, and within the changing healthcare landscape
- The amount of funds provided by other sources like Medicaid, Medicare, state and local government, and private funders—since RWHAP is the “payor of last resort” and should not pay for services that can be provided with other funding.

ELIGIBLE RWHAP PART A & PART B SERVICES

Core medical-related services, including:

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support services, including:

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Linguistic Services
7. Medical Transportation
8. Non-Medical Case Management Services
9. Other Professional Services [for example, Legal Services and Permanency Planning]
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Healthcare and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)

The planning council also has the right to provide directives to the recipient on how best to meet the service priorities it has identified. It may direct the recipient to fund services in particular parts of the EMA or TGA (such as outlying counties), or to use specific service models. It may tell the recipient to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month). It may also require that services be appropriate for particular subpopulations—for example, it may specify funding for medical services that target young gay men of color. However, the planning council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will qualify. The planning council may review sections of the Request for Proposals (RFP) the recipient develops for RWHAP Part A services, to ensure that directives are appropriately reflected, but it cannot be involved in any aspect of contractor selection (**procurement**) or in managing or monitoring RWHAP Part A contracts. These are recipient responsibilities.

The planning council allocates RWHAP Part A service funds only. The planning council's own budget is a part of the recipient's administrative budget (as described in the Planning Council Operations section above). The planning council does not participate in decisions about the use of administrative funds other than planning council support, or in the use of clinical quality management (CQM) funds. These decisions are made by the recipient.

Once the EMA or TGA receives its grant award for the upcoming year, the planning council usually needs to adjust its allocations to fit the exact amount of the grant. During the year, the recipient usually asks the planning council to consider and approve some **reallocation** of funds across service categories, to ensure that all RWHAP Part A funds are spent and that priority service needs are met, or establishes a standard mechanism to reallocate up to some agreed-upon percentage.

Integrated/Comprehensive Planning

The planning council works with the recipient in developing a written plan that defines short- and long-term goals and objectives for delivering HIV services and strengthening the system of care in the EMA or TGA. This is called a comprehensive plan in the legislation, but is now called the CDC and HRSA Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN).

The legislation gives the planning council a lead role in the planning process, which must be carried out in close coordination with the recipient. The EMA or TGA may submit a joint plan with the state RWHAP Part B program. The plan is based, in part, on the results of the needs assessment and other information such as client utilization data. It is used to guide decisions about how to deliver HIV services for people living with HIV. The plan should be consistent with other existing local or state plans and with national goals to end the HIV epidemic.

The plan should ensure attention to each stage of the **HIV care continuum**, which measures the steps or stages of HIV medical care from diagnosis to linkage to care, retention in care and treatment, prescribing of HIV medications, and achieving the goal of viral suppression (a very low level of HIV in the body).

CDC and HRSA/HAB provide joint guidance on what the integrated HIV Prevention and Care Plan should include and when it needs to be completed. The first Integrated Prevention and Care Plan was submitted to CDC and HRSA on September 30, 2016 as a five-year plan covering the years 2017–2021. The plan should be reviewed, and where necessary updated, annually, and should be used as a roadmap for implementation of the jurisdiction's RWHAP Part A programs.

NATIONAL GOALS TO END THE HIV EPIDEMIC

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a more coordinated national response to HIV

HIV Care Continuum



Coordination with Other RWHAP Parts and Other Services

The planning council is responsible for ensuring that RWHAP Part A resource allocation decisions account for and are coordinated with other funds and services. The planning tasks described earlier (needs assessment, priority setting and resource allocation, integrated/comprehensive planning) require getting lots of input, including finding out what other sources of funding exist. This information helps avoid duplication in spending and reduce gaps in care. For example, the needs assessment should find out what HIV prevention and substance abuse treatment services already exist. Integrated/comprehensive planning helps the planning council consider the changing healthcare landscape and the implications for HIV services.

The ***Statewide Coordinated Statement of Need***, called the SCSN, is a way for all RWHAP activities in a state to work together to identify and address significant HIV care issues related to the needs of people living with HIV, and to use that information to maximize coordination, integration, and effective linkages across programs. Representatives of the planning council—and the recipient—must participate with other RWHAP Parts (Parts B, C, D and F) in the state to develop a written SCSN. The SCSN is a part of each state's Integrated HIV Prevention and Care Plan.

Assessment of the Efficiency of the Administrative Mechanism

The planning council is responsible for evaluating how rapidly RWHAP Part A funds are allocated and made available for care. This involves ensuring that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether the amounts contracted for each service category are the same as the planning council's allocations. The results of this ***assessment of the efficiency of the administrative mechanism*** are shared with the recipient, who develops a response including corrective actions if needed. Both the results of the assessment and the recipient response are summarized in the RWHAP Part A funding application for the following year.

Development of Service Standards

Establishing service standards is a shared responsibility of the recipient and the planning council. While it is ultimately the responsibility of the recipient to ensure that service standards are in place, the planning council typically takes the lead in developing service standards for funded service categories.⁶ **Service standards** guide providers in implementing funded services. They typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities. The service standards set the minimum requirements of a service and serve as a base on which the recipient's clinical quality management (CQM) program is built. Developing service standards is usually a joint activity; the planning council works with the recipient, providers, consumers, and experts on particular service categories. These service standards must be consistent with HHS guidelines on HIV care and treatment as well as HRSA/HAB standards and performance measures, including the National Monitoring Standards.

Evaluation of Services

The planning council may choose to evaluate how well services funded by RWHP Part A are meeting identified community needs, or it can pay someone else to do such an evaluation. The Part A recipient's CQM program can provide information on clinical outcomes that informs the planning council about the impact of services. The recipient may include planning council members on its CQM committee. In addition, most planning councils regularly review EMA/TGA performance along the HIV care continuum. The planning council uses evaluation findings in considering ways to improve the system of care, including changing service priorities and allocations and developing directives.

To carry out the array of planning tasks described above the planning council meets regularly throughout the year, as a whole and in committees. See Appendix II for a sample calendar describing the approximate timing of various planning council activities by months of the year.

⁶ Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/Planning Bodies. 2014. Available at www.targethiv.org/servicestandards

CEO and Recipient Duties

CEO Duties Related to the Planning Council

The CEO has three important duties related to the planning council:

- **Establish the Planning Council:** The CEO must establish and maintain the planning council—or, in the case of a TGA, some other process to obtain community input, particularly from people living with HIV. This includes making sure that the planning council membership meets requirements related to representation, reflectiveness, and participation of unaffiliated consumers. The CEO should ensure that these requirements are specified in planning council bylaws.
- **Choose Planning Council Members:** The CEO establishes the first planning council. After that, the council itself is responsible for identifying and screening candidates and forwarding their names, the membership categories they will fill, and other requested information to the CEO so they can be considered for appointment. The CEO retains sole responsibility for appointment and removal of planning council members. If some nominees submitted by the planning council are not appointed, the CEO informs the planning council, and it provides additional nominees.
- **Review and Approve Bylaws and Other Processes:** The CEO establishes the planning council and thus has the authority to review and approve planning council bylaws and other policies. Often, the planning council is considered an official board or commission of the city or county. Its bylaws and procedures must fit the policies established for these bodies as well as meeting RWHAP legislative requirements.

Recipient Duties

The recipient has several planning duties that are shared with the planning council. These include assisting the planning council with needs assessment and integrated/comprehensive planning and providing information the planning council needs to carry out its priority setting and resource allocation responsibilities. It also shares responsibility for coordination with other RWHAP activities and services. In addition, the recipient has administrative duties, which means that it is responsible for making sure that RWHAP Part A funds are fairly and correctly managed and used. The main duties of the recipient are described below.

ADDITIONAL RECIPIENT ADMINISTRATIVE DUTIES

- ☐ Establish intergovernmental agreements (IGAs) with other cities/counties in the EMA or TGA
- ☐ Establish grievance procedures to address funding-related decision making
- ☐ Ensure delivery of services to women, infants, children, and youth with HIV
- ☐ Ensure that RWHAP funds are used to fill gaps and do not pay for care that can be supported with other existing funds
- ☐ Ensure that services are available and accessible to eligible clients
- ☐ Control recipient and provider administrative costs
- ☐ Prepare and submit the annual RWHAP Part A funding application
- ☐ Meet HRSA/HAB reporting requirements

Appendix III briefly describes these duties.

RECIPIENT ADMINISTRATIVE DUTIES

Below are the major RWHAP Part A recipient duties designed to make sure that funds are used fairly and appropriately, in a way that maximizes linkage of people living with HIV to care, retention in care, and positive medical outcomes. Additional duties are listed in the box and described in Appendix III.

Procurement of Services

The recipient is responsible for identifying and selecting qualified service providers for delivering RWHAP Part A services. The recipient must award service funds to eligible providers (***subrecipients***) based on a fair and equitable system, usually through a competitive Request for Proposals (RFP) process.

In contracting for services, the recipient must distribute RWHAP Part A funds according to the priority setting and resource allocation decisions of the planning council. The recipient can only spend the amount of money that the planning council decides should be used for each funded service category. In addition, the recipient must follow planning council directives about “how best to meet” priority needs.

The planning council has no say about how the recipient uses funds for its own administrative expenses.

Contract Monitoring

Once subrecipient contracts have been awarded, the recipient must manage them and regularly monitor subrecipients. The recipient must make sure that the providers who receive RWHAP Part A funds use the money according to the terms of the subrecipient contract they signed with the recipient and meet RWHAP Part A National Monitoring Standards and other federal requirements established by HRSA/HAB. The recipient monitors subrecipients to determine how quickly they spend RWHAP Part A funds, and if they are providing the contracted services, providing services only to eligible clients, using funds only as approved, and meeting reporting and other requirements. Contract monitoring is solely a recipient responsibility.

The planning council receives monitoring results only by service category, not by subrecipient.

The recipient must keep track of how rapidly RWHAP Part A money is, or isn't, being spent. If funds are not being spent in a timely fashion, there are two options:

1. The recipient may reallocate the funds to another provider within the same service category, or
2. The planning council may agree to reallocate funds to a different prioritized service category.

The recipient and the planning council must share information and work together to ensure that any changes are in agreement with the priorities and allocations established by the planning council.

Clinical Quality Management Activities and Evaluation of Performance and Outcomes

The recipient must establish a **clinical quality management (CQM)** program, designed to improve patient care, health outcomes, and patient satisfaction. Components include infrastructure, performance measurement, and quality improvement.

- An ideal **infrastructure** includes leadership, dedicated staffing and resources, a quality management plan that covers all funded medical and support services, a CQM committee, consumer and stakeholder involvement, and assessment of the CQM program.
- **Performance measurement** is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, and patient satisfaction with the services they receive. Recipients select a portfolio of performance measures based on funded services, local HIV epidemiology, the identified needs of PLWH, and the national goals to end the epidemic.
- Based on performance measurement results, recipients work with subrecipients in the development and implementation of **quality improvement** activities to make changes to the program to improve services.

Subrecipients must be actively involved in CQM activities. Recipients are expected to ensure that subrecipients have the capacity to contribute to the CQM program, have the resources to conduct CQM activities, and implement a CQM program in their organization.

Recipients can use up to 5 percent of the award or \$3 million (whichever is less) to conduct CQM programs. The recipient shares with the planning council the results of its CQM activities. The planning council receives information by service category, but not about individual providers/subrecipients. These CQM data help the planning council in future cycles of priority setting and resource allocation.

QUALITY MANAGEMENT, QUALITY ASSURANCE, AND QUALITY IMPROVEMENT

Clinical Quality Management is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction, as described in this section.

Quality Assurance refers to activities aimed at ensuring compliance with minimum quality standards. Quality assurance activities include the process of looking back to measure compliance with standards (e.g., HHS guidelines, professional guidelines, service standards). Site visits and chart reviews are examples of commonly used quality assurance activities.

Quality Improvement is a part of CQM. It uses CQM performance data as well as data collected as part of quality assurance processes to strengthen patient care, health outcomes, and patient satisfaction.

As part of, or along with, CQM, the recipient often evaluates clinical outcomes. These outcomes are often measured using the HIV care continuum, with its focus on linkage to care, retention in care, use of antiretroviral therapy, and viral suppression. These results may be reviewed for all people living with HIV in the service area, for all RWHAP clients, and for key client subpopulations. Subpopulations may be defined by characteristics such as race/ethnicity, gender, age, place of residence, and/or risk factor. This helps the planning council in future decision making.

RECIPIENT DUTIES SHARED WITH THE PLANNING COUNCIL

Support for Planning Council Operations

The recipient must cooperate with the planning council by negotiating and managing its budget, providing staff expertise to support committees, and providing information the planning council needs to carry out its responsibilities. This includes data on client characteristics, service utilization, and service costs, as well as information for assessing the efficiency of the administrative mechanism.

Both the planning council and the recipient have the responsibility to support participation of people living with HIV on the planning council, although primary responsibility lies with the planning council. Examples include reimbursing expenses of consumer members such as travel and child care costs. The planning council establishes reimbursement policies; the recipient helps to ensure timely payment of reimbursements. The recipient assists in training planning council members by explaining recipient roles and helping planning council members understand information provided by the recipient such as data on service costs and client utilization of funded services.

Needs Assessment

The recipient works with the planning council to assess the needs of communities affected by HIV. It usually arranges for an epidemiologic profile to be provided by its surveillance unit or by the state's surveillance unit, and it ensures that funded providers cooperate with needs assessment efforts such as surveys and focus groups of people living with HIV and providers.

Integrated/Comprehensive Planning

The recipient and planning council work together to develop, review, and periodically update the CDC and HRSA Integrated HIV Prevention and Care Plan for the organization and delivery of HIV services. The recipient helps develop goals and objectives, and works with the planning council to ensure a workable joint plan for implementing them. Usually the recipient plays a key role in arranging to collect performance and outcomes data to evaluate progress towards the goals and objectives of the plan. Both recipient and planning council participate in reviewing and updating the plan.

Coordination with Other RWHAP Parts and Other Services

The recipient and planning council work together to make sure that RWHAP Part A funds are coordinated with other services and funders. This coordination occurs partly through planning, including needs assessment and the Statewide Coordinated Statement of Need. Throughout the year, the recipient helps keep the planning council informed about changes in HIV-related prevention and care services and funding, as well as the evolving healthcare landscape.

RECIPIENT PLANNING DUTIES SHARED WITH THE PLANNING COUNCIL

- ☐ Needs assessment
- ☐ Integrated/comprehensive planning
- ☐ Development of service standards
- ☐ Coordination with other RWHAP activities and other services, including:
 - Participation in the Statewide Coordinated Statement of Need (SCSN)
 - Ensuring that use of RWHAP funds is coordinated with other funding sources and with other healthcare systems and services

Technical Assistance

The RWHAP Part A recipient and the planning council/planning body may request technical assistance from HRSA to help them develop the knowledge and skills needed to meet the responsibilities outlined in this Primer. Examples of the kinds of technical assistance that HRSA can provide include: supporting participation of people living with HIV in RWHAP planning, training the planning council on using data for decision making, helping in the design of a needs assessment, assisting the planning council to refine committee structures and operations, and providing training to help the planning council and recipient understand their roles and work well together. HRSA can provide information describing what other EMAs or TGAs have done, offer model training materials, or provide experts to work with the planning council and recipient either long distance or on-site.

RWHAP Part A recipients and planning councils may seek and request technical assistance through the following channels:

- **HRSA/HAB Project Officer:** HRSA federal Project Officers are the first point-of-contact for RWHAP recipients in accessing technical assistance. Requests for technical assistance for the recipient or the planning council must be made in writing by the recipient to the HRSA/HAB Project Officer. For more information, visit the HAB Web Site at www.hab.hrsa.gov
- **TargetHIV.org** The TargetHIV website is the central source and “one-stop shop” for finding technical assistance and training resources for the Ryan White HIV/AIDS Program. Among the website’s key features are a resource library, a calendar of technical assistance and training events, contact information for RWHAP recipients, a Help Desk, and information about specific programs and services including tools and tips. Users can search for information on a particular topic or directed at a particular audience. Visit the TargetHIV website at www.targetHIV.org
- **Planning CHATT:** The *Community HIV/AIDS TA and Training for Planning* project (*Planning CHATT*) builds the capacity of RWHAP Part A planning councils and planning bodies across the U.S. to meet their legislative requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning. The Planning CHATT project provides training and technical assistance to support the work of planning council/planning body members, staff, and RWHAP Part A recipients. Find Planning CHATT on the TargetHIV website: www.targetHIV.org/planning-chatt

References and Resources for Further Information

Descriptions of Ryan White HIV/AIDS Treatment Extension Act of 2009

Materials available on the HRSA/HAB website describing the Ryan White HIV/AIDS program (RWHAP), including each of its Parts:

Overview

- About the Ryan White HIV/AIDS Program
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program

RWHAP Fact Sheets

Fact sheets on all RWHAP Parts

www.hab.hrsa.gov/publications/hiv-aids-bureau-fact-sheets

- Part A: Eligible Metropolitan Areas and Transitional Grant Areas
- Part B: States and U.S. Territories
- Part B: AIDS Drug Assistance Program
- Part C: Early Intervention Services and Capacity Development
- Part D: Women, Infants, Children, and Youth
- Part F: Special Projects of National Significance
- Part F: AIDS Education and Training Centers Program
- Part F: Dental Programs

RWHAP Part A

- RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas, including list of current Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-a-grants-emerging-metro-transitional-areas

RWHAP Part B

- RWHAP Part B: Grants to States & Territories
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-b-grants-states-territories
- RWHAP Part B: AIDS Drug Assistance Program
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-b-aids-drug-assistance-program

RWHAP Part C

- RWHAP Part C: Early Intervention Services and Capacity Development Program Grants
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-c-early-intervention-services-and-capacity-development-program-grants

RWHAP Part D

- RWHAP Part D: Services for Women, Infants, Children, and Youth
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-d-services-women-infants-children-and-youth

RWHAP Part F

- Special Projects of National Significance
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-special-projects-national-significance-spns-program
- AIDS Education and Training Centers
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-aids-education-and-training-centers-aetcc-program
- Dental Programs
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-dental-programs
- Minority AIDS Initiative
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-minority-aids-initiative

RWHAP Recipients

- Recipient lists and addresses by RWHAP Part, and list of RWHAP Part A planning councils/planning bodies
www.targethiv.org/content/grantees-part

Planning Council Legislative Requirements

Current legislation, which is a part of the Public Health Service Act

- Ryan White HIV/AIDS Treatment Extension Act of 2009
www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf
- Title XXVI, HIV Health Care Services Program, of the Public Health Service Act
www.legcounsel.house.gov/Comps/PHSA-merged.pdf

Service Standards

- Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/Planning Bodies. December 2, 2014
www.targetHIV.org/ServiceStandards

The Planning Process

Strengthening the Healthcare Delivery System through Planning: a three-part planning institute at the 2016 National Ryan White Conference on HIV Care and Treatment

www.targetHIV.org/planning-CHATT/planning-institute-2016

- Planning Bodies 101
- Planning Infrastructures 201
- Data-Driven Decision Making 301

Planning Council Roles, Responsibilities, and Operations

RYAN WHITE HIV/AIDS PROGRAM PART A MANUAL, REVISED 2013

A primary source of information about requirements, expectations, and suggested practices for planning council operations and for implementation of legislative responsibilities. Chapters identified below address legislative duties and some key aspects of planning council operations.

www.hab.hrsa.gov/sites/default/files/hab/Global/happartamanual2013.pdf

Implementing Legislative Responsibilities

- Planning Council Responsibilities: Section X. Chapter 3
- Needs Assessment: Section XI. Chapter 3
- Priority Setting and Resource Allocations: Section XI. Chapter 4
- Integrated/Comprehensive Plan: Section XI. Chapter 5
- Effectiveness of Funded Services to Meet Identified Need: Section X. Chapter 9
- Outcomes Evaluation: Section X. Chapter 10

Planning Council Operations

Membership

- Planning Council Membership: Section X. Chapter 4
- Planning Council Nominations: Section X. Chapter 5
- Member Involvement and Retention: Section XI. Chapter 8

People living with HIV/Consumer Participation

- Section X. Chapter 6
- Section XI. Chapter 9

Policies and Procedures

- Grievance Procedures: Section X. Chapter 7
- Conflict of Interest: Section X. Chapter 8

Federal Regulations and Guidelines

National Monitoring Standards (NMS)

See Monitoring Standards Guidance under www.hab.hrsa.gov/program-grants-management/ryan-white-hiv-aids-program-recipient-resources

- Frequently Asked Questions
www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringfaq.pdf
- Universal Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf
- RWHAP Part A Fiscal Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringparta.pdf
- RWHAP Part A Program Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf

Policy Clarification Notices (PCNs) and Program Letters

www.hab.hrsa.gov/program-grants-management/policy-notice-and-program-letters

Among the PCNs and program letters most important to Planning Councils are the following:

- *Transitional Grant Areas and Planning Councils Moving Forward, Program Letter*, December 4, 2013. Clarifies expectations and recommendations around the continued maintenance of planning councils by Transitional Grant Areas (TGAs) that were formerly Eligible Metropolitan Areas (EMAs) after Fiscal Year 2013.
- *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds* Policy Clarification Notice (PCN) #16-02, Revised December 5, 2016 and effective for awards made after October 1, 2016. Identifies eligible individuals, describes allowable service categories for RWHAP, and provides program guidance for implementation.
- *Clinical Quality Management*, Policy Clarification Notice (PCN) #15-02, undated. Clarifies HRSA RWHAP expectations for clinical quality management (CQM) programs.

Uniform Guidance

- For all federal awards, *OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Guidance)*, 2 CFR [Code of Federal Regulations] Part 200. The Guidance will supersede and streamline requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up.
www.bit.ly/2EJqWwt
- For HHS Programs: *45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards*
www.bit.ly/2GX2Cc9

RWHAP Part A Application Requirements

Ryan White HIV/AIDS Program Part A, HIV Emergency Relief Grant Program, Notice of Funding Opportunity (NOFO) No. HRSA-18-066

www.targetHIV.org/library/funding-opportunity-rwhap-fy18-part-hrsa-18-066

Program Use and Impact

- *Annual Client-Level Data Report: Ryan White HIV/AIDS Program Services Report (RSR) 2015*. Health Resources and Services Administration, December 2016.
www.hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf

Appendix I: Types of Data Reviewed by Planning Councils for Priority Setting and Resource Allocation

Epidemiologic profile: A description of the HIV epidemic in the EMA or TGA, usually prepared annually by local or state HIV surveillance staff, for use in both HIV prevention and HIV care planning. It usually describes characteristics of the general population, persons newly diagnosed with HIV infection, persons living with HIV disease, and persons at risk for HIV. Data help planning councils identify trends in the epidemic that will affect service needs.

Needs assessment data: Information about the number, characteristics, and service needs and barriers of people living with HIV, both in and out of care; current provider resources available to meet those needs; and service gaps. These data help the planning council improve service access and quality, overall and for specific subpopulations.

Service expenditure and cost data: Information provided by the recipient showing how much money is spent for each funded service category and what it costs to provide one “unit” of service or to serve one client for a year. Planning councils use this information in funding decisions and estimating the costs of serving additional clients.

Client characteristics and service utilization data: Data on the total number and characteristics of local RWHAP clients, including the number and characteristics of RWHAP Part A clients served in each service category. Data usually come from the annual Ryan White Services Report (RSR). Data help planning councils understand the demand for specific services and identify subpopulations facing barriers to access.

HRSA performance measures and clinical outcomes data: Data used to monitor and improve the quality of care across the EMA/TGA and in individual provider organizations, usually based on the percent of clients that meet the goal or service standard. Measures may relate to a process (such as frequency of medical visits or development of a case management care plan) or clinical outcome (such as viral suppression). Data help planning councils make funding decisions and agree on changes in service standards or models of care.

Clinical Quality Management (CQM) data: Information on patient care, health outcomes, and patient satisfaction. Performance measures are gathered through CQM processes. Then subrecipients work together on structured quality improvement projects that make changes to address identified weaknesses. CQM data help planning councils decide whether program or funding changes are needed to improve service quality and outcomes.

Testing/EIHA data: Data on the number of people who receive HIV tests, the number and percent testing positive and their characteristics, and the number referred to needed services. HRSA/HAB requires RWHAP Part A programs to implement a strategy for the Early Identification of Individuals with HIV/AIDS (EIHA). This includes identifying key target populations, locating individuals with HIV who do not know their HIV status, informing them of their status through testing, and helping link them to medical care and support services.

Unmet Need data: An estimate of the number of people living with HIV in the service area who know they are HIV-positive but are not receiving HIV-related medical care. May also include an assessment of the characteristics of individuals with unmet need and their service barriers and gaps. Planning councils use this information to make decisions about use of funds to find people with unmet need and link or relink them to care.

HIV care continuum data: Data that outline the steps or stages of HIV care that people living with HIV go through, and the number and proportion of individuals at each stage in the EMA or TGA. The continuum may begin with the estimated total number of people living with HIV (including those unaware of their status) or with the number diagnosed and living with HIV. Typical steps include diagnosis, linkage to care, retention in care (based on doctor visits and/or laboratory tests), treatment with antiretroviral therapy, and viral suppression (a very low level of HIV in the body). Planning councils use this information to improve services all along the continuum, often based on HIV care continuum data for specific RWHAP Part A subpopulations (for example, young gay men of color or African American women).

Appendix II: Sample Planning Council/ RWHAP Part A Program Calendar

Most planning councils operate on a RWHAP Part A program year, which runs from March through February. The chart below provides a “typical” annual calendar, though of course planning councils vary in their timing of key activities. Recipient activity is included in the chart, since some tasks, especially priority setting and resource allocations (PSRA), need to link to recipient deadlines, especially submission of the RWHAP Part A application. The application is usually due in September. The chart does not include regular committee meetings, but most planning councils have them monthly except in December. Most planning councils also have a retreat and/or some training during the year, but there is no set time for them.

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
January	- Beginning of member terms [most frequent date] - Orientation for new members - Needs assessment	- Final reallocations - Review of RWHAP Part A competitive applications and selection of subrecipients for program year beginning March 1
February	- Election of officers [date varies] - Needs assessment (continued) - Committee development/approval of work plans for coming year	Receipt of Notice of Award (NOA) for program year starting March 1—often a partial award
March	- Final allocations based on actual award amount [if full award is received; happens later if a partial award is received because there is not yet a final federal HHS budget] - Needs assessment (continued) - Review of progress on Integrated Plan	- Initial closeout of prior program year - Submission of Ryan White Services Report (RSR) - Review/preparation of response to conditions of award - Contracting with providers
April	- Town halls for input to PSRA - Obtain and review/integration of data from various sources - Directives development - Updating of Integrated Plan work plan as needed, with assignments to committees [process more complicated if joint plan was developed with state]	- Review of performance and outcome measures for prior year - Input to Integrated Plan update - Completion or obtaining of epi profile/trends report
May	- Identification of any data problems or gaps - Assessment of the efficiency of the administrative mechanism (AAM) begins - Data presentation	- Final closeout of prior year - Submission of Annual Progress Report for prior year - Submission of Program Expenditure Report for prior year
June	- Directives development (continued) - Priority setting and resource allocation (PSRA) begins	- Review of first quarter expenditures - Subrecipient monitoring [ongoing]

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
July	• PSRA work sessions and final approval • Presentation/adoption of directives • Submission of PSRA results to recipient	• Submission of Annual Federal Financial Report • Planning for submission of RWHAP Part A application
August	• Presentation/discussion of AAM report • PC sections of RWHAP Part A application • Negotiation of PC budget amount with recipient • Development of PC budget • Reallocation of funds if needed based on expenditures	• Preparation of RWHAP Part A application • Negotiation of PC budget amount • Recommendations for reallocation of funds if needed based on expenditures • Response to AAM report
September	• Review of draft application • Preparation of PC letter to accompany application, signed by Chair/Co-Chairs	• Completion and submission of RWHAP Part A application
October	• Review of service standards	• Issuance of RFP for RWHAP Part A services (selected services each year; often a 3-year cycle)
November	• Rapid reallocations • Planning for needs assessment	• Rapid reallocations • Receipt of provider applications in response to RFP for RWHAP Part A services
December	• Planning for new program year, including committee work plans	• Estimated Unobligated Balance (UOB) and estimated carryover request

Appendix III: Additional Recipient Administrative Duties

Establish Intergovernmental Agreements (IGAs): The recipient must make sure that RWHAP Part A funds reach all communities in the EMA or TGA where need exists. Thus, it must establish formal, written agreements with cities and counties within the EMA or TGA that provide HIV-related services and also account for at least 10 percent of the EMA's or TGA's reported AIDS cases. This agreement is called an Intergovernmental Agreement (IGA.) An IGA should describe how RWHAP Part A funds will be distributed and managed.

Establish Grievance Procedures: The recipient must develop grievance procedures to handle complaints about funding, such as the process by which contractors (subrecipients) are chosen. Like the planning council's grievance procedures, they must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled.

Ensure Services to Women, Infants, Children, and Youth with HIV/AIDS: The recipient must assure that the percentage of money spent on serving women, infants, children, and youth with HIV is at least in proportion to each group's percent of the total number of cases of HIV disease in the EMA or TGA. An exception is allowed when the recipient can show that their needs are met through other programs like Medicaid, Medicare, or RWHAP Part D. The planning council must consider this requirement when setting priorities and allocating resources.

Ensure that RWHAP Funds are Used to Fill Gaps: RWHAP Part A recipients must ensure that RWHAP Part A funds do not pay for services that are funded by other sources and are not used to replace local spending on HIV care. The legislation requires that RWHAP be the "payor of last resort." This means, for example, that the recipient must require subrecipients such as clinics to make sure clients are not eligible for Medicaid or some other source of funding before they use RWHAP Part A funds to pay for their care. This requirement makes sure that RWHAP funds are used to assist people living with HIV who do not have any other source of payment for the services they need.

Ensure Availability and Accessibility of Services to Eligible Clients: Recipients must ensure that RWHAP Part A services are available regardless of an individual's health condition or ability to pay and in settings that are accessible to low-income people living with HIV.

Outreach must be provided to inform people of the availability of services and to link them to care. One of the most important

priorities of the RWHAP legislation is to identify people who are unaware of their HIV status and need to be tested, help them determine their status, and refer and link people newly diagnosed with HIV to care. (This process is called Early Identification of Individuals with HIV and AIDS, or EIIHA.) Another priority is to find people who know their HIV status but are not receiving regular HIV-related medical care (people with “unmet need”) and help them to enter and stay in care.

Subrecipients receiving RWHAP Part A funds must be required to work with other providers so that people living with HIV have access to services. This network of providers is called a “continuum of care” or “system of care.” As part of this, providers should prioritize getting people into care as soon after diagnosis as possible by maintaining what the legislation calls “appropriate relationships with entities that constitute key points of access to the health care system.” Key points of access include, for example, testing sites, emergency rooms, substance abuse treatment programs, and sexually transmitted disease clinics. Processes must be in place to ensure that people newly diagnosed with HIV are immediately referred and linked to care and helped to remain in care.

Control Administrative and Quality Management Costs: The recipient may use up to 10 percent of the RWHAP Part A grant for managing the RWHAP Part A program and for other administrative activities, including planning council support, and up to 5 percent of the grant for Clinical Quality Management. Examples of administrative duties include writing applications, preparing reports, and activities related to procurement and contract monitoring (including reviewing provider applications, negotiating and monitoring contracts, and paying subrecipients). The recipient must control those costs, and also ensure that local subrecipients, contractors, and other entities, collectively, spend no more than 10 percent of total RWHAP Part A service funds for administrative expenses.

Prepare and Submit the RWHAP Part A Application: The recipient is responsible for preparing and submitting a RWHAP Part A application to the federal government each year. Although this is the recipient’s responsibility, the planning council should participate in the preparation of this application because the application requires information about the planning council and how it works, as well as the planning council’s priorities and proposed resource allocations for the coming year. The Chair or Co-Chairs of the planning council must certify in writing to HRSA that the priorities in the application are the ones developed by the planning council. They must also verify that the recipient spent funds in the past year according to the planning council’s allocation decisions and indicate how the planning council established priorities for the upcoming program year.

Meet HRSA/HAB Reporting Requirements: As a federal grantee, the recipient is required to meet a variety of HRSA/HAB requirements, including submission of data, programmatic, and fiscal reports. Some reports include input from the planning council/planning body or reflect its decisions. For example, the Program Terms Report and the Program Submission are due 90 days after the final Notice of Award. The Program Terms Report includes information such as a consolidated list of contractors (subrecipients). Among the information required for the Program Submission are a signed endorsement letter from the planning council Chair or Co-Chairs endorsing the priorities and allocations submitted by the recipient, and a planning council membership roster and information on member reflectiveness. The recipient also submits an Estimated Unobligated Balance (UOB) and an estimate of anticipated carryover funding to HRSA by December 31, a RWHAP Part A and Minority AIDS Initiative Final Expenditure Report and an Annual Progress Report 90 days after the end of the program period, and a Carryover Request for any unspent funds within 30 days after the Final Expenditure Report.

All recipients under RWHAP Parts A-D, along with their contracted subrecipients, must also submit an annual client-level data report called the Ryan White Program Services Report (RSR) that covers the calendar year. The RSR provides data on the characteristics of RWHAP recipients, providers, and clients served. RSR data document program performance and accountability. RSR data on client characteristics and service utilization are used by the planning council and recipient in decision making about use of funds and the system of care. Because it provides data from all recipients, the RSR provides information used by HRSA/HAB for monitoring client health outcomes, assessing organizational capacity and service utilization, monitoring the use of RWHAP to address HIV in the U.S., and tracking progress toward the national goals to end the epidemic.



PLANNING **CHATT**

Community HIV/AIDS
Technical Assistance & Training

5. CO-CHAIR REPORT:

- B. Executive At-Large Member Elections
- F. Community HIV/AIDS TA and Training for Planning (Planning CHATT): Setting the Foundation for a Good Relationship Between PC/PB and Part A Recipient Webinar



LOS ANGELES COUNTY COMMISSION ON HIV

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<http://hiv.lacounty.gov>

DUTY STATEMENT

AT-LARGE MEMBER, EXECUTIVE COMMITTEE

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, there are three At-Large members of the Executive Committee, elected annually by the body, to provide the following representation, leadership and contributions:

COMMITTEE PARTICIPATION:

- ① Serve as a member of the Commission's Executive and Operations Committees, and participates, as necessary, in Committee meetings, work groups and other activities.
- ② As a standing member of the Executive Committee, fill a critical leadership role for the Commission; participation on the Executive Committee requires involvement in key Commission decision-making:
 - Setting the agenda for Commission regular and special meetings;
 - Advocating Commission's interests at public events and activities;
 - Voting and determining urgent action between Commission meetings;
 - Forwarding and referring matters of substance to and from other Committees and to and from the Commission;
 - Arbitrating final decisions on Commission-level grievances and complaints;
 - Discussing and dialoguing on a wide range of issues of concern to the HIV/AIDS community, related to Commission and County procedure, and involving federal, state and municipal laws, regulations and practices.

REPRESENTATION:

- ① Understand and voice issues of concern and interest to a wide array of HIV/AIDS and STI-impacted populations and communities
- ② Dialogue with diverse range perspectives from all Commission members, regardless of their role, including consumers, providers, government representatives and the public
- ③ Contribute to complex analysis of the issues from multiple perspectives, many of which the incumbent with which may not personally agree or concur
- ④ Continue to be responsible and accountable to the constituency, parties and stakeholders represented by the seat the member is holding
- ⑤ As a more experienced member, with a wider array of exposure to issues, voluntarily mentor newer and less experience Commission members
- ⑥ Actively assist the Commission and Committee co-chairs in facilitating and leading Commission discussions and dialogue
- ⑦ Support and promote decisions resolved and made by the Commission when representing the Commission, regardless of personal views

Duty Statement: Executive Committee At-Large Member

Page 2 of 2

KNOWLEDGE/BACKGROUND:

- ① CDC HIV Prevention Program, Ryan White Program (RWP), and other general HIV/AIDS and STI policy and information
- ② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
- ③ LA County's HIV/AIDS and other service delivery systems
- ④ County policies, practices and stakeholders
- ⑤ RWP legislation, State Brown Act, applicable conflict of interest laws
- ⑥ County Ordinance and practices, and Commission Bylaws
- ⑦ **Minimum of one year's active Commission membership prior to At-Large role**

SKILLS/ATTITUDES:

- ① Sensitivity to the diversity of audiences and able to address varying needs at their levels
- ② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
- ③ Ability to demonstrate parity, inclusion and representation
- ④ Multi-tasker, take-charge, "doer", action-oriented
- ⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
- ⑥ Capacity to attend to the Commission's business and operational side, as well as the policy and advocacy side
- ⑦ Strong focus on mentoring, leadership development and guidance
- ⑧ Firm, decisive and fair decision-making practices
- ⑨ Attuned to and understanding personal and others' potential conflicts of interest

COMMITMENT/ACCOUNTABILITY TO THE OFFICE:

- ① Put personal agenda aside and advocate for what's in the best interest of the Commission
- ② Devote adequate time and availability to the Commission and its business
- ③ Assure that members' and stakeholders' rights are not abridged
- ④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
- ⑤ Always consider the views of others with an open mind
- ⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
- ⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

Raquel Cataldo

April 5, 2019

Dear Fellow Commissioners:

I am honored to have been nominated for the at Large Seat. I have worked in the field for over 15 years and been on the Commission since we merged prevention and care together. I have been involved in many of the subcommittees and am keenly aware of the importance of the work we do. I believe that I can bring a commonsense voice to the Operations and Executive Committee and would appreciate your support.

Sincerely,

Raquel Cataldo

[View this email in your browser](#)

Upcoming webinar: Setting the Foundation for a Good Relationship between PC/PB and the RWHAP Recipient

Join Planning CHATT on Tuesday, April 16 for a webinar on managing the relationship between planning council/planning body (PC/PB) and RWHAP recipient.

Setting the Foundation for a Good Relationship between PC/PB and RWHAP Recipient

Tuesday, April 16 • 1 to 2:30 p.m. ET

Presenters will describe strategies that PC/PBs can use to build a strong, trusting relationship that can prevent conflict. The webinar will cover the early identification of pressure points and the selection of appropriate approaches to manage and work through them. The webinar will also explore how “positive tension” can be beneficial and present strategies to respond to tension in a constructive manner. Presenters from Los Angeles EMA and Memphis TGA will share real-life examples of successful management of their relationship with their recipient that have enabled them to build a productive and mutually respectful relationship.

Register for the webinar



Visit Planning CHATT on TargetHIV



PlanningCHATT@jsi.com

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6. COLLOQUIA SERIES:

- A. National Youth HIV/AIDS Awareness Day (NYHAAD)
Panel Discussion on the Impact of HIV/AIDS Among
Young People and their Efforts in Response to the
Epidemic

HIV Research & Community Colloquia Series 2019

In observance of
National Youth HIV/AIDS Awareness Day.

We would like to invite you to attend a special panel discussion to discuss the impact of HIV and AIDS among young people and to highlight the work young people are doing to respond to the epidemic.



Antwon Chaplin
UCLA ATN CARES



Thomas Davis
The Catharsis Project



Omar Nieto
UCLA Department of Family
Medicine



Vincent Pancucci
LA LGBT Center



Miranda Ramirez
Friends Research Institute Inc.

St. Anne's Maternity Home
155 N. Occidental Blvd
Los Angeles, CA 90026

Thursday, April 11, 2019
9:30am to 10:30am*

A resource table will be available at the event, and ALL providers are welcome and encouraged to bring any informational materials for youth to share.



LOS ANGELES COUNTY
COMMISSION ON HIV



CHIPTS
Center for HIV Infection Science, Prevention
and Treatment Research

*as part of the Commission on HIV meeting agenda. No registration required.

HIV and Youth

OF THE 39,782 HIV DIAGNOSES IN 2016:

8,451 WERE AMONG
YOUTH* AGED 13 - 24



6,848 WERE AMONG
YOUNG GAY AND
BISEXUAL MEN

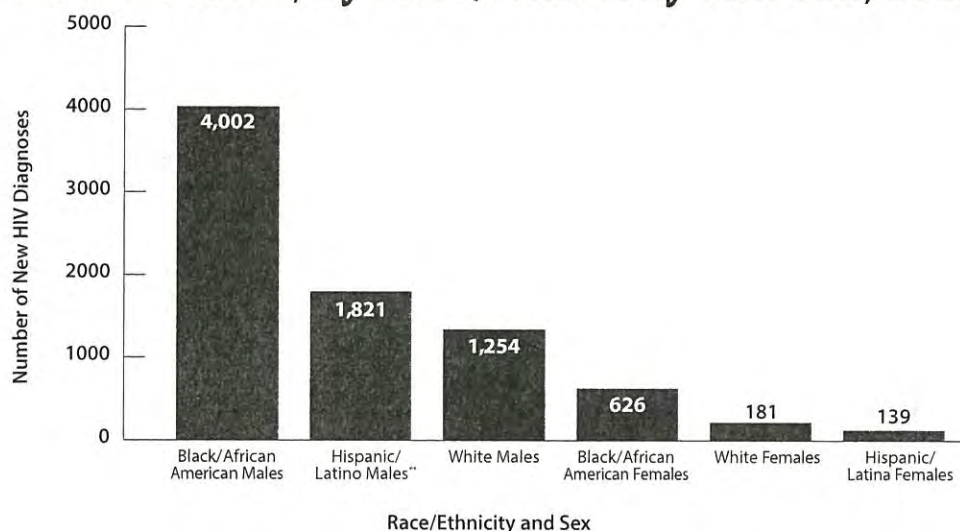


4 OUT OF 5 YOUTH DIAGNOSED
WITH HIV WERE AGED 20 - 24



21% OF ALL NEW HIV DIAGNOSES IN THE US WERE AMONG YOUTH

HIV Diagnoses Among Youth in the United States, by Race/Ethnicity and Sex, 2016



Subpopulations representing 2% or less of all people who received an HIV diagnosis in 2016 are not represented in this chart.

From 2011 to 2015, HIV diagnoses among youth remained stable overall.***

remained stable
among young African
American and white gay
and bisexual men



fell
25%
among young
women



* Unless otherwise noted, people aged 13 to 24 are referred to as youth or young in this fact sheet.

** Hispanics/Latinos can be of any race.

*** From 2010 to 2015, new HIV infections (incidence) fell 24% among youth. Incidence data includes the number of people who get HIV (both diagnosed and undiagnosed) each year. Diagnosis data includes the number of people receiving an HIV diagnosis each year (regardless of the year they were infected). In general, any difference between an incidence trend and a diagnosis trend can be attributed to HIV testing and diagnosis.

Around 1.1 million people are living with HIV in the US. People living with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable. A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.



Unfortunately, thousands of Americans still die each year from HIV. In 2015, 100 youth aged 15 to 24 died from HIV disease.

What places some young people at higher risk?

- Many students are not getting the sexual health education they need, and sex education is not starting early enough.
- Certain risk behaviors put youth at higher risk for HIV, including low HIV testing rates, substance use, low rates of condom use, and multiple sex partners. Research has also shown that young gay and bisexual men who have sex with older partners are at a greater risk for HIV infection.
- Youth aged 20 to 24, especially youth of color, have some of the highest STD rates. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Many young people avoid talking about HIV with their sex partners.
- Stigma, fear, homophobia, isolation, and lack of support may also place many youth at higher risk for HIV.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among youth.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for youth and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

Visit www.cdc.gov/hiv and www.cdc.gov/healthyouth for more information about CDC's HIV prevention activities among youth.

AT THE END OF 2015,
AN ESTIMATED
60,300
YOUTH WERE
LIVING WITH HIV.

1 in 2
DIDN'T KNOW THEY WERE
LIVING WITH THE VIRUS

**FOR EVERY 100
YOUNG PEOPLE
LIVING WITH HIV IN 2014:**



received
some
HIV care



were
retained
in care



were virally
suppressed

Reduce Your Risk



Not having sex



Using
condoms



Not sharing
needles



Taking medicine
to prevent
or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing needles with a person who is living with HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you are living with HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

7. LOS ANGELES COUNTY HIV/AIDS STRATEGY (LACHAS):

A. Stigma Reduction Action Planning Series Summary

Stigma Reduction Planning Series

Tim Vincent

tvincent1206@gmail.com

Plan and Strategy Documents: Stigma Reduction Needed

- Los Angeles County has long acknowledged the impact of HIV and other stigma (e.g., mental illness, alcohol/substance abuse, homophobia and transphobia) on access to the full spectrum of HIV prevention and care services.
- Evidence continues to show that racism, **HIV-related stigma and discrimination**, homophobia and transphobia have a profound impact on HIV prevention efforts and exacerbate the fear and unease that our most vulnerable residents face accessing information, services, and prevention tools

Planning for the Plan: January

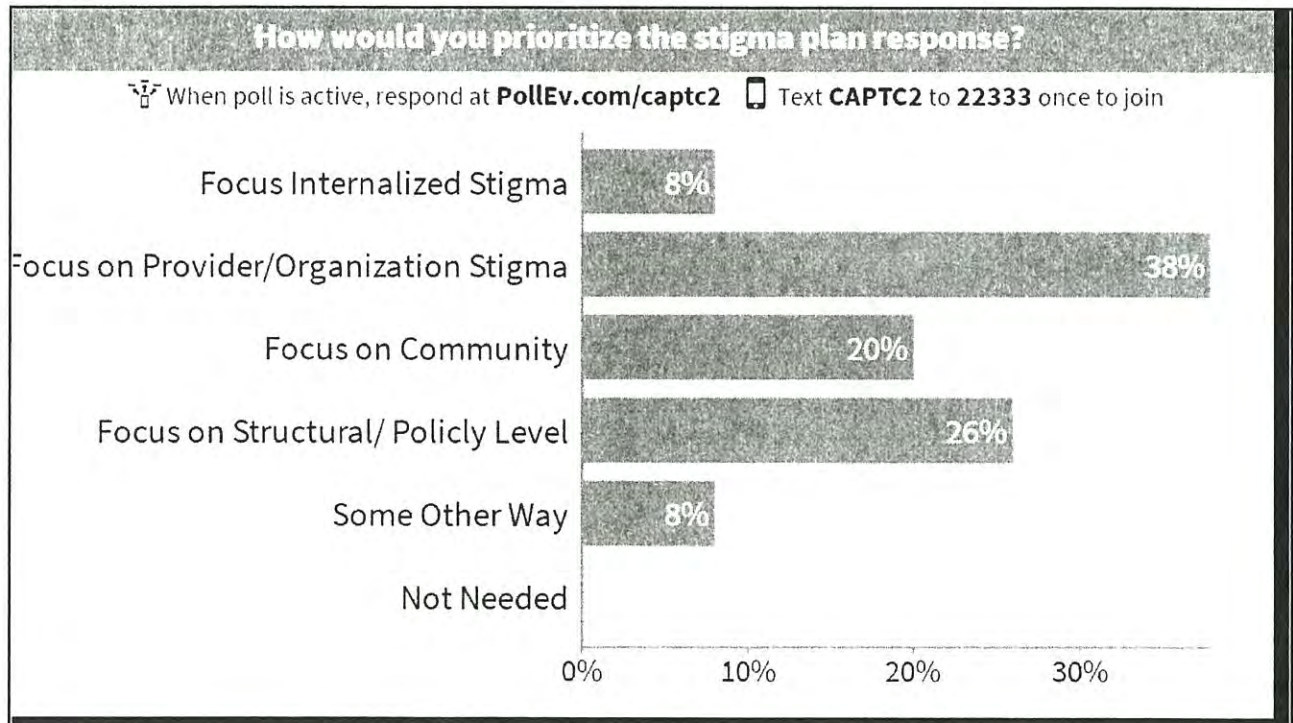
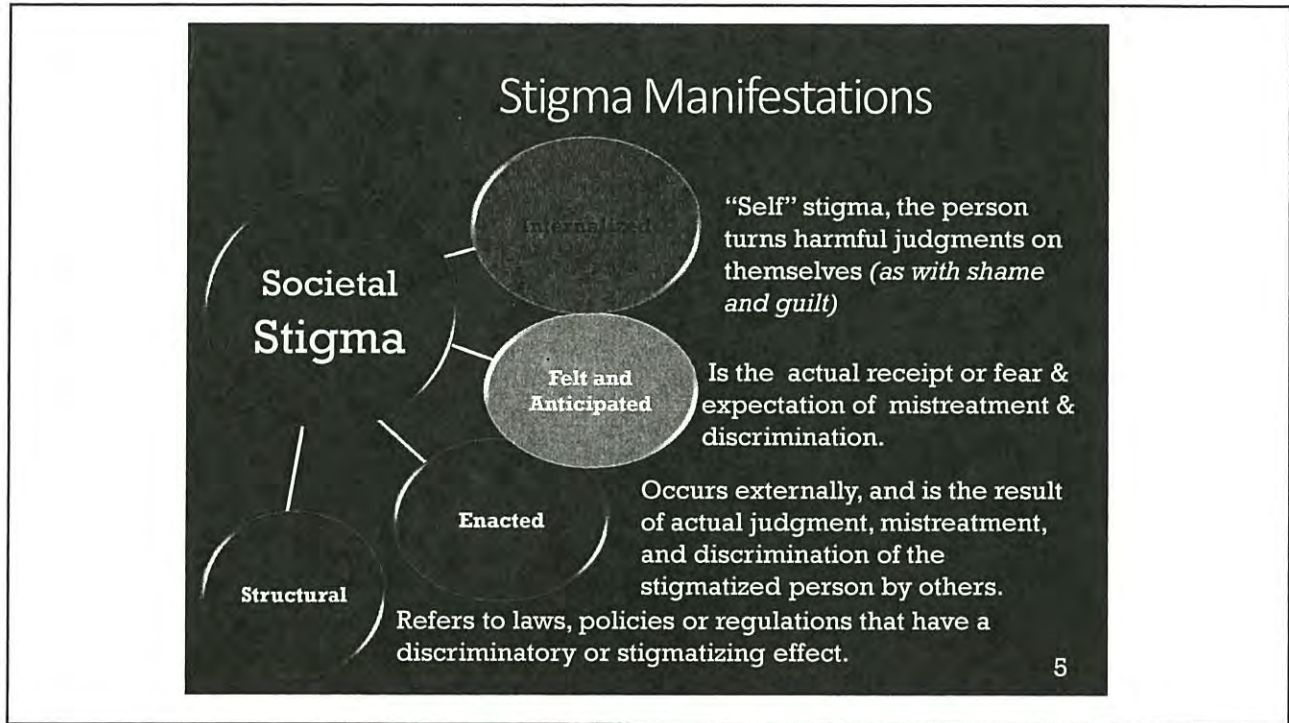
Series of Meetings with Commission Jan-April:

January: Defining and Examining Stigma

- Relationship it has to HIV-related disparities
- Framework for Addressing Manifestations of Stigma
- Consideration of Intersectionality

Planning Series February/March

- February: Facilitated Panel on State of HIV in Black Communities
- March: Considerations for Developing the Plan
 - Prioritization of Levels of Intervention
 - Information Needed
 - Recommendations from Commission and Community Members



QUESTIONS FROM MARCH MEETING

What more information is needed to move forward with stigma reduction planning?

What recommendations do you have for focusing and moving forward with a stigma reduction plan?

Themes

- A needs assessment/data collection via surveys or listening sessions is needed to determine the next step in moving forward with plan development
- Research on best practices in other jurisdictions will help guide plan development
- Conducting provider trainings on implicit bias, stigma, and cultural competency is imperative
- Educate the general community on the different types of stigma
- Engage the community throughout the entire plan development process to ensure buy-in and lift up the voices of those that have experienced stigma.
- Organizational change is needed to change the systems that are caring for clients that have and continue to experience stigma (e.g. trainings for organizations, policies)
- Change the intake tools and assessments utilized in provider settings to decrease stigma and promote inclusivity

Special thanks to Julie Tolentino

Recommendations

- For the HIV Commission:
 - Common Language
 - Adopt a framework in which to respond to stigma
 - Internalized work on communication re: stigma
 - Communicate intention to community members/organizations
- For the Plan:
 - Prioritize "interventions" that correspond to the level you are trying to address (provider, organizational, structural)
 - Create or suggest evaluation measures for interventions to connect to HIV prevention/care continuum
 - Plan to include voices and wisdom of community on this topic.
 - Institutionalize training on stigma (providers/org.)
 - Collect "best practices" from communities to support or expand or disseminate.
 - Funding priority for stigma workgroup, reduction coordinator, training and technical assistance.
 - Create or use framework to "connect the dots" from stigma reduction to improvements in prevention/care goals.

Framework (example)



YOUR COMMITMENT TO REDUCE STIGMA

- What are you willing to do to support the stigma reduction plan?

How will you be accountable?

Who will benefit?

Back to the Roots

- **Los Angeles County has cause for hope.** The end of HIV in our lifetime is possible. Transmission can be curtailed through viral suppression and use of ART for PrEP. However, the work of the county needs to be strategic and focused—get persons diagnosed who are unaware of their HIV disease, get PLWH who are out of care into care, get persons at high-risk of HIV onto PrEP, **mitigate the impact of HIV and related stigma**, and provide the necessary education and services to prevent future HIV transmission and that support retention of PLWH in medical care and the continuum of HIV services.

- **THIS PLAN NEEDS YOU!**

9. RYAN WHITE PROGRAM PARTS C, D AND F REPORT



LOS ANGELES COUNTY COMMISSION ON HIV



Ryan White HIV/AIDS Program Parts

The Ryan White HIV/AIDS Program is divided into five Parts, following from the authorizing legislation. Note that all Parts utilize the same service categories.

- **PART A** provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic.
- **PART B** provides grant funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. Grant recipients include all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 5 U.S. Pacific Territories. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).
- **PART C** provides grant funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services.
- **PART D** provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.
- **PART F** provides grant funding that supports several research, technical assistance, and access-to-care programs. These programs include:
 - **The Special Projects of National Significance Program**, supporting the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations;
 - **The AIDS Education and Training Centers Program**, supporting the education and training of health care providers treating people living with HIV through a network of eight regional centers and three national centers;
 - **The Dental Programs**, providing additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program; and
 - **The Minority AIDS Initiative**, providing funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

10. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. April 2019 Report and Newsletter

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The [Integrated Plan](http://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf) is available on the Office of AIDS' (OA) website at: www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf.

Staff Highlight:

OA is cultivating many new exciting changes to streamline processes, work more resourcefully and better serve the community. In an effort to effectively work with our community, we are restructuring the California Planning Group (CPG). Our intent is to better engage and empower our community stakeholders while establishing a more cohesive working relationship between the community and OA.



OA-Based CPG Steering Committee Members (L-R): Chioko Grevious, Committee Co-Chair; Tiffany Woods; Kevin Sitter; Chelsea Carney, Committee Co-Chair; Yesenia Corona; Angelique Skinner; Sharisse Kemp, Committee Manager; Chris Paular; and Ivan Mendoza-Manzo.



STDCB-Based CPG Steering Committee Members (L-R): Carlos DeLeon and Jessica Frasure-Williams.

In This Issue:

- **Staff Highlight**
- **Strategy A**
- **Strategy J**
- **Strategy K**
- **Strategy M**

With a stronger partnership, together we will be able to help ensure HIV prevention and care activities are responsive to the needs of people living with and disproportionately affected by HIV. Additionally, we have included the Sexually Transmitted Disease Control Branch (STDCB) to foster their mission to reduce the transmission and impact of sexually transmitted diseases and viral hepatitis. Collaboratively, we can all work towards reaching the goals of the statewide Integrated Plan and meet the needs of the community. We look forward to this new venture with the CPG!

Strategy A: Improve Pre-Exposure Prophylaxis (PrEP) Utilization

- A poster called, "Prepping Providers for Pre-Exposure Prophylaxis (PrEP) Implementation: Findings from California Office of AIDS' (OA) Local Site Evaluation of Project PrIDE PrEP Training Activities" was presented at the National HIV Prevention Conference on Wednesday, March 20, 2019.
- An oral presentation called, "Understanding Pre-Exposure Prophylaxis (PrEP) Uptake

Among Trans Women, Trans Men, and Gender Non-Binary Persons: California Office of AIDS' (OA) Local Specific Evaluation of Project PrIDE PrEP Activities" will be presented at the National Transgender Health Summit on April 13, 2019 or April 14, 2019 (TBD).

PrEP Assistance Program (PrEP-AP):

- Effective January 30, Heplisav-B (Hepatitis B Vaccine (Recombinant), Adjuvanted), a two-dose hepatitis B virus vaccine, was added to the PrEP-AP formulary. The management memorandum containing additional information can be found at: <https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2019-06%20ADAP%20MM%20Addition%20of%20HBV%20Vaccine%20to%20the%20PrEP-AP%20Formulary.pdf>.

- Effective March 1, PrEP-AP clients insured by Kaiser are able to access PrEP at Kaiser pharmacies without using their Gilead co-payment coupon card or paying any money out of pocket. PrEP-AP enrollment workers are still required to enroll clients in the Gilead Co-Payment Assistance Program. The management memorandum containing additional information can be found at: <https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/ADAP%20MM%202019-03%20Update%20to%20PrEP%20Access%20at%20Kaiser%20Pharmacies.pdf>.
- As of March 19, there are 152 PrEP-AP enrollment sites covering 63 clinics that currently make up the PrEP-AP Provider Network. As of March 26, there are 1,475 clients enrolled in the PrEP-AP. See the chart below and continued on page 3.

Clinical Provider Name	County	Number of Clinics on Contract
AIDS Healthcare Foundation	Alameda and San Francisco	2
Lifelong Medical Care	Alameda	2
Alameda Health System - Highland Hospital	Alameda	1
Asian Health Services	Alameda	1
East Bay AIDS Center (EBAC)	Alameda	1
Primary Care at Home, Inc.	Alameda	1
Clinicas de Salud del Pueblo	Imperial	4
Kern County Department of Public Health	Kern	1
Banj Health Center, Inc.	Los Angeles	4
Children Hospital Los Angeles	Los Angeles	1
Saban Community Clinic	Los Angeles	1
Planned Parenthood	Los Angeles	4
El Proyecto del Barrio, Inc. - Esperanza Clinic	Los Angeles	1
City of Long Beach	Los Angeles	1
Men's Health Foundation	Los Angeles	1
Tarzana Treatment Centers, Inc.	Los Angeles	1
Bartz-Altadonna Community Health Center	Los Angeles	1
Northeast Valley Health Corporation	Los Angeles	1

(continued from page 2)

Clinical Provider Name	County	Number of Clinics on Contract
JWHC Institute, Inc.	Los Angeles	1
East Valley Community Health Center	Los Angeles	2
St. John Well Child and Family Center	Los Angeles	1
Los Angeles LGBT Center	Los Angeles	1
Watts Healthcare Corporation	Los Angeles	1
APLA Health & Wellness	Los Angeles	3
Dignity Health - St. Mary's Medical Center	Los Angeles	1
Vista Community Clinic	Los Angeles and Orange	2
Desert AIDS Project, Inc.	Riverside	1
One Community Health	Sacramento	1
Regents UC San Diego Medical Center	San Diego	1
Vista Community Clinic	San Diego	1
San Ysidro Health	San Diego	2
Asian & Pacific Islander Wellness	San Francisco	1
HealthRIGHT360	San Francisco	4
UCSF 360 Positive Care	San Francisco	1
San Francisco AIDS Foundation	San Francisco	1
Community Action Partners	San Luis Obispo	2
County of San Luis Obispo Public Health Department	San Luis Obispo	2
Santa Rosa Community Health	Sonoma	1
West County Health Centers	Sonoma	4

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

health plan, Medi-Cal, Medicare Part D plan, employer-based health insurance) at 9 ADAP enrollment sites.

Access, Adherence, and Navigation Program:

Since the inception of the Access, Adherence, and Navigation Program in January of 2018, 487 AIDS Drug Assistance Program (ADAP) clients have been transitioned to health coverage (Covered California health plan, off-exchange

ADAP Insurance Assistance Programs:

As of March 26, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart below and continued on page 4.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from February
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	450	+4%

(continued from page 3)

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from February
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	4,643	+1%
Medicare Part D Premium Payment (MDPP) Program	1,672	+2%
Total	6,765	+2%

Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

In its most recent progress report to CDC, the Prevention Branch described the 2018 guidance OA provided to LHJs to improve capacity to deliver HIV prevention and other necessary services for people who inject drugs (PWID), as well as the responses OA received from LHJs. LHJs submitted work plans to OA throughout the last quarter of 2018, and the activities described include a host of new and expanded initiatives to prevent disease transmission and improve the overall health and wellness of PWID.

Of the 20 jurisdictions in the California Project Area, 12 reported that they plan to conduct a community assessment of readiness to provide harm reduction services and increase access to sterile syringes. Ten jurisdictions plan to strengthen infrastructure for currently-authorized SSPs, expand current services, or establish new SSPs. Six jurisdictions, including two with currently authorized SSPs, intend to initiate plans to increase the availability of Non-Prescription Sale of Syringes (NPSS) in pharmacies. To assist jurisdictions expanding syringe access through NPSS, OA provides a web page that includes an [online toolkit](https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_npss.aspx) for health departments, pharmacists, and customers at: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_npss.aspx.

Strategy M: Improve Usability of Collected Data

The 2017 HIV surveillance report was released March 13, and is available at: <https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California%20HIV%20Surveillance%20Report%20-%202017.pdf>.

The Office of AIDS has released new reports, "Epidemiology of HIV in California" for years 2015, 2016, and 2017. These companion reports to the previously released Surveillance Reports provide an epidemiologic profile and statewide overview of HIV in California, and help measure progress toward meeting OA's getting to zero goals and objectives. The reports highlight areas of success and gaps that can be addressed by effectively collaborating and targeting resources. The reports are available below:

2017 - https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2017_Epi_Report.pdf.

2016 - https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2016_Epi_Report.pdf.

2015 - https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/2015_Epi_Report.pdf.

For questions regarding this newsletter, please contact: angelique.skinner@cdph.ca.gov.



California Department of Public Health



Office of AIDS

ADAP Update for Stakeholders

March 2019, Notice #72

Contact Information

ADAP Call Center

Open 8 a.m. to 5 p.m. Monday through Friday

Toll-Free Phone: (844) 421-7050

Fax: (844) 421-8008

Mailing Address:

CDPH

P.O. Box 997426

Mail Stop 7704

Sacramento, CA 95899

Magellan Call Center

Open 24 hours a day, 7 days a week.

Toll-Free Phone: (800) 424-5906

Pool Administrators Inc. (PAI)

Open 8 a.m. to 5 p.m. Monday through Friday.

Toll-Free Phone: (877) 495-0990

Updates

The California Department of Public Health (CDPH) is committed to providing excellent customer service to its ADAP clients. Thank you for all of your hard work ensuring clients receive their life-saving medication.

Reminder: Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) Refresher Training for Kaiser Enrollment Workers

This is a reminder to Kaiser enrollment workers that trainings regarding PrEP-AP policy and enrollment processes will take place on the following dates:

- Wednesday, March 27 from 1:00 p.m. – 3:00 p.m.
- Thursday, March 28 from 9:00 a.m. – 11:00 a.m.

The training is optional for Kaiser enrollment sites that have already taken the training and can be taken as a refresher. For all other Kaiser sites that are not yet performing PrEP-AP enrollment but are planning to do so before April 11, the training is required. Both training sessions will cover the same material. An email containing the WebEx and dial-in information was sent by PrEP.Support@cdph.ca.gov on March 14. Other PrEP-AP training sessions will be held on April 11 and June 13 as part of the new enrollment worker training schedule.

Kaiser enrollment workers were advised to email PrEP.Support@cdph.ca.gov if they have questions.

Updated Income Verification Affidavit

The Income Verification Affidavit has been updated. The affidavit should be used for applicants who are **not** Medi-Cal eligible and (1) have no income, (2) are homeless, and/or (3) receive financial support from an agency or individual who is not the applicant's spouse or registered domestic partner (RDP). Beginning April 1, 2019, the previous version of the Income Verification Affidavit will not be accepted.

If an applicant is receiving financial support from an agency, non-spouse or non-RDP, the agency/non-spouse/non-RDP does not have to sign the form for client confidentiality reasons.

Please note, this form should only be used to prove income and not residency. If a client is homeless, the client will need to use the [Residency Verification Affidavit](#) to prove residency.

Please see the [English](#) and [Spanish](#) versions of the Income Verification Affidavit.

Enrollment workers were advised to contact their ADAP Advisor with any questions.

2019 Federal Poverty Levels

On March 20, all enrollment workers received [Management Memorandum 2019-09: 2019 Federal Poverty Levels and Cutoff for Accepting 2017 Tax Returns](#), informing enrollment workers that effective April 1, 2019, ADAP will use the 2019 U.S. Department of Health and Human Services Federal Poverty Level (FPL). The updated FPL chart is attached to the memorandum.

The cutoff date for accepting 2017 tax returns for income documentation is April 15, 2019. After this date, only 2018 taxes will be accepted unless proof of an extension is provided.

Enrollment workers were advised to contact their ADAP Advisor with any questions.

Amended ADAP Memorandum 2019-03: Update Regarding PrEP Access at Kaiser Pharmacies

On March 4, all enrollment workers were provided with an amended Management Memorandum 2019-03: Update Regarding PrEP Access at Kaiser Pharmacies, informing enrollment workers that effective March 1, 2019, PrEP-AP clients insured by Kaiser are able to access PrEP at Kaiser pharmacies without using their Gilead co-payment coupon card or paying any money out of pocket.

Management Memorandum 2019-03 was amended to provide clarification of the PrEP-AP enrollment process. While the Gilead co-payment coupon card is no longer required by Kaiser clients, enrollment workers are still required to enroll clients in the Gilead Co-Payment Assistance Program. A copy of the Gilead application submission must be uploaded and the Gilead start date must be entered in the ADAP Enrollment System (AES) in order to submit the PrEP-AP application. The amended memorandum also contains a list of Kaiser enrollment sites that have been confirmed as a PrEP-AP enrollment site.

Enrollment workers were advised to email PrEP.Support@cdph.ca.gov with any questions.

Updates to the ADAP Formulary

The following management memorandums were sent to all enrollment workers regarding updates to the ADAP formulary:

- On March 4, Management Memorandum 2019-04: Addition of Generic Efavirenz to the ADAP Formulary was sent to all enrollment workers notifying them that effective February 25, 2019, copay coverage for generic efavirenz became available to ADAP clients with private insurance or Medicare with a valid prescription.
- On March 6, Management Memorandum 2019-05: Addition of darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza™) to the ADAP Formulary, was sent to all enrollment workers notifying them that effective March 1, 2019, Symtuza™, which received Food and Drug Administration approval on July 17, 2018, was added to the ADAP Formulary. The dispensing of Symtuza™ will require prescribers to complete a prior authorization and its dispensing will be based on clinical criteria approved by the ADAP Medical Advisory Committee (MAC).
- On March 19, Management Memorandum 2019-08: Addition of lamivudine/tenofovir disoproxil fumarate (Cimduo™) and efavirenz/lamivudine/tenofovir disoproxil fumarate (Symfi™) to the ADAP Formulary, was sent to all enrollment workers notifying them that effective March 8, 2019, Cimduo™ and Symfi™ were added to the ADAP formulary.

The ADAP formulary has been updated and can be accessed at the following [link](#).

Enrollment workers were advised to contact their ADAP Advisor with any questions.

Update to the PrEP-AP Formulary

On March 11, all enrollment workers received Management Memorandum 2019-06: Addition of Hepatitis B Recombinant Vaccine to the PrEP-AP Formulary, informing enrollment workers that effective January 30, 2019, Heplisav-B (Hepatitis B Vaccine (Recombinant), Adjuvanted), a two-dose hepatitis B virus vaccine, was added to the PrEP-AP formulary.

The PrEP-AP formulary has been updated and can be accessed at the following [link](#).

Enrollment workers were advised to email PrEP.Support@cdph.ca.gov with any questions.

Updated Consent and Attestation Forms

On March 12, all enrollment workers received Management Memorandum 2019-07: Notification of Updated Consent and Attestation Forms, informing enrollment workers that the ADAP Client Attestation form has been updated to include the PrEP-AP, and that the ADAP and PrEP-AP Consent forms have been modified to add language regarding federal requirements to be payer of last resort. Beginning April 1, 2019, previous versions of the ADAP and PrEP-AP Consent forms will not be accepted.

The updated consent and attestation forms can be found at the links below:

[PrEP-AP Forms](#)

[ADAP Forms](#)

Enrollment workers were advised to contact their ADAP Advisor with any questions.

Updated Comprehensive Health Care Coverage Form

The Comprehensive Health Care Coverage Form has been updated in both [English](#) and [Spanish](#). Clients who elect not to enroll into comprehensive health coverage must sign the updated Comprehensive Health Care Coverage form informing the client of options to enroll into private insurance or Medicare Part D (if eligible).

Enrollment workers were advised to contact their ADAP Advisor with any questions.

PrEP-AP Updates

As of March 19, there are 152 PrEP-AP enrollment sites covering 63 clinics that currently make up the PrEP-AP Provider Network:

Clinical Provider Name	County	Number of clinics on contract
AIDS Healthcare Foundation	Alameda and San Francisco	2
Lifelong Medical Care	Alameda	2
Alameda Health System - Highland Hospital	Alameda	1
Asian Health Services	Alameda	1
East Bay AIDS Center (EBAC)	Alameda	1
Primary Care at Home, Inc.	Alameda	1
Clinicas de Salud del Pueblo	Imperial	4
Kern County Department of Public Health	Kern	1
Banj Health Center Inc	Los Angeles	4
Children Hospital Los Angeles	Los Angeles	1
Saban Community Clinic	Los Angeles	1
Planned Parenthood	Los Angeles	4
El Proyecto del Barrio, Inc. - Esperanza Clinic	Los Angeles	1
City of Long Beach	Los Angeles	1
Men's Health Foundation	Los Angeles	1
Tarzana Treatment Centers, Inc.	Los Angeles	1
Bartz - Altadonna Community Health Center	Los Angeles	1
Northeast Valley Health Corporation	Los Angeles	1
JWHC Institute, Inc.	Los Angeles	1
East Valley Community Health Center	Los Angeles	2
St. John Well Child and Family Center	Los Angeles	1
Los Angeles LGBT Center	Los Angeles	1
Watts Healthcare Corporation	Los Angeles	1
APLA Health & Wellness	Los Angeles	3
Dignity Health - St. Mary's Medical Center	Los Angeles	1
Vista Community Clinic	Los Angeles and Orange	2
Desert AIDS Project, Inc.	Riverside	1
One Community Health	Sacramento	1
Regents UC San Diego Medical Center	San Diego	1
Vista Community Clinic	San Diego	1
San Ysidro Health	San Diego	2
Asian & Pacific Islander Wellness	San Francisco	1
HealthRIGHT360	San Francisco	4
UCSF 360 Positive Care	San Francisco	1
San Francisco AIDS Foundation	San Francisco	1
Community Action Partners	San Luis Obispo	2

County of San Luis Obispo Public Health Department	San Luis Obispo	2
Santa Rosa Community Health	Sonoma	1
West County Health Centers	Sonoma	4

For More Information

Thank you for your partnership and commitment to the health and safety of Californians living with HIV. With your assistance, we strive to ensure all eligible ADAP clients get the life-saving medication they need. We welcome and value your feedback. Please contact me with any suggestions, questions, or concerns.

Marisa Ramos, Ph.D.
Acting Chief, Office of AIDS
Marisa.Ramos@cdph.ca.gov

12. STANDING COMMITTEE REPORTS:

- A. Planning, Priorities & Allocations (PP&A) Committee:
 - (1) (Revised) 2019 RWP Service Category Rankings
MOTION #6
 - (2) (Revised) 2019 RWP Allocations **MOTION #7**
- B. Operations Committee
 - (1) Membership Management
 - (a) Membership Applications
 - (i) Susan Alvarado | City of Long Beach Rep
MOTION #8
 - (ii) Maribel Ulloa | HOPWA Rep **MOTION #9**
 - (iii) Justin Valero | Rep, Board Office 4
MOTION #10
 - (2) (Revised) Code of Conduct **MOTION #11**
- D. Public Policy Committee
 - (1) County, State and Federal Legislation & Policy
 - (a) (Draft) 2019 Policies Priorities **MOTION #12**

12. STANDING COMMITTEE REPORTS (cont'd):

A. Planning, Priorities & Allocations (PP&A) Committee:

(1) (Revised) 2019 RWP Service Category Rankings

MOTION #6

(2) (Revised) 2019 RWP Allocations **MOTION #7**

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE REPORT

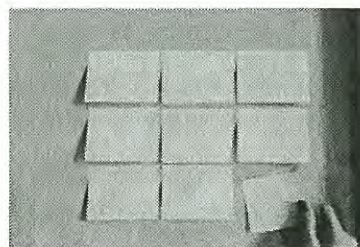
Priority Setting and Resource Allocations
Process and Motions for Commission on
HIV (COH) Approval
April 11, 2019



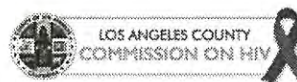
2

What is Priority Setting & Resource Allocation (PSRA)?

- Priority Setting: the process of deciding which HIV/AIDS services are the most important in providing a comprehensive system of care for all PLWH in the Eligible Metropolitan Area (EMA)



Source: Planning CHATT, Conducting RWHAP Part A Planning Council/Planning Body
Priority Setting and Resource Allocation, 7/17/18



3

Resource Allocation

- Resource allocation: the process of determining how much RWHAP Part A funding will be allocated to each service category
- COH instructs DHSP on how to distribute funds when contracting for service
- Service categories with low prioritization may receive larger allocations than categories with higher prioritization, which can be due to service costs per client or service available through other funding sources

Source: Planning CHATT, Conducting RWHAP Part A Planning Council/Planning Body
Priority Setting and Resource Allocation, 7/17/18



4

A few things to keep in mind

- Ryan White program year (PY) is from March 1 to the end of February.
- We completed PY 28 on February 28, 2019.
- Finalizing the PY 28 expenditure report requires a few months to allow contactors to submit their final invoices.
- PP&A reviews previous and current year expenditures to help inform allocations/reallocations recommendations.
- We are currently in PY 29.



5

Process Highlights

- Led by the Planning, Priorities and Allocations (PP&A) Committee
- Data-driven process is balanced with community and consumer perspectives
- Paradigms and operating values are used to focus discussions on common goals
- Priority Setting and Resource Allocation (PSRA) informs the Comprehensive Program Directives and Minority AIDS Initiative (MAI) Plan



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Paradigms and Operating Values for Program Year (PY) 29

Paradigms	Operating Values
Beliefs that define boundaries in which the body operates	Understanding what is most important to the body and incorporating it into the decision-making process
➤ Equity: relatively equal portions with attention paid to those disproportionately impacted (e.g. funding allocations with directive for special circumstances) ➤ Compassion: response to suffering of others that motivates a desire to help	➤ Efficiency: accomplishing the desired operational outcomes with the least use of resources ➤ Quality: the highest level of competence in the decision-making process ➤ Advocacy: addressing the asymmetrical power relationships of stakeholders in the process ➤ Access: assuring access to the process for all stakeholders and/or constituencies



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Data Sources Used

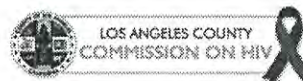
- Financial reports
- Programmatic reports on Housing Services which included Housing for Health (HFH), Housing Opportunities for Persons with AIDS (HOPWA) and Substance Abuse Prevention and Control (SAPC)
- Los Angeles Coordinated HIV Needs Assessment (LACHNA) 2016 Report
- Ryan White Care Utilization Data
- Comprehensive HIV Plan (CHP)
- Los Angeles County HIV/AIDS Strategy (LACHAS)



8

Factors Considered

- Uncertainty with the Affordable Care Act
 - Need to be prepared for the possibility of movement of eligible People Living with HIV (PLWH) into Ryan White (RW)
 - Prepare for possible changes in funding and eligibility requirements
- RW is payer of last resort
 - Must consider influx of local funding
 - Substance use treatment funded by Drug Medi-Cal
 - Mental health services funded by Mental Health Services Act (MHSA)
 - Housing funded by Measure H/HHH
 - Protracted county procurement process may restrict timely implementation or new/renewal services
 - Maximizing Part A funds is priority



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Service Categories

CORE MEDICAL SERVICES	SUPPORT SERVICES
Outpatient/Ambulatory Health Services	Non-Medical Case Management Services
AIDS Drug Assistance Program Treatments	Child Care Services
AIDS Pharmaceutical Assistance	Emergency Financial Assistance
Oral Health Care	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	Housing
Home Health Care	Other Professional Services
Home and Community-Based Health Services	Linguistic Services
Hospice Services	Medical Transportation
Mental Health Services	Outreach Services
Medical Nutrition Therapy	Psychosocial Support Services
Medical Case Management, including Treatment Adherence Services	Referral for Health Care and Support Services
Substance Abuse Outpatient Care	Rehabilitation Services
	Respite Care
	Substance Abuse Services (residential)

10

Motion #6

Approve the (Revised) 2019 Ryan White Program Rankings, as presented or revised.

➤ Refer to table in your packet.

• Revisions made to PY 29 service category rankings:

- Health Education/Risk Reduction (HERR) moved to #6 from #16
 - To support stigma reduction plan
 - Inclusion of messages endorsed under the Undetectable = Untransmittable (U=U) and Treatment as Prevention in client's ongoing education and treatment plan
 - Prevention counseling (trauma informed)
- Hospice moved to #27 from #21
 - HIV has become a chronic disease
 - Need for service is reduced



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Motion #7

Approve the (Revised) 2019 Ryan White Program Allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.

➤ Refer to table in your packet.

- Revisions were made to maximize Part A grant funds due to:
 - Increase funding received for program year 29
 - DHSP's identification of services that can be funded and implemented in PY 29
 - PY 28 estimated expenditures for HIV services.



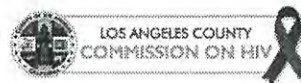
12

Motion #7 (continued)

Approve the (Revised) 2019 Ryan White Program Allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.

➤ Refer to table in your packet.

- Revisions were made to maximize Part A grant funds due to:
 - Increases and augmentations in Home and Community Based Health Services (HCBCM), Oral Health, Nutrition Support
 - Lack of reporting data and staffing issues (LRP)
 - Implementation issues (Housing and Linguistic)



13

Motion #7 (continued)

Approve the (Revised) 2019 Ryan White Program Allocations, as presented or revised, and provide DHSP the authority to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to this body.

➤ Refer to table in your packet.

- Revisions were made to maximize MAI grant funds to:
 - Better align actual service utilization and expenditures with Program Year 28 actual expenditures
 - Ease data reporting required under MAI for targeted populations (Medical Transportation)
 - Funding changes were done to Maximize Part A funds



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Opportunities for Improvement/Next Steps

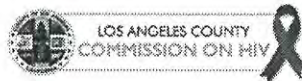
- PP&A will:
 - Evaluate and review PY 28 and 29 PSRA process (what went well, what didn't, what can we do better?)
 - Work with DHSP to develop specific recommendations on how to maximize grant funds.
 - Review PSRA tools/methods to increase the effectiveness of the planning process
 - The outcomes will be used in the planning process for future service category prioritization and percentage allocations.
 - Additional discussions on multi-year planning.
 - Strengthen the Comprehensive Care and Prevention Directives



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THANK YOU.





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MOTION #6:
4/11/19 COH Meeting

Planning, Priorities and Allocations Committee
[DRAFT] Service Category Rankings for PY 29 (FY 2019-20)

COH 2019-20 Ranking		Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
Rev ⁱ	Appvd ⁱⁱ			
1	1	Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
		Medical Subspecialty Services		
		Therapeutic Monitoring Program		
2	2	Housing	S	Housing
		Permanent Support Housing		
		Transitional Housing		
		Emergency Shelters		
		Transitional Residential Care Facilities (TRCF)		
		Residential Care Facilities for the Chronically Ill (RCFCI)		
3	3	Mental Health Services	C	Mental Health Services
		MH, Psychiatry		
		MH, Psychotherapy		
4	4	Medical Care Coordination (MCC)	C	Medical Case Management (including treatment adherence services)
5	5	Outreach Services	S	Outreach Services
		Engaged/Retained in Care		
6	16	Health Education/Risk Reduction	S	Health Education/Risk Reduction
7	6	Early Intervention Services	C	Early Intervention Services
8	7	Direct Emergency Financial Assistance	S	Emergency Financial Assistance
9	8	Medical Transportation	S	Medical Transportation
10	9	Non-Medical Case Management	S	Non-Medical Case Management Services
		Linkage Case Management		
		Benefit Specialty		
		Benefits Navigation		

COH 2019-20 Ranking		Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
		Transitional Case Management		
		Housing Case Management		
11	10	Oral Health Services	C	Oral Health Care
12	11	Psychosocial Support Services	S	Psychosocial Support Services
13	12	Nutrition Support	S	Food Bank/Home Delivered Meals
14	13	Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
15	14	Home Based Case Management	C	Home and Community Based Health Services
16	15	Home Health Care	C	Home Health Care
17	17	Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
18	18	Referral	S	Referral for Health Care and Support Services
19	19	Child Care Services	S	Child Care Services
20	20	Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost-Sharing Assistance for Low-income individuals
21	22	Other Professional Services	S	Other Professional Services
		Legal Services		
		Permanency Planning		
22	23	Language	S	Linguistics Services
23	24	Medical Nutrition Therapy	C	Medical Nutrition Therapy
24	25	Rehabilitation Services	S	Rehabilitation Services
25	26	Respite	S	Respite Care
26	27	Local Pharmacy Assistance	C	AIDS Pharmaceutical Assistance
27	21	Hospice	C	Hospice

ⁱ Rev: The first column represents revisions recommended by the Planning, Priorities and Allocations Committee.

ⁱⁱ Appvd: The second column represents Commission on HIV approved PY 29 service category rankings. Approved September 13, 2018.

FY 2019 Revised RWP Allocations (3.25.19 version)

Row	Service Category	Revised Part A Allocations	Revised Part A %	Original Part A	Original Part A %	Revised MAI Allocations	Revised MAI %	Original MAI	Original MAI %	Revised Total Part A/MAI %	Original Total Part A/MAI %
1	Outpatient/Ambulatory Health Services	\$ 9,810,822	28.23%	\$ 7,460,225	20.40%	\$ -	0.00%	\$ -	0.00%	25.85%	18.8%
2	AIDS Drug Assistance Program (ADAP) Treatments	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
3	AIDS Pharmaceutical Assistance (local)	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
4	Oral Health	\$ 6,300,000	18.13%	\$ 5,814,587	15.96%	\$ -	0.00%	\$ -	0.00%	16.60%	14.6%
5	Early Intervention Services	\$ 500,000	1.44%	\$ 841,104	2.30%	\$ -	0.00%	\$ -	0.00%	1.32%	2.1%
6	Health Insurance Premium & Cost Sharing Assistance	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
7	Home Health Care	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
8	Home and Community Based Health Services	\$ 2,390,352	6.88%	\$ 2,011,335	5.50%	\$ -	0.00%	\$ -	0.00%	6.30%	5.1%
9	Hospice Services	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
10	Mental Health Services	\$ 300,000	0.86%	\$ 292,558	0.80%	\$ -	0.00%	\$ -	0.00%	0.79%	0.7%
11	Medical Nutritional Therapy	\$ 21,000	0.06%	\$ 36,570	0.10%	\$ -	0.00%	\$ -	0.00%	0.06%	0.1%
12	Medical Case Management (MCC)	\$ 10,569,206	30.42%	\$ 9,727,548	26.60%	\$ -	0.00%	\$ 1,001,097	31.10%	27.85%	27.0%
13	Substance Abuse Services Outpatient	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
14	Case Management (Non-Medical) BSS/TCM/CM for new positives/RW clients	\$ 1,753,458	5.05%	\$ 1,938,196	5.30%	\$ 752,024	23.45%	\$ 218,889	6.80%	6.60%	5.4%
15	Child Care Services	\$ -	0.00%	\$ 365,697	1.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.9%
16	Emergency Financial Assistance	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ 151,291	4.70%	0.00%	0.4%
17	Food Bank/Home-delivered Meals	\$ 1,299,557	3.74%	\$ 1,462,789	4.00%	\$ -	0.00%	\$ 498,939	15.50%	3.42%	4.9%
18	Health Education/Risk Reduction	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
19	Housing Services RCFCI/TRCF/Rental Subsidies with CM	\$ 500,000	1.44%	\$ 2,596,451	7.10%	\$ 1,455,000	45.37%	\$ 849,805	26.40%	5.15%	8.7%
20	Legal Services	\$ 137,436	0.40%	\$ 255,988	0.70%	\$ -	0.00%	\$ -	0.00%	0.36%	0.6%
21	Linguistic Services	\$ 17,976	0.05%	\$ 255,988	0.70%	\$ -	0.00%	\$ -	0.00%	0.05%	0.6%
22	Medical Transportation	\$ 1,148,939	3.31%	\$ 731,394	2.00%	\$ -	0.00%	\$ 498,939	15.50%	3.03%	3.1%
23	Outreach Services (LRP)	\$ -	0.00%	\$ 1,865,056	5.10%	\$ 1,000,000	31.18%	\$ -	0.00%	2.63%	4.7%
24	Psychosocial Support Services	\$ -	0.00%	\$ 182,849	0.50%	\$ -	0.00%	\$ -	0.00%	0.00%	0.5%
25	Referral	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
26	Rehabilitation	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
27	Respite Care	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
28	Substance Abuse Residential	\$ -	0.00%	\$ 731,394	2.00%	\$ -	0.00%	\$ -	0.00%	0.00%	1.8%
29	Treatment Adherence Counseling	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	0.00%	0.0%
30	Overall Total	\$ 34,748,746	100.00%	\$ 36,569,729	100.00%	\$ 3,207,024	100.00%	\$ 3,218,960	100.00%	\$ 37,955,770	\$ 39,788,689

CORE SERVICES (from 68.4% to 78.8%)

SUPPORT SERVICES (from 31.6% to 21.2%)

12. STANDING COMMITTEE REPORTS (cont'd):

B. Operations Committee

(1) Membership Management

(a) Membership Applications

(i) Susan Alvarado | City of Long Beach Rep

MOTION #8

(ii) Maribel Ulloa | HOPWA Rep **MOTION #9**

(iii) Justin Valero | Rep, Board Office 4

MOTION #10

(2) (Revised) Code of Conduct **MOTION #11**



LOS ANGELES COUNTY COMMISSION ON HIV



MOTION #11:
4/11/19 COH Meeting

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • <http://hiv.lacounty.gov>

GUIDELINES FOR CONDUCT

(OPERATIONS COMMITTEE APPROVED 3/28/19)

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following **Guidelines for Conduct** for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

- 1) We strive for consensus and compassion in all our interactions.
- 2) We respect others' time by starting and ending meetings on time, being punctual, and staying present.
- 3) We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.
- 4) We encourage all to bring forth ideas for discussion, community planning, and consensus.
- 5) We focus on the issue, not the person raising the issue.
- 6) We give and accept respectful and constructive feedback.
- 7) We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.
- 8) We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).
- 9) We give ourselves permission to learn from our mistakes.

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005)

12. STANDING COMMITTEE REPORTS (cont'd):

D. Public Policy Committee

(1) County, State and Federal Legislation & Policy

(a) (Draft) 2019 Policies Priorities **MOTION #12**



LOS ANGELES COUNTY COMMISSION ON HIV



3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010
(213) 738-2816 / Fax (213) 637-4748
hivcomm@lachiv.org

MOTION #12:
4/11/19 COH Meeting

2019 POLICY PRIORITIES

***Approved by Public Policy Committee 3/4/19
For Executive Committee Review 3/28/19***

The Public Policy Committee recommends the following policy priorities for the Commission on HIV to focus on in 2019 (in no particular order):

- Preserve access to and continuity of care for PLWHA and communities at highest risk for the acquisition and transmission of HIV disease.
 - Preserve federal funding for Medicaid, Medicare, and for HIV/AIDS programs.
 - Preserve health insurance coverage for individuals with pre-existing conditions.
- Protect and expand HIV and STD service access and availability in California's annual budgeting process.
- Maintain and preserve the Ryan White Program at current or increased funding levels and, where appropriate and strategically viable, support stronger compatibility and greater effectiveness between the RWP, Medicaid, Medicare, and other health systems.
- Advance and enhance routine HIV testing, expanded linkage to care, and other improvements to the local, state, and national HIV service delivery systems that optimize health outcomes in the HIV Continuum and advance HIV services in LA County consistent with the National HIV AIDS Strategy goals, LA County HIV/AIDS Strategy, and LA County Comprehensive HIV Plan.
- Support policies that use data, without risking personal privacy and health, to improve health outcomes and eliminate health disparities among PLWHA and communities highly impacted by HIV/STDs.
- Enhance Federal accountability for deliverables from a heightened and coordinated federal response, particularly in the context of local planning and responsiveness to the NHAS.
- Support proposals and increased funding for the provision of and access to: prevention, care and treatment services, bio-medical interventions (such as PrEP and PEP) for people at risk for acquiring HIV and people living with HIV/AIDS, and comprehensive HIV/STD counseling, testing, education, outreach, research and social marketing programs.
- Support proposals that seek to advance health equity, reduce stigma, and address social determinants of health such as poverty, education, violence, substance abuse, and transportation in order to improve health outcomes for people living with HIV/AIDS and special populations at highest risk for contracting HIV.
- Preserve and/or support systems, strategies and proposals that seek to expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of contracting, HIV/AIDS.



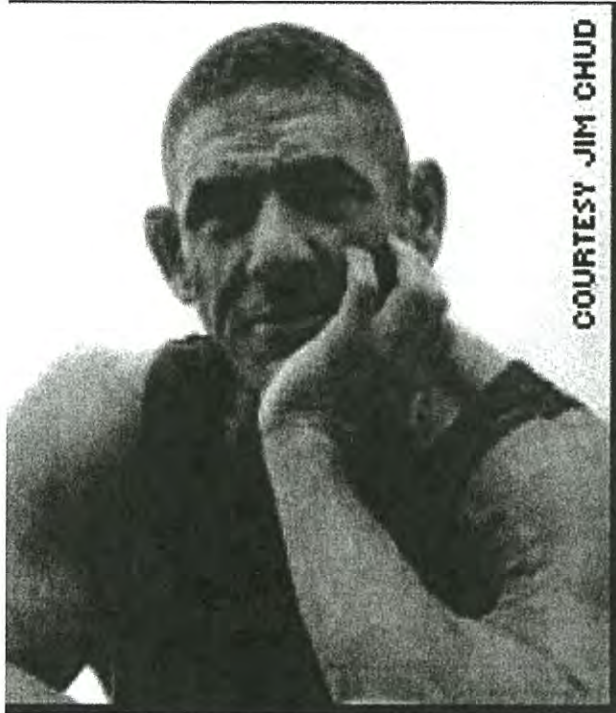
LOS ANGELES COUNTY COMMISSION ON HIV



- Support proposals that eliminate discrimination against or the criminalization of people living with, or at risk of, HIV/AIDS.
- Support proposals that expand access to and reduce the cost of HIV/AIDS and STD prevention and treatment medication.
- Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Pre-Exposure Prophylaxis Assistance Program (PrEP-AP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.

16. ANNOUNCEMENTS

A Celebration of Jim Chud's Life



**Please join us as we celebrate the
extraordinary life of Jim Chud**

When: Sunday, April 7, 2019, 5:00 PM – 7:00 PM

Where: Plummer Park, Rooms 1 and 2
7377 Santa Monica Blvd., West Hollywood, 90046

What: Celebration of Jim Chud's life.

If you'd like to say a few words during the program, or want to submit written remarks, please reply to info@projectchickensoup.org

The LA County Commission on HIV is pleased to announce HIV Connect, an online tool for community members and providers looking for resources on HIV and STD testing, prevention and care, service locations, and housing throughout LA County.

