TRAINING

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Overview

July 19, 2023

LOS ANGELES COUNTY
COMMISSION ON HIV

TRAINING

Membership Structure and Responsibilities

July 19, 2023

LOS ANGELES COUNTY
COMMISSION ON HIV

Learning Objectives

Learn about the duties of a Commissioner, the 51 seats on the body, and the functions of the Operations Committee.

Learn how different member perspectives help facilitate a sound integrated HIV/STD prevention and care planning process.

Understand the concepts of Parity, Inclusion, Reflectiveness, and Representation.

LOS ANGELES COUNTY
COMMISSION ON HIV

http://hiv.lacounty.gov

EXECUTIVE OFFICE
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

The Commission on HIV (COH) serves as the local planning council for the planning, allocation, coordination and delivery of HIV/AIDS and Sexually Transmitted Diseases (STD)

MEMBERS

51

Nominated by the Commission on HIV.

APPOINTMENT

By Board of Supervisors.

TERM OF OFFICE*

2 years

Serve at the pleasure of the Board.

FORM 700

MUST file annually and upon leaving the COH or face a $100 (max) fine! $10 per day

QUALIFICATIONS*

Recommended entities shall forward candidates to the Commission for membership consideration.

Recommending entities and the nominating body are strongly encouraged to nominate candidates living with HIV disease or members of populations disproportionately affected by HIV/ STDs.

INCENTIVES*

Gift cards or stipends, and reimbursements for mileage, transportation, childcare are available only to unaffiliated consumers.

No more than $150 per month as determined by the Commission policy.

DUTIES*

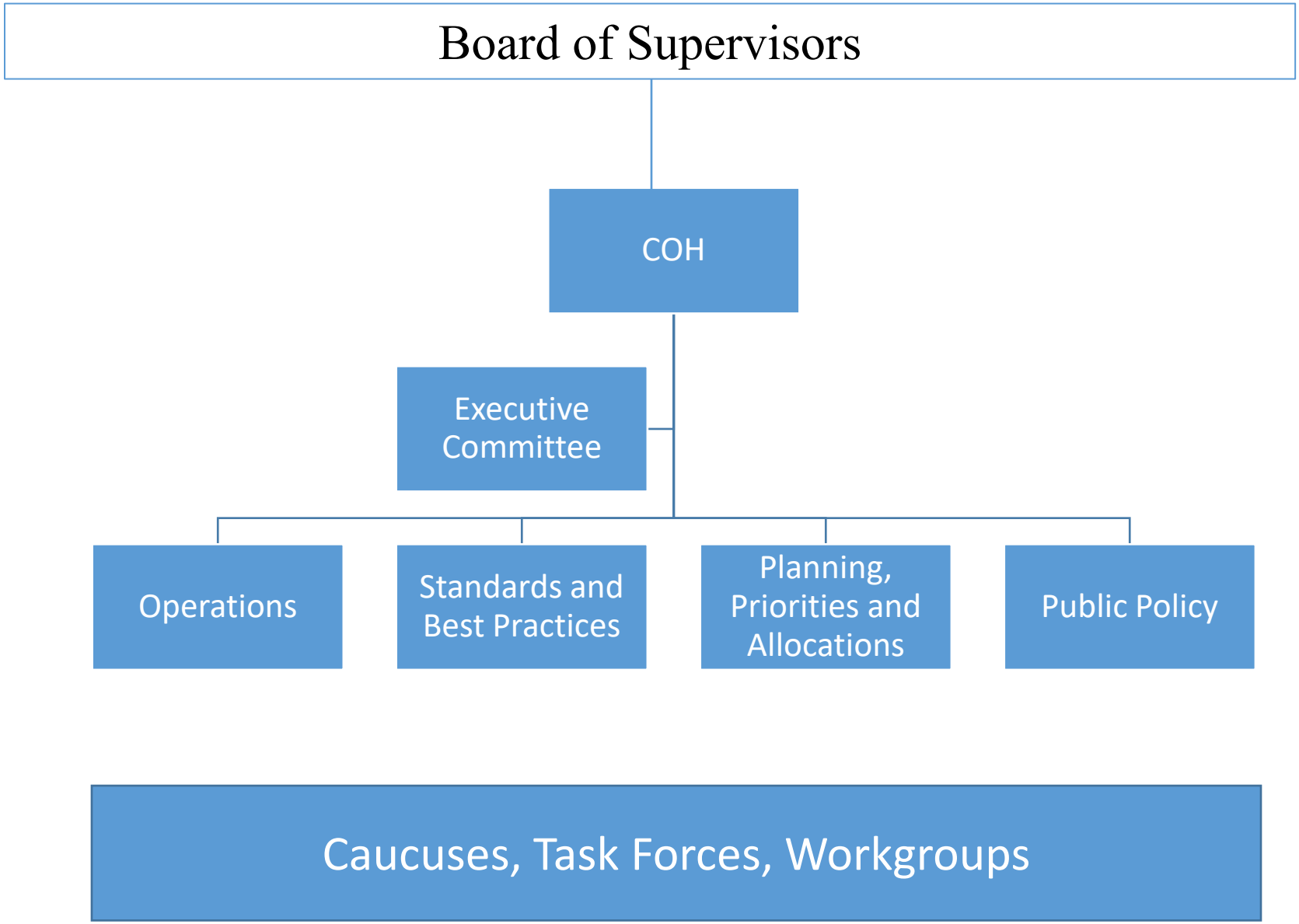
The Commission on HIV is tasked with planning, allocation, coordination and delivery of HIV/AIDS and Sexually Transmitted Disease(s) (STDs) services in Los Angeles County.

Consistent with Section 2602(b)(4) (42 U.S.C. § 300ff-12) of Ryan White legislation, HRSA guidance, and requirements of the CDC HIV Planning Guidance.

MEETINGS*

At least ten (10) times per year, plus monthly Committee meetings.

Additional time commitment may be required.


Board of Supervisors
COH
Executive Committee
Operations
Standards and Best Practices
Planning, Priorities and Allocations
Public Policy
Caucuses, Task Forces, Workgroups

51 Seats

- 5 Governmental Representatives
- 1 DHSP Director/Part A
- 4 Ryan White Parts
- 8 Provider Representatives
- 17 Unaffiliated Consumers
- 5 Board Office Representatives
- 1 HOPWA
- 1 Health or Hospital Planning Agency
- 1 Behavioral or Social Scientist
- 8 HIV Stakeholders

Definitions

Consumer: a person living with HIV or AIDS who uses Ryan White funded services or is the caretaker of a minor with HIV/AIDS who receives those services, or
an HIV-negative prevention services client.

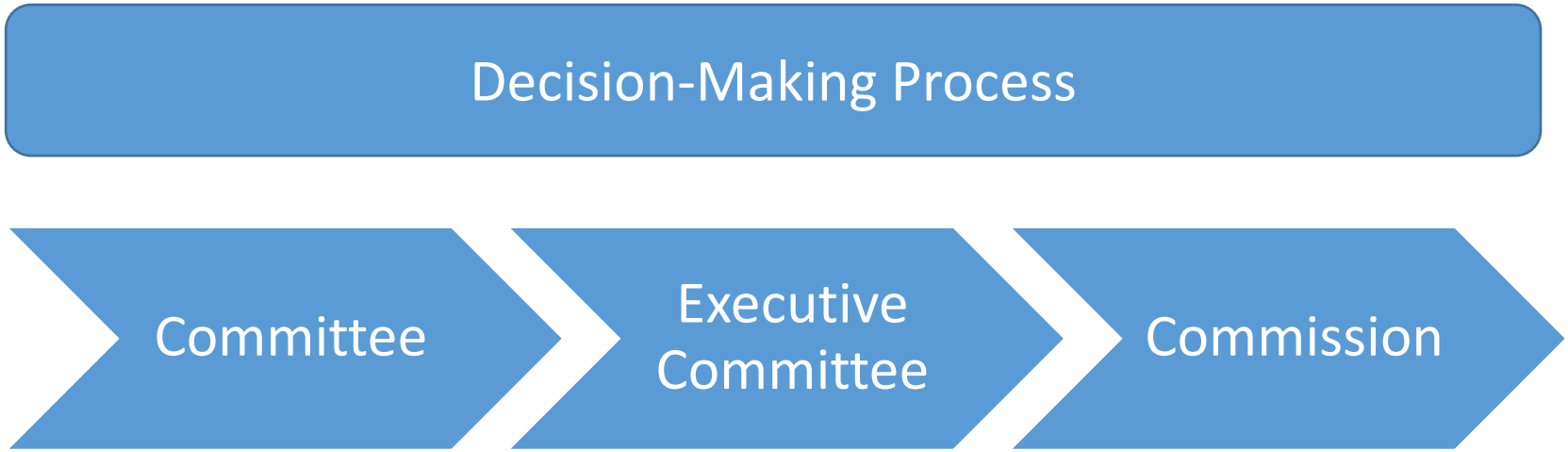
Unaffiliated consumer: a person living with HIV or AIDS and a user of Ryan White-funded HIV services; and does not serve in a decision-making capacity (including but not limited to an employee, consultant and/or board of directors member) at any Part A funded organization or agency.

Members

- **Commissioner (Member):** appointed by the BOS as full voting members to execute the duties and responsibilities of the Commission
- **Alternates:** appointed by the BOS to substitute for PLWH Commissioners when those Commissioners cannot fulfill their respective Commission duties and responsibilities
- **Committee-only Member**: professional expertise, as a means of further engaging community participation in the planning process.

Committees and Working Units

- The Commission completes most of its work through a strong committee and working unit structure.



A Commissioner's Calendar

Attendance requirements:

1. All regularly scheduled Commission meetings
2. Monthly Committee meetings
3. Priority allocation setting meetings
4. Orientation and training sessions
5. Annual Meeting (November)

Operations Committee

- Membership recruitment, retention, outreach, and engagement
- Leadership development and mentorship
- Bylaws, policies, and procedures
- Ensure parity, inclusion and representation
- Promote HIV services
- Assessment of Administrative Mechanism (AAM)
- Training

Assessment of the Efficiency of the Administrative Mechanism (AAM)

- **COH responsibility**
- **Legislation requires PC to** "assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area"
- Should be done annually – directly or through a consultant
- Involves assessing how efficiently DHSP does procurement, disburses funds, supports the COH's planning process, and adheres to COH priorities and allocations
- Written report goes to DHSP, which indicates what action it will take to address any identified problem areas

DHSP and COH Roles and Responsibilities

- DHSP and COH = two independent entities, both with legislative authority and roles
- Some roles belong to one entity and some are shared
- Effectiveness requires clear understanding of the roles and responsibilities of each entity, *plus:*
  - Communications, information sharing, and collaboration between the recipient, COH, and COH support staff
  - Ongoing consumer and community involvement

COH, DHSP, Roles & Responsibilities

Task	Committee	DHSP	COH
Carry Out Needs Assessment	PP&A	X	X
Do Comprehensive Planning	PP&A	X	X
Set Priorities*	PP&A		X
Allocate Resources*	PP&A		X
Manage Procurement		X	
Monitor Contracts		X	
Evaluate Effectiveness of Planning Activities	PP&A	X	X
Evaluate Effectiveness of Care Strategies	SBP	X	X
Do Quality Management	SBP	X	[Care Standards & Committee Involvement]
Assess the Efficiency of the Administrative Mechanism*	Operations		X
Member Recruitment, Retention and Training	Operations		X

* Sole responsibility of RWHAP Part A Planning Councils

Parity, Inclusion and Representation (PIR)

From the COH Ordinance

"Parity, Inclusion and Representation (PIR)" is the CDC principle to ensure that all HIV planning council members can:

1. participate equally (parity),
2. that the planning process actively includes a diversity of views, perspectives and stakeholders (inclusion), and that
3. members should represent the range of ethnicities, gender, backgrounds and other characteristics of people affected by HIV (representation).

Ryan White Legislation: "Reflectiveness"

- Planning Council (PC) "shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations" [Section 2602(b)(1)]

HRSA Expectations: "Reflectiveness"

- "Reflectiveness is the extent to which the demographics of the planning council's membership look like the epidemic of HIV/AIDS in the EMA/TGA."
- Must include "at least the following: race/ethnicity, gender, and age at diagnosis."
- Reflectiveness required for both the whole planning council membership and the consumer membership.
- PLWH should be selected "without regard to the individual's stage of disease."
- "Reflectiveness does not mean that membership must identically mirror local HIV/AIDS demographics." [p 111]
- "The composition of the PC or planning body must reflect the demographics of the HIV/AIDS epidemic in the EMA/TGA." [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 22]
- The required PC/B letter that accompanies the RWHAP Part A application must indicate "that representation is reflective of the epidemic in the EMA/TGA" or, if it is not, "Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA and "provide a plan and timetable for addressing each vacancy." [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 24]

Planning Council Reflectiveness

(updated 6/18/20)

Race/Ethnicity	Newly Diagnosed PLWH (2018)		Living with HIV/AIDS in EMA/TGA (2018/2019)		Total Members of the Planning Council		Non- Aligned Consumers on Planning Council	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White, not Hispanic	323	19.5%	14186	27.3%	7	20.00%	3	25.00%
Black, not Hispanic	379	22.8%	10446	20.1%	9	25.71%	4	33.33%
Hispanic	817	49.2%	23351	44.9%	14	40.00%	4	33.33%
Asian/Pacific Islander	88	5.3%	1958	3.8%	3	8.57%	0	0.00%
American Indian/Alaska Native	10	0.6%	303	0.6%	0	0%	0	0.00%
Multi-Race/Not Specified	43	2.6%	1736	3.3%	2	5.71%	1	8.33%
Total	1660	100%	51980	100%	35	100%	12	100%
Gender	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Male	1445	87.1%	45313	87.2%	23	65.71%	9	75.00%
Female	180	10.8%	5777	11.1%	10	28.57%	3	25.00%
Transgender	35	2.1%	890	1.7%	1	2.86%	0	0.0%
Unknown/Other	0	0.0%	0	0.0%	1	2.86%	0	0.0%
Total	1660	100%	51980	100%	35	100%	12	100%
Age	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
13-19 years	64	3.9%	105	0.2%	0	0.0%	0	0.0%
20-29 years	637	38.4%	4056	7.8%	3	8.57%	1	8.33%
30-39 years	485	29.2%	10082	19.4%	13	37.14%	3	25.00%
40-49 years	257	15.5%	11506	22.1%	7	20.00%	3	25.00%
50-59 years	140	8.4%	15989	30.8%	10	28.57%	4	33.33%
60+ years	77	4.6%	10242	19.7%	2	5.71%	1	8.33%
Other/Unknown	0	0.0%	0	0.00%	0	0.0%	0	0.0%
Total	1660	100.0%	51980	100.00%	35	100%	12	100%

Image is for illustration purposes only.

- Reflectiveness table is reported to HRSA.
- Compliance with meeting 1/3 unaffiliated consumers on the PC is a priority for HRSA.
- "Unaffiliated consumer" (non-aligned) means:
  1. A PLWH user of Ryan White-funded Part A HIV services AND
  2. who does not serve in a decision-making capacity (including but not limited to an employee, consultant and/or board of directors member) at any Part A funded organization or agency."

The PC Reflectiveness table does NOT address "Parity" or "Inclusion".

Roe, Kathleen & Montes, Henry & Roe, Kevin. (2008). Parity, inclusion, and representation: Lessons from a decade of HIV prevention community planning for the movement to eliminate health disparities.

- Parity refers to true equity in decision-making regardless of education, status, employment, language, or other hierarchical constructs.
- Inclusion requires that all process elements respect, reflect, and engage the diversity of participants and perspectives, at all times and without fail
- Representation means that all relevant perspectives are present and that those representing a perspective are authentically connected to that community or experience. (Representation not the same as Reflectiveness)

Los Angeles County Policy of Equity

- https://ceop.lacounty.gov/policy-of-equity/
- **SCOPE OF COVERAGE**
  - The Policy applies to all employees, including board members, supervisors, managers, commissioners, applicants, interns, outside vendors, and volunteers.

Protected Status

- age (40 and over)
- ancestry
- color
- ethnicity
- religious creed (including religious dress and grooming practices)
- denial of family and medical care leave
- disability (including mental and physical disability)
- marital status
- medical condition (cancer and genetic characteristics)
- genetic information
- military and veteran status
- national origin (including language use restrictions)
- race
- sex (including pregnancy, childbirth, breastfeeding, and medical conditions related to pregnancy, childbirth or breastfeeding)
- gender
- gender identity
- gender expression
- sexual orientation
- any other characteristic protected by state or federal law

Public Statements by Commissioners to Media and Other Organizations

- Only Executive Director and Co-Chairs are authorized to speak on behalf of the Commission
- When speaking to the media, Commissioners should not imply they are speaking on behalf of the Commission.
- Proactively clarify with reporters that they do not speak on behalf of the Commission and are only commenting as an individual affiliated with an outside organization.
- Commissioners comments (verbal or written) as a private citizen solely reflect your personal position and not as a representative of the Commission.


Q&A

HIV CONNECT
CONNECTING COMMUNITIES TO RESOURCES

https://hivconnect.org/

510 S. Vermont Ave, 14th Floor,
Los Angeles, CA 90020

hivcomm@lachiv.org

213.738.2816

HIVCommissionLA

@HIVCommissionLA

LOS ANGELES COUNTY
COMMISSION ON HIV

Learning Objective

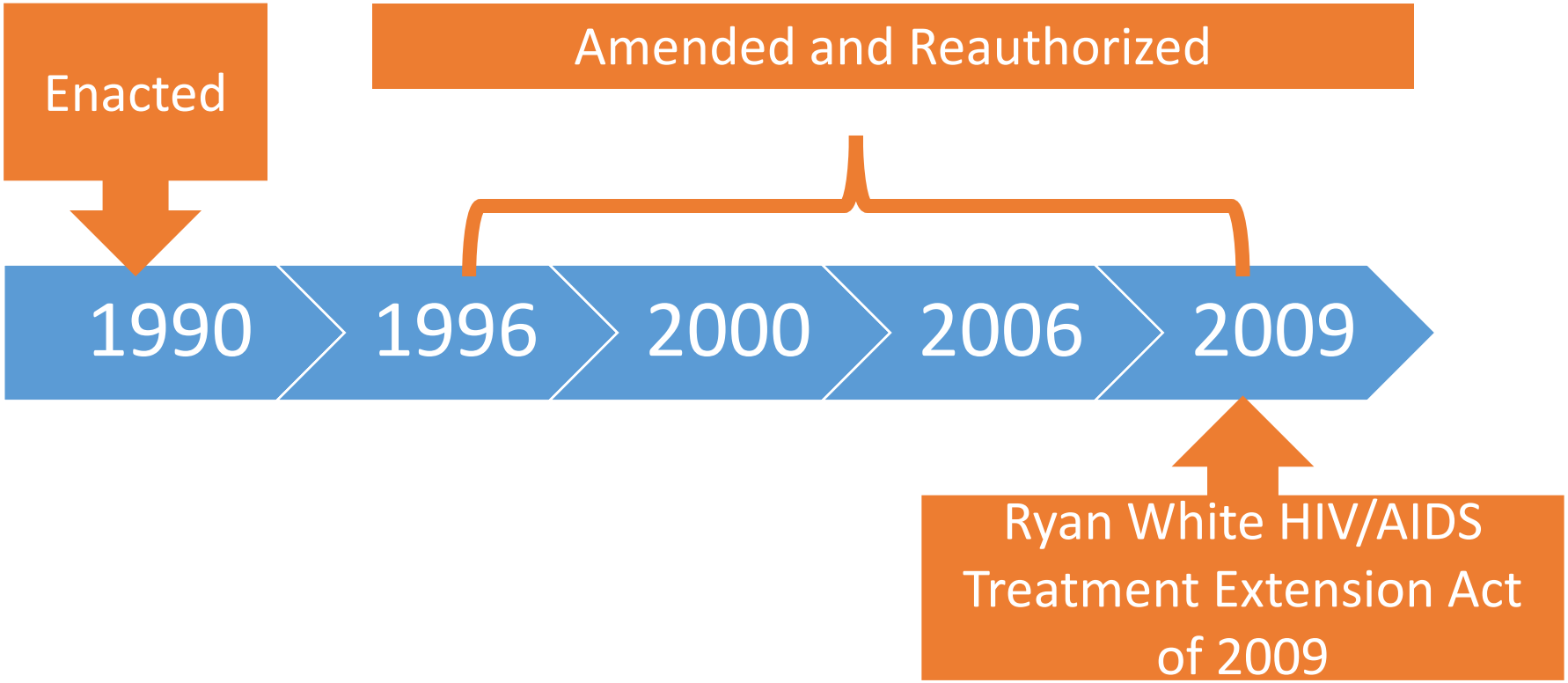
Learn about the landmark law that established lifesaving care for people living with HIV in the United States.

30 Years and Counting

August 18, 2020 marked the 30th anniversary of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Landmark legislation created the largest Federal program focused exclusively on providing care and treatment services to people with HIV, called the Ryan White HIV/AIDS Program.

Ryan White CARE Act Brief Timeline



Revised Purpose of Ryan White Legislation

- No longer “emergency relief” for overburdened health care systems
- Now “Revise and extend the program for providing life-saving care for those with HIV/AIDS”
- “Address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care”

Ryan White Treatment Extension Act

- Largest Federal government program *specifically designed* to provide services for people living with HIV/AIDS
- Third largest Federal program serving people living with HIV/AIDS – after Medicaid and Medicare
- Enacted as the Ryan White Comprehensive AIDS Resources Emergency Act in 1990
- Amended in 1996, 2000, 2006, 2009 – no longer an "emergency" act

- The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.
- Oversees and administers the Ryan White CARE Act dollars.

Ryan White Programs: RWHAP Part A (Division of HIV & STD Programs)

- Funding for 52 eligible metropolitan areas (EMAs) and Transitional Grant Areas (TGAs) that are severely & disproportionately affected by the HIV epidemic
  - **24 EMAs** (≥2,000 cases of AIDS reported in past 5 years and ≥3,000 living cases)
  - **28 TGAs** – (1,000-1,999 cases reported in past 5 years and ≥1,500 living cases)
- Administered by the Division of Metropolitan HIV/AIDS Programs (DMHAP), Health Resources Services Administration (HRSA)
- Carryovers not allowed; temporary special waiver only due to COVID

Ryan White Programs: Part B
(State Office of AIDS)

- Grants to all 50 States, DC, Puerto Rico, territories and jurisdictions:
  - Base Award
  - Supplemental (competitive) Award
  - AIDS Drug Assistance Program (ADAP)
  - Supplemental ADAP Award
  - Grants to Emerging Communities (500-999 new cases in past 5 years)
- Administered by the Division of State HIV/AIDS Programs (DSHAP)

Parts C & D and Part F Dental Services

- **Part C:** Funding to local community-based organizations, community health centers, health departments, and hospitals to support comprehensive primary health care and support services in an outpatient setting
  - Planning grants and capacity development grants to more effectively deliver HIV care and services
- **Part D:** family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV and their affected family members
- **Part F:** Special Projects of National Significance, AIDS Education Training Centers, Dental Reimbursement Programs and Community Based Dental Partnership

Part F Minority AIDS Initiative (MAI)

- Congress authorized MAI in 1999 to improve access to HIV care and health outcomes for disproportionately affected minority populations
- Allowable uses of MAI funds vary by Part
- RWHAP Part A programs receive MAI formula grants to use for core medical and related support services designed to improve access and reduce disparities in health outcomes
- Formula is based on the number of racial and ethnic minority individuals with HIV/AIDS in the jurisdiction
- Carryover allowed for 1 year only

Other Part F Programs

- **Special Projects of National Significance (SPNS):** supports the development of innovative models of care and effective delivery systems for HIV care, and the dissemination of successful models
- **HIV/AIDS Education and Training Centers (AETCs):** supports a network of regional centers that conduct targeted, multidisciplinary education and training programs for health care providers serving PLWH

Legislative Context: Facts and Factors Important to the Commission on HIV

Factors Affecting HIV/AIDS Services Nationally & Locally

1. Epidemic continues, especially among traditionally underserved populations – but important progress in prevention. ***HIV health disparities persist!***
2. Because of available and emerging therapies, people with HIV/AIDS can live long and productive lives
3. Treatment IS prevention – virally suppressed PLWH rarely infect other people – which means an increased focus on coordination and collaboration between prevention and care
4. Changes in the larger health care system and financing affect HIV services
5. Policy and funding increasingly are determined by clinical outcomes
6. Social determinants of health, racism and stigma must be addressed in order to end HIV

Medical Model

Major focus on core medical services (medical model)

- 75% of funds must be spent on core medical services (waiver available)
- Support services must contribute to positive clinical outcomes
- Refinements to service categories and definitions in 2016 (HRSA Program Clarification Notice (PCN)) #16-02)

Core Medical Services: Parts A & B

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

75%

Support Services

- **Must be:**
  - ≤25% of total service expenditures
  - Needed to achieve medical outcomes

25%

- **Medical outcomes** = outcomes affecting the *HIV-related clinical status* of an individual with HIV/AIDS
- Commissioners need to know allowable service categories and service definitions
- DHSP and Commission need to be able to link funded support services to positive medical outcomes

Support Services: Parts A & B

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 [e.g., Legal Services and Permanency Planning]
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Health Care and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)

Limits on Non-Service Funding

- **Focus:** maximize funding for direct services
- **10% administrative cap** for administrative costs, including DHSP Clinical Quality Improvement Program, and Commission operational costs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