2019 ANNUAL MEMBER TRAINING
OCTOBER 10, 2019

Thank you for your service!

LOS ANGELES COUNTY
COMMISSION ON HIV

COH Executive Committee/Leadership Introductions

- Co-Chairs/: Grissel Granados and Al Ballesteros
- Operations: Traci Bivens-Davis and Juan Preciado
- Planning, Priorities & Allocations: Jason Brown and Miguel Martinez
- Standards and Best Practices: Erika Davies and Kevin Stalter
- Public Policy: Katja Nelson and Aaron Fox
- Executive-At-Large: Bridget Gordon, Greg Wilson, Michelle Daniels

Ice-Breaker Activity

1. What strengths or skills do you bring to the table?
2. What kind of community planner would you like to be?

Let's Create a Learning Space

- It's ok to ask questions. It takes a few years to fully understand this complex and important work.
- Diversity of Ryan White experience: new and veteran members
- New members: learn the Ryan White program as it now exists
- Veteran members and staff: learn the *new* legislation and make good space for the new members
- Everyone: learn, become a team, and commit to using sound practices

Objectives

1. To understand the size, scope, & key trends in the local HIV/AIDS epidemic
2. To become familiar with the Ryan White Treatment Extension Act of 2009
3. To describe the roles and responsibilities of a Ryan White HIV/AIDS Program (RWHAP) Part A Planning Councils (PCs)
4. To differentiate Planning Council and recipient/ administrative agency roles (Commission on HIV vs Division of HIV and STD Programs)
5. To describe the challenges and key priorities for this Planning Council and EMA/TGA (Eligible Metropolitan Area/Transitional Grant Area)
6. To understand the structure and operations of this Planning Council
7. To be ready to serve as an active PC member

Groundrules

1. Focus on our shared purpose: the best possible care for people living with HIV (PLWH) in the metro area
2. Ask questions that help clarify the information presented
3. View this as an opportunity to get updated information on federal and local expectations for Ryan White HIV/AIDS Program (RWHAP) planning councils and members
4. Wait to speak until recognized
5. Treat everyone with respect
6. Try to identify practical solutions as well as problems
7. Recognize that the facilitator may have to limit discussion to move the agenda
8. Both follow and help enforce these groundrules

Members as Advocates and Planners

- **Members often come as Advocates:**
  - Bring passion
  - Provide a voice for their communities or for populations their organization serves
  - Also learn to advocate on behalf of other subpopulations that may be underrepresented in COH deliberations
- **Need to know when/how to be Planners:**
  - Consider the entire community
  - Seek Win-Win versus Win-Lose
  - Listen to others/ask questions
  - Come prepared – review data and reports; ask questions
  - Use data to make decisions – not “impassioned pleas”
  - Understand boundaries

Why Community Planning?

- Public process increases transparency and accountability
- Diverse perspectives (populations, disciplines, and services)
- Informed by personal and professional experiences
- Opportunity for equitable access to information and to influence how services are prioritized and shaped

Agenda

- Why We are Here
- Ryan White Legislation: What Every Commission on HIV Member should Know
- Legislative Context: Facts and Factors Important to the Commission on HIV
- Roles and Responsibilities of Planning Councils: An Overview
- The Annual Planning Cycle
- Commission on HIV Operations
- How the Commission on HIV Operates
- Looking Ahead
- Sum Up and Assessment

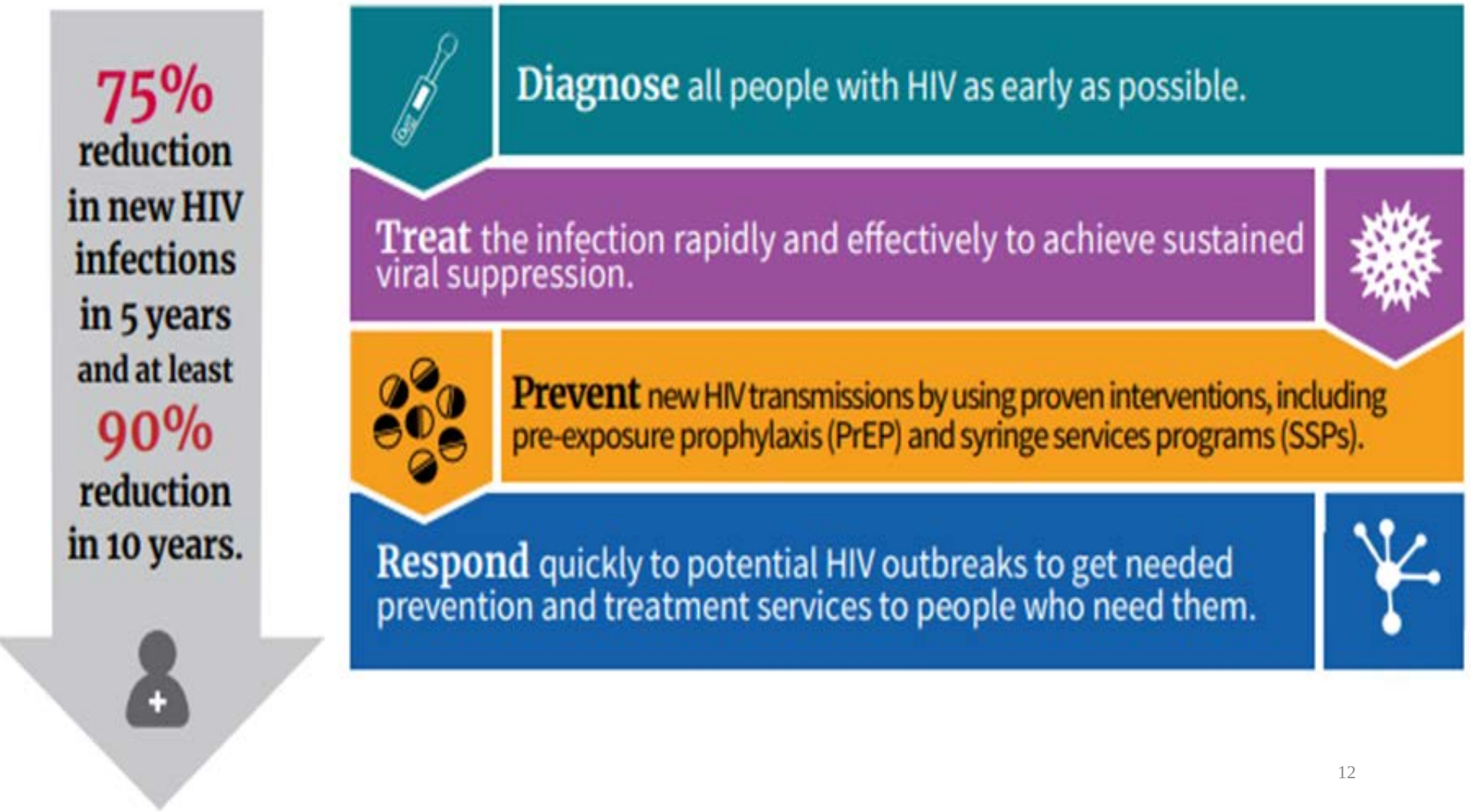
Why We are Here
Why our Work Matters

The Los Angeles County HIV/AIDS Strategy Call to Action

"Despite many advances in HIV prevention and treatment strategies, the annual incidence of HIV in Los Angeles County of 1,750 to 2,000 new infections persists. At the end of 2016, only 60% of all PLWH in LAC were virally suppressed. We now have a complementary set of tools to significantly reduce new infections, but we must amplify key messages and we must act!"

End HIV, Once and For All

Four Pillars of Ending the HIV Epidemic



Public Policy Committee

Meets every 1st Monday of the month from 1 pm to 3pm

Public Policy Committee

- Leads the development of policy, white papers, and other advocacy work that advances the work of the Commission.
- Engages local, regional, state, and federal stakeholders in assessing and developing policies that address HIV health disparities
- Monitors federal, state, and local funding for STD and HIV prevention

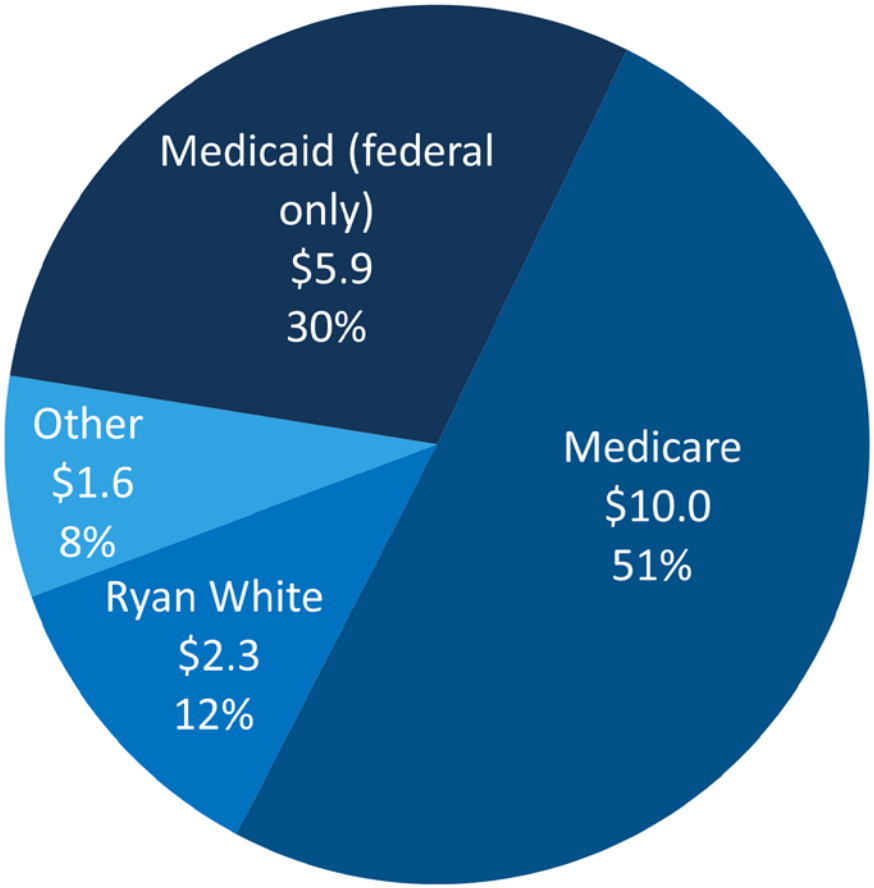
Ryan White Legislation: What Every Commission on HIV Member should Know

Ryan White Treatment Extension Act

- Largest Federal government program *specifically designed* to provide services for people living with HIV/AIDS – $2.32 billion in funding in FY 2019
- 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

Federal Funding for HIV/AIDS Care in the U.S., by Program, FY 2016

In Billions



Total = $19.7 Billion

SOURCE: KFF analysis of data from FY2016 Congressional Budget Justifications, White House Office of Management and Budget personal communication.
Note: Total program amounts may not add to $19.74 billion due to rounding; Percentages may not add to 100% due to rounding.

Importance of Ryan White HIV/AIDS Program (RWHAP)

- About 1.2 million people in the U.S. are living with HIV or AIDS
- About 13% (1 in 8) do not know their status
- About half of PLWH who know their status receive at least one medical, health, or related support service from a Ryan White HIV/AIDS Program provider – 534,750 in 2017
- RWHAP is the provider/payer of last resort for low-income, uninsured, and underinsured people living with HIV/AIDS
- Continues to play a critical role under health care reform

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 Programs: RWHAP Part A

- 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)

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

- 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: (Aaron Fox)**
  - 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 (Dr. LaShonda Spencer):** family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV and their affected family members
- **Part F (Jerry Gates, PhD):** Special Projects of National Significance, AIDS Education Training Centers, Dental Reimbursement Programs and Community Based Dental Partnership
- Administered by the Division of Community HIV/AIDS Programs (DCHAP)

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

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
- Administered by the Office of HIV/AIDS Training and Capacity Development (OHATCD)

Quiz: What's My "Part"?

Individually answer the 10 questions provided in the Quizzes Handout, using the following lettered responses (some may be used more than once, some not at all) – then share at your table.

A = Part A
B = Part B
C = Part C
D = Part D
E = All Parts
F = Part F
G = Parts A and B
H = Parts C and D
I = None of the Parts

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

Factors Affecting HIV/AIDS Services Nationally

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

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 (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)

Ryan White HIV Care Continuum

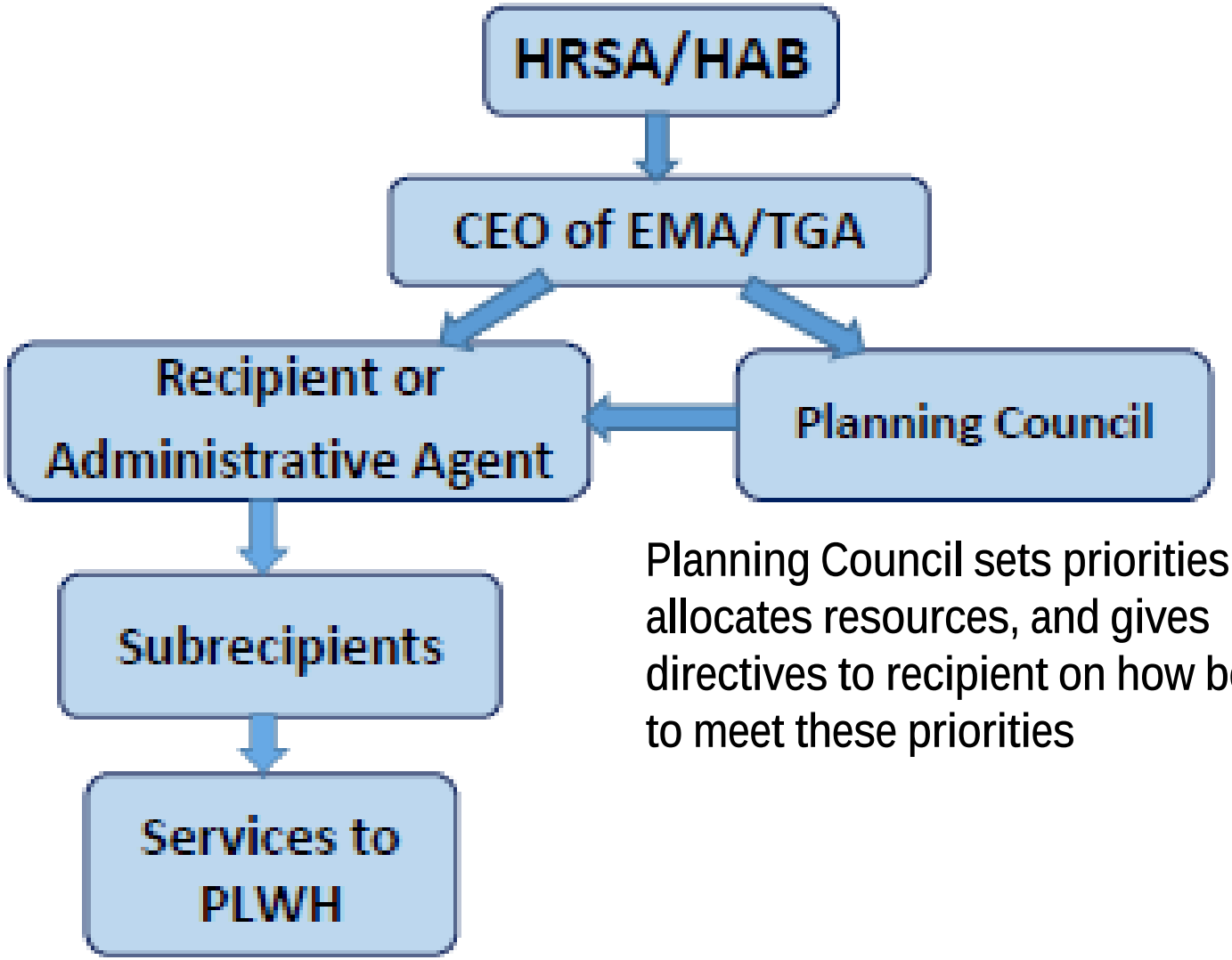
In 2017:

- 534,750 people received at least 1 service paid for by the RWHAP (15,747 between March 1, 2018 and February 28, 2019)
- 81% of clients were retained in care (at least 2 medical visits 90 days apart) (81.8% YR 26/2016-2017)
- 85.9% of clients were virally suppressed (81.9% YR 26)

Limits on Non-Service Funding

- **Focus:** maximize funding for direct services
- **10% administrative cap** for administrative costs, including Commission support costs

Flow of RWHAP Part A Decision Making & Funds



DHSP

COH

Contractors

Planning Council sets priorities, allocates resources, and gives directives to recipient on how best to meet these priorities

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Sum Up: Key Facts about RWHAP Part A

- Planning Council is decision making body under its Ryan White Part A role
- Ryan White services are not an entitlement
- Ryan White is the payer of last resort
- Key role for consumers of RWHAP Part A services

Operations Committee

Meets every 4th Thursday of each month from 10 am to 12 pm

Integrated Planning Council

Care

Prevention

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

COH Formation and Membership

- Established by Board of Supervisors (BOS)– BOS appoints all members
- Membership must meet legislated requirements:
  - Representation (legislatively required categories)
  - 33% unaffiliated consumers (UCs)of RWHAP Part A services
  - Uses RWHAP Part A services and not employed by a funded agency
  - Reflectiveness (of the epidemic in Los Angeles County)
- Must use an open nominations process
- DHSP has no role in membership selection
- Bylaws call for a DHSP representative on the COH

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

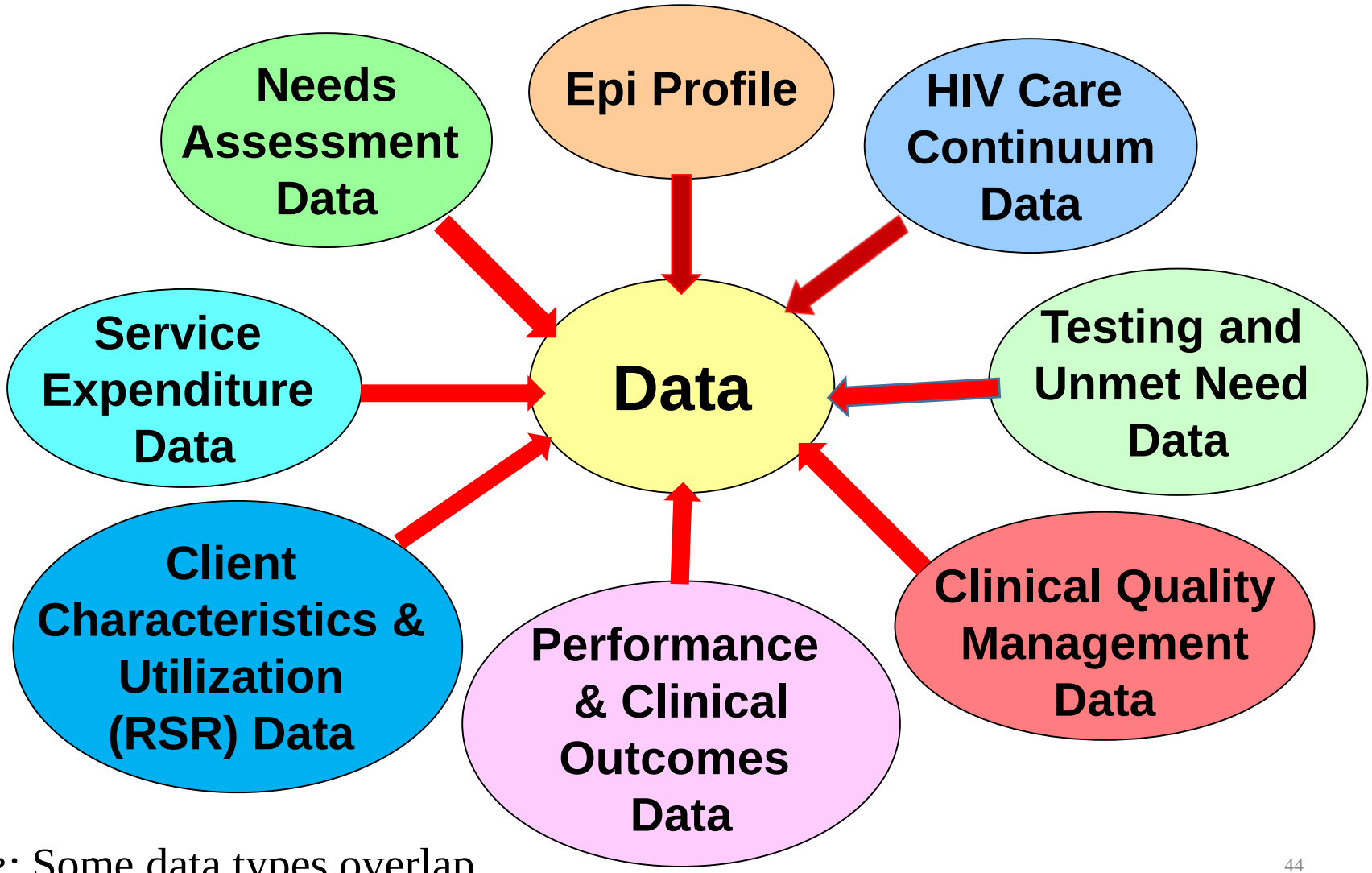
Operations Committee

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

Planning, Priorities & Allocations (PP&A)

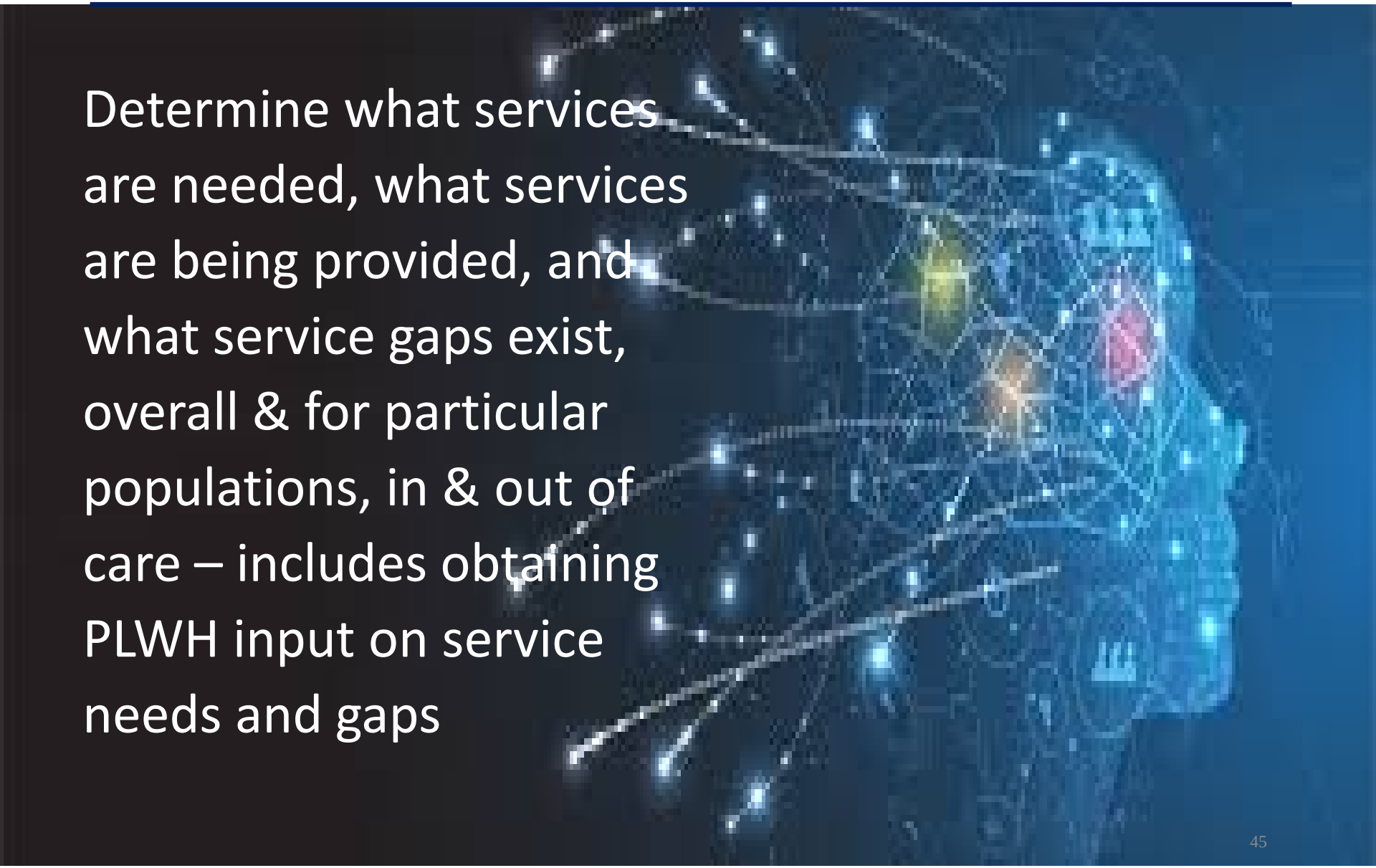
Meets every 3rd Tuesday of each month from 1pm to 3 pm; some meetings are longer or all-day

Data Needs for HIV Planning



Note: Some data types overlap

Expectations: Needs Assessment



Determine what services are needed, what services are being provided, and what service gaps exist, overall & for particular populations, in & out of care – includes obtaining PLWH input on service needs and gaps

Components of Needs Assessment

1. **Epi profile** of HIV & AIDS cases and trends
2. **Estimate & assessment of unmet need and undiagnosed** – PLWH who know their status but are not in care and PLWH who do not know their status
3. **Service needs** of PLWH in & out of care
4. **Existing services**, including a resource inventory & provider capacity/capability (availability, accessibility & appropriateness overall and for specific populations)
5. **Barriers** to testing and care
6. **Service gaps** for those in and out of care
7. **Disparities in access** to services for subpopulations
8. **Prevention-related** data

Purpose of the Planning Cycle: Putting the Pieces Together

Knowing who needs the services and how to reach them

+

Knowing who, where, what and to whom services are now provided

=

Making data driven decisions about which services are most needed and for whom

The Annual Planning Cycle

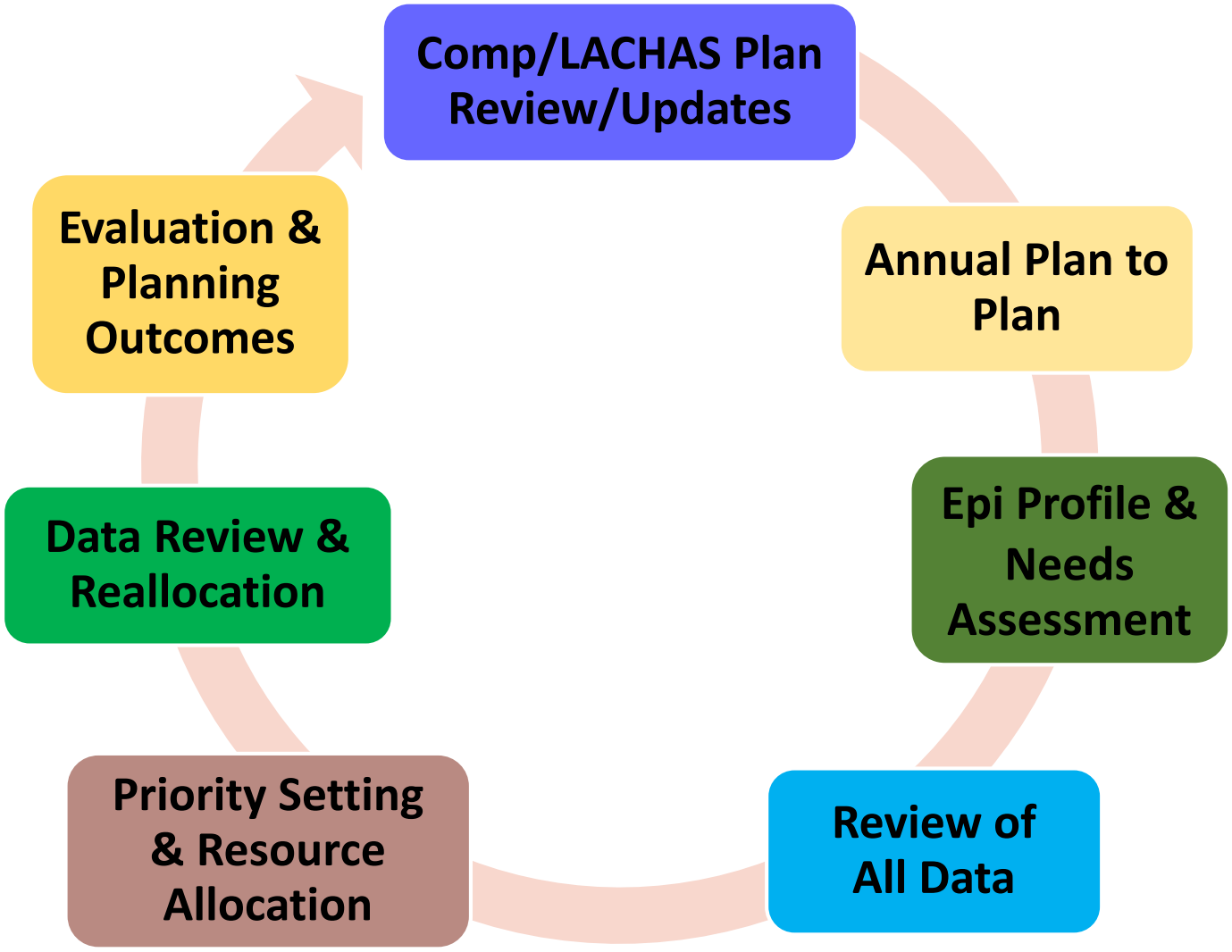
Annual to Multi-Year Planning Cycle

- Under the leadership of the PP&A Committee, the Commission started a multi-year planning process in 2019.
- In October 2019, the committee completed ranking and allocation guidelines for PY 31 and 32.
- The committee will review plan recommendations semi-annually and make adjustment where appropriate based on program data.

Annual Planning Cycle

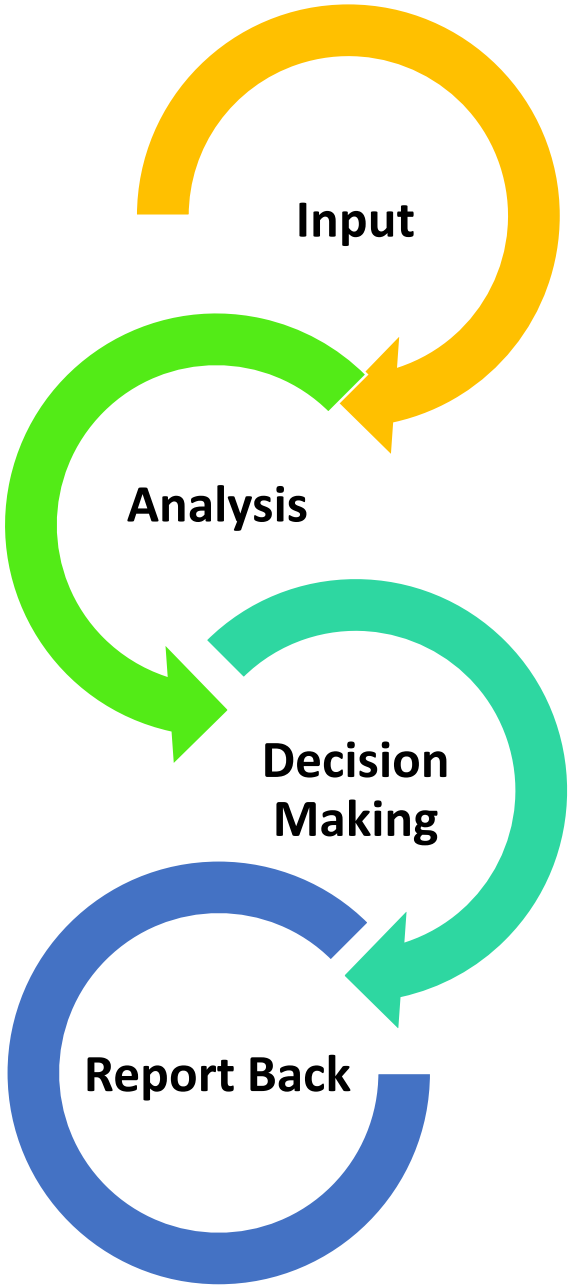
- Core responsibility of the COH: carry out community planning to establish and maintain the best possible system of care for PLWH in the jurisdiction – through a well-defined and fully-implemented planning cycle
- Centrality of the comprehensive/integrated plan
- Importance of needs assessment – identified as a weakness in the national 2016 PC/B assessment
- Critical need for access to many types of data for decision making

Annual Planning Cycle



Feedback Loop

Includes obtaining input from stakeholders, analyzing that information, using it for decision making, and reporting back to the community



Priority Setting and Resource Allocations (PSRA)

The most important legislative responsibility of Planning Councils – should involve all members

- **Priority setting:** deciding what service categories are most important for PLWH in Los Angeles County
- **Resource allocations:** deciding how much (%) RWHAP Part A funding to provide for each service priority – including separate allocation of RWHAP Part A and RWHAP Part A MAI funds
- **Directives to DHSP** on how best to meet these priorities – e.g., what service models for what populations in what geographic areas
- **Reallocation of funds** during the program year so all funds are expended on needed services

Priority Setting

- **Planning Council responsibility**
- Means determining what service categories are most important for PLWH in Los Angeles County– unrelated to who provides the funding for these services
- DHSP provides information – especially service utilization data – and advice, but has no decision-making role
- COH must establish a sound, fair process for priority setting and ensure that decisions are data based
- Important to prioritize needed service categories even if there may not be enough money to fund them all, in case the COH is able to reallocate some funds into a previously unfunded category during the program year

Applying Knowledge

The Planning Council is setting priorities. Members have agreed to make decisions based on hard data indicating what services are most needed by PLWH in the EMA/TGA. Two members want to add another factor: how much funding is available from other sources. They say that it doesn't make sense to give a service category high priority under RWHAP Part A if it has enough funding through other sources. *Are they right or wrong? Why?*

Directives

- **COH role**
- Providing guidance to DHSP on how best to meet the priorities
- Often specify use or non-use of a particular service model, or address geographic access to services, language issues, or specific target populations
- Must not have the effect of limiting open procurement by making only 1-2 providers eligible
- COH needs to be aware of cost implications

Examples of Directives

- Funded primary care services must be available in each of the major jurisdictions
- Providers must have bilingual staff in positions with direct client contact, including clinical staff
- At least one substance abuse treatment provider must offer services appropriate for women with young children and pregnant women

Resource Allocation

- **COH responsibility**
- Process of deciding how much funding to allocate to each priority service category or sub-category
- ≥75% of service dollars must go to core services (unless program has a waiver)
- ≤ 25% to support services needed for achieving medical outcomes
- DHSP provides data and advice, but has no decision-making role
- Need a fair, data-based process that controls conflict of interest
- Consider other funding streams, cost per client, plans for bringing people into care – *so some highly ranked service categories may receive little or no funding*

Non-Service Funds

- DHSP may take 10% for administrative costs and up to 5% for clinical quality management (QM) activities
- COH budget comes out of 10% administrative costs
  - Amount for COH must be negotiated with DHSP
  - Then COH budgets those funds to meet legislative requirements
- COH has no say in the amount or use of other administrative or QM funds

Reallocation

- **Planning Council role:** must approve any reallocation of funds among service categories
- Reallocation usually means moving funds:
  - From underspent providers to those *in the same service category* spending at a higher level [recipient decision], or
  - From underspent service categories to *different service categories* spending at a higher level or with additional need [PC must approve]
- Recipient provides expenditure data by service category to PC, usually monthly, and requests permission for reallocations as needed
- Some recipients do regular "sweeps" or request reallocation permission at set times each year – *rapid reallocations process very important to avoid unobligated funds and ensure funds are used to address priority service needs*

Coordination of Services

- **Shared responsibility of DHSP and COH**
- Focus on ensuring that RWHAP Part A funds fill gaps, do not duplicate other services, and make Ryan White the payer of last resort
- Involves coordination in planning, funding, and service delivery
- COH reviews other funding streams as input to resource allocation
- DHSP ensures that providers have linkage agreements and use other funding where possible – for example, help clients apply for entitlements like Medicaid

Grievance Procedures

- Both COH and DHSP must have HRSA/HAB-approved grievance procedures
- DHSP grievance line is for services NOT the same as the COH grievance procedures
- COH must have procedures to handle grievances related to funding – usually involving deviations from its priority-setting and resource-allocation procedures; may also cover other policies and processes

Managing Conflict of Interest

- COH must have and enforce conflict of interest policies including disclosure
- Conflict of interest occurs when a COH member has a monetary, personal, or professional interest in a decision or vote – through being an employee, consultant, or officer/director of a RWHAP Part A service provider
- Being a consumer of a specific provider is not considered a conflict of interest
- COH members should not *discuss* particular providers and members should not *advocate* for providers – discussion should focus on service categories

How Planning Councils Manage Conflict of Interest (COI)

Each member must:

- Sign a Disclosure Form every year (IRS form)
- Update the form if affiliations change
- Declare any COI before discussion begins
- In decision making about priorities and allocations: answer questions but not *initiate* discussion about service categories for which they have a COI
- Not vote on priorities or allocations for categories where there is a real or perceived conflict of interest
- Not vote on other matters where there is a conflict (e.g., hiring of consultants)

Procurement

- **DHSP role**
- No COH involvement
- Involves:
  - Publicizing the availability of funds
  - Writing Requests for Proposals (RFPs)
  - Using a fair and impartial review process to choose providers
  - Contracting with providers – and requiring that they follow standards of care (SOC) and meet reporting and quality management (QM) requirements
- Contract amounts by service category or sub-category must be consistent with COH allocations and directives

Contract Monitoring

- **DHSP role**
- No COH involvement, except that standards of care [approved by COH] are typically included in contracts and therefore a basis for monitoring
- Involves site visits and document review for monitoring of
  - **Program** quality and quantity of services
  - **Finances/fiscal management,** including expenditure patterns and adherence to HRSA/HAB and Los Angeles County regulations in use of funds
- Aggregate findings (by service category or across categories) shared with the COH as input to decision making

Applying Knowledge

A recipient staff member is participating in a Planning Committee meeting on needs assessment. The committee is reviewing information on the continuum of care and provider capacity within the EMA, and one member says she would like to know more about the Ryan White providers. She asks the recipient representative to provide "copies of information from provider proposals so we can better understand their capabilities." *How should the recipient staff member respond? Why?*

Standards and Best Practices

Meets every 1st Tuesday of each month from 10 am to 12 noon

Comprehensive HIV Continuum Framework

Aspirational framework for people to stay healthy, have improved quality of life, and to live longer

Serves as a guide for community planning and developing Standards of Care

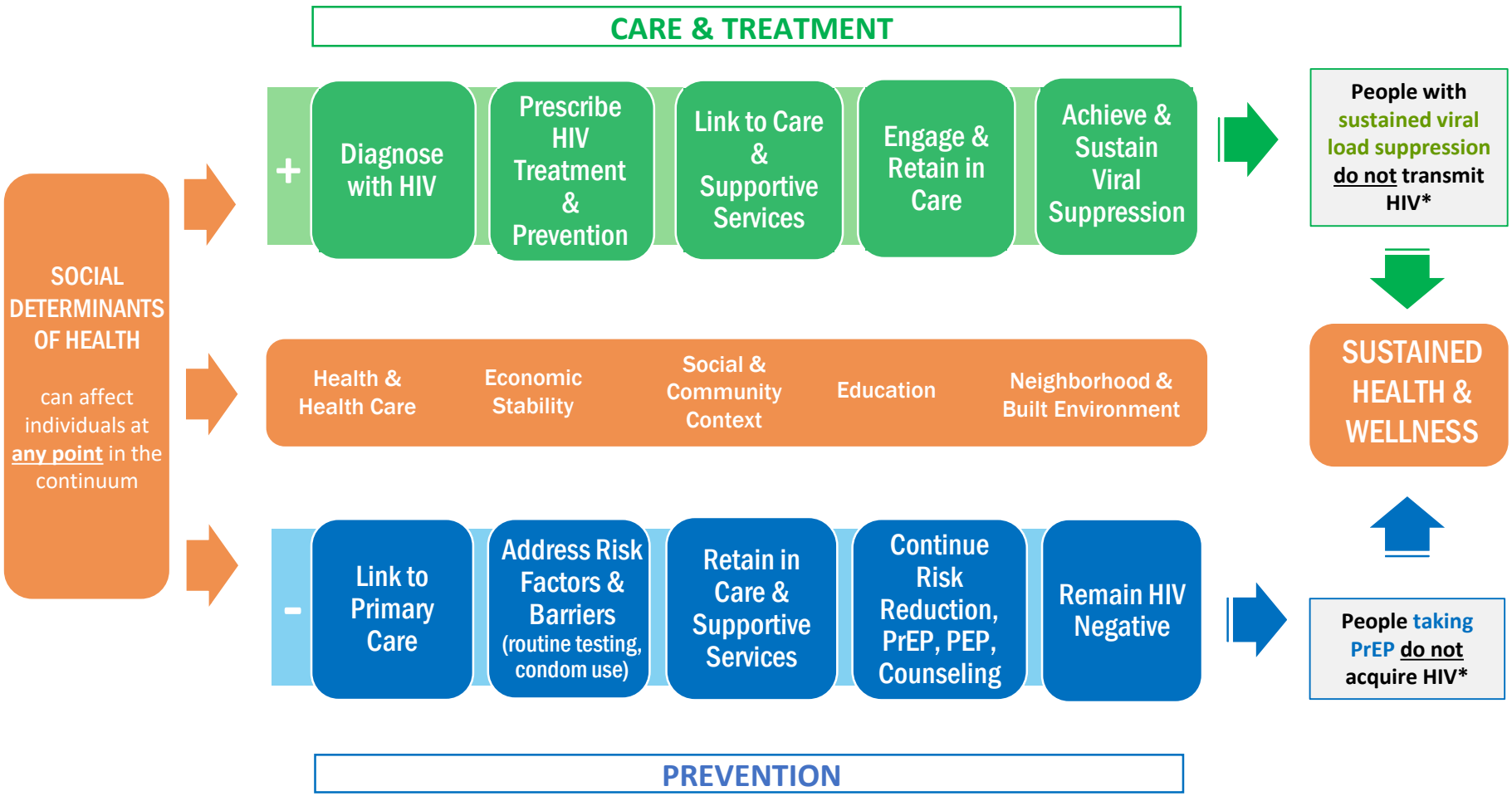
SBP made a commitment to conduct an annual review and update if necessary

Begins annual review in April

LOS ANGELES COUNTY
COMMISSION ON HIV

Comprehensive HIV Continuum Framework

The HIV Continuum is a framework for people to stay healthy, have improved quality of life, and live longer. The Commission on HIV adapted the Continuum to demonstrate HIV, sexual health, and overall health are influenced by individual, social, and structural determinants of health. Individuals can enter and exit at any point in the Continuum. The Continuum guides the Commission on community planning and standards of care development.



Revised 9/10/19

*For more information visit https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

Standards of Care

- Minimal service expectations for HIV prevention and care
- Developed for Ryan White service categories along with Universal Service standards
- Involves subject matter expert panels, reviews, and public comments
- Ensures that services are client-centered and adheres to latest scientific advances and clinical guidelines

Clinical Quality Management

- **DHSP plays primary role**
- **Involves ensuring that:**
  - Services meet clinical guidelines and local standards of care
  - Supportive services are linked to positive medical outcomes
  - Demographic, clinical, and utilization data are used to understand and address the local epidemic
- DHSP requires providers to develop QM plans, monitors providers based on quality standards, and recommends improvements
- COH establishes standards of care for use in QM
- DHSP reports to COH on QM findings by service category or across categories for use in decision making

Cost-Effectiveness and Outcomes Evaluation

- COH has the option of assessing the effectiveness of services offered – usually best done in coordination with QM; usually led by DHSP
- DHSP monitors performance, clinical outcomes, and cost effectiveness of services as part of QM
- Major focus on HIV Care Continuum
- Findings used by DHSP in selecting and monitoring providers
- Findings used by COH in priority setting, resource allocation, and development of directives on service models

Role of Staff

Commission on HIV Staff
Statement of Commitment

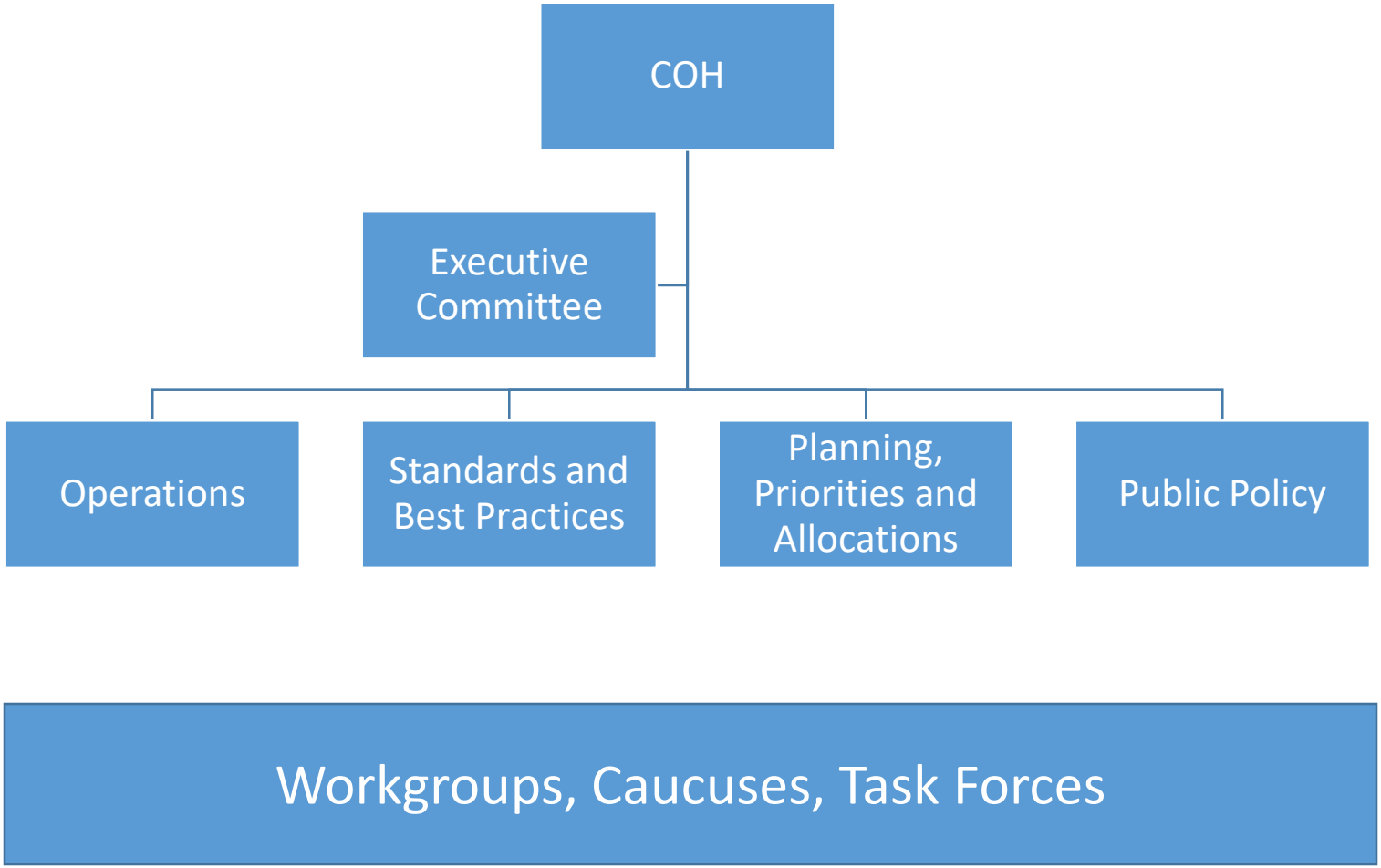
As the planning council support staff for the Los Angeles County Commission on HIV, we are committed to providing first-rate training, technical assistance, and guidance to Commissioners to ensure that they excel in fulfilling their duties as HIV/STD community planners. We foster positive and collaborative relationships and provide Commissioners with the knowledge, skills and tools to make well-informed decisions. Our actions are guided and driven by ***supporting the Commissioners lead the way in ending the HIV epidemic.***

Role of COH Staff

- **Assist the COH to carry out its legislative responsibilities and to operate effectively as an independent planning body**
- Staff committees and COH meetings
- Provide expert advice on Ryan White legislative requirements and HRSA/HAB/C DC regulations and expectations
- Oversee a training program for members
- Encourage member involvement and retention, with special focus on consumers
- Serve as liaison with DHSP
- Help the PC manage its budget
- Be involved *only* with supporting RWHAP Part A-related activities; COH public policy activities do not use RW funds

DHSP Staff Roles with COH

- Attend and make a report at COH meetings
- Regularly provide agreed-upon reports and data (e.g., costs and service utilization)
- Provide advice on areas of expertise without unduly influencing discussions or decisions
- Assign staff to attend most committees regularly
- Collaborate on shared roles
- Carry out joint efforts such as task forces and special analyses consistent with roles and resources


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

Discussion – What We are Working Towards: Envisioning a System of Care

- Why did you join the Planning Council?
- What is your vision for HIV/AIDS care in the EMA/TGA?
- What will make you feel your work on the Planning Council has been worthwhile – what do you most want to help accomplish?

Sum Up and Assessment

Summary

- COH has clearly defined legislative responsibilities
- COH decisions must be data-based, using the best available data
- Responsibilities are interrelated – emphasizing the importance of committee work
- Many functions best in collaboration with DHSP

Session Assessment

+ - What You Liked	Δ – What you would like to change

Quiz: What's My "Part"?

Work individually. Indicate which "Part" of the Ryan White legislation fits each of the following, choosing from the response categories below. You may use some responses more than once, and some not at all.

Response categories:

A = Part A	D = Part D	G = Parts A and B
B = Part B	E = All Parts	H = Parts C and D
C = Part C	F = Part F	I = None of the Parts

____1. Provides Funds to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)

____2. Special Projects of National Significance

____3. Early Intervention Services including comprehensive medical care and support services, funded through competitive grants, mostly to health centers and other clinics

____4. Dental Reimbursement Programs, Community Based Dental Partnerships, and AIDS Education and Training Centers (AETCs)

____5. Competitive grants designed to improve Access to Care for Women, Infants, Children and Youth

____6. Funding for Minority AIDS Initiative (MAI)

____7. Part Administered by the Division of State HIV/AIDS Programs (DSHAP)

____8. Improve Access to Quality HIV Care and Treatment

____9. Entitlements that are the Right of all HIV Infected and Affected Individuals

____10. Includes the AIDS Drug Assistance Program

Quiz: Test Your Knowledge of the Ryan White Legislation and the Work of the Planning Council

Indicate whether each of the following is TRUE or FALSE.

True or False:

_____1. The Ryan White legislation provides the single largest source of federal funding for HIV/AIDS care.

_____2. The Ryan White program is based on a "medical model," and at least 75% of Ryan White HIV/AIDS Program (RWHAP) Part A funds must be spent on core medical-related services.

_____3. The Planning Council is the decision maker about what types of services ("service categories") an Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) will fund with RWHAP Part A dollars, and how much money will be allocated to each service category.

_____4. The recipient has the lead role and the Planning Council has a supportive role in procurement – choosing specific agencies to be funded with RWHAP Part A funds.

_____5. Only the Chief Elected Official (the Mayor) can appoint people to the RWHAP Part A Planning Council.

_____6. Collaboration with RWHAP Part B is important, so the RWHAP Part A recipient may approve cost-sharing arrangements or agreements with the State about who pays for what services even if they don't quite fit the established RWHAP Part A priorities and allocations.

_____7. Planning Council members should not receive quality management or contract monitoring results for individual, identified provider agencies – they should get information only at the service category level.

_____8. The Planning Council and recipient work together on Needs Assessment, but the Planning Council plays a lead role in determining what data are needed for its decision making and overseeing the process.

_____9. An EMA or TGA that has a lot of RWHAP Part A formula grant funds left over and unspent at the end of the year will get less funding in a future year.

_____10. A person with HIV/AIDS who is eligible for Medicaid must choose whether to get primary care services through Medicaid or through Ryan White funding.