

Understanding the Legislation

Authorizing the Ryan White HIV/AIDS Program (RWHAP)

Slides for Module 1

Understanding the Legislation

- History and Evolution of the Ryan White HIV/AIDS Program (RWHAP) Legislation
- Overview of RWHAP Parts
- Understanding Part A

Training Objectives

Following the training, participants will be able to:

1. Describe how the RWHAP legislation evolved from 1990 to 2009 to reflect changes in the epidemic and advances in prevention and treatment
2. Identify the 3 largest sources of funding for HIV care and treatment in the U.S.
3. Identify and differentiate the 5 RWHAP Parts
4. Describe at least 3 important similarities between RWHAP Part A and Part B
5. Describe at least 4 key characteristics of RWHAP Part A

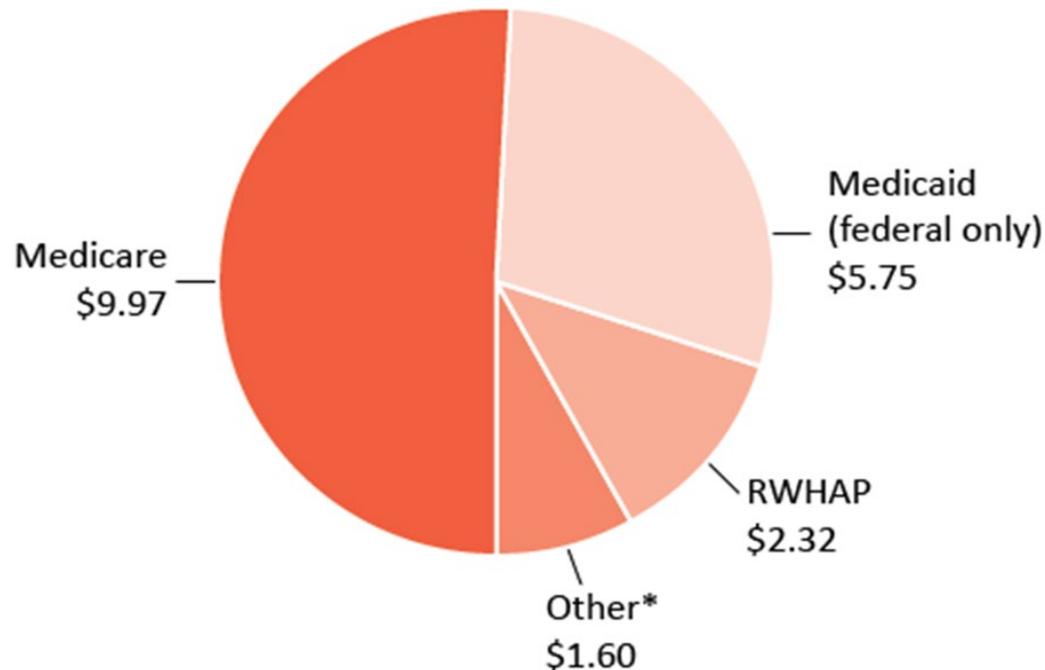
History and Evolution of RWHAP Legislation

RWHAP Legislation

- Largest Federal government program specifically designed to provide services for people living with HIV (PLWH) – \$2.32 billion in funding in FY 2017
- Third largest Federal program serving PLWH – after Medicaid and Medicare
- First enacted as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990
- Current legislation is the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act)

Federal Funding for HIV/AIDS Care in the U.S. by Program, FY 2017 [\$ in Billions]

Total = \$19.65 billion



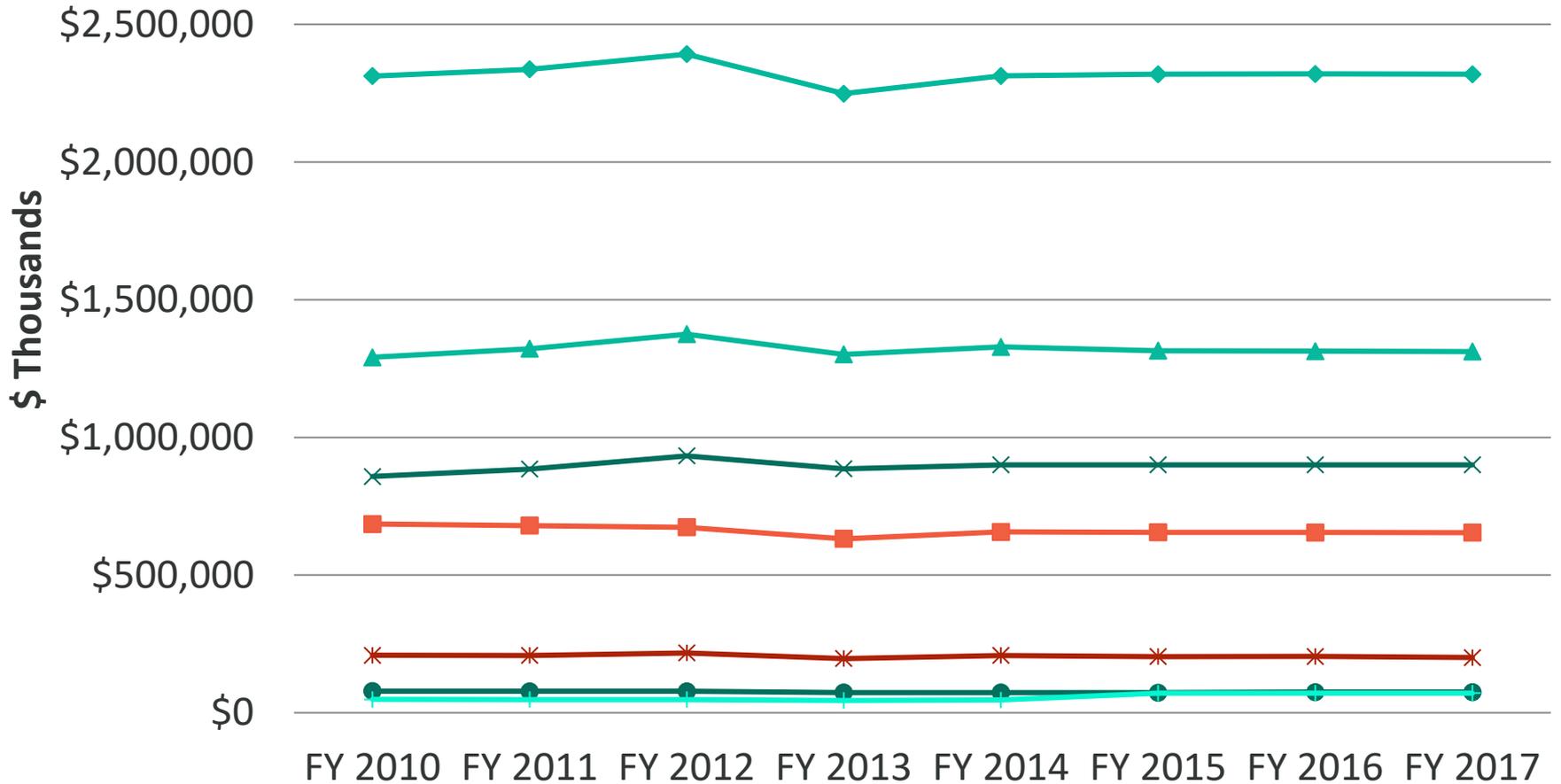
***Other** includes VA, SAMHSA, and FEHB (Federal Employees Health Benefits) Plan

Source: Kaiser Family Foundation Fact Sheet, "U.S. Federal Funding for HIV/AIDS: Trends Over Time"

RWHAP Appropriations, Total and by Part

RWHAP Appropriations, Total and by Part

FY 2010, FY 2017



Purpose of RWHAP Legislation

- Began as “emergency relief” for overburdened healthcare systems at a time when effective medications were not available
- **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”

RWHAP and the HIV Timeline: 1987-1996

- **1987:** AZT becomes the first approved drug for HIV/AIDS treatment
- **1990:** Ryan White Comprehensive AIDS Resources Emergency (CARE) Act becomes law
- **1994:** Clinical trials demonstrate that AZT can substantially reduce perinatal transmission
- **1995:** First highly active antiretroviral therapy (HAART) is approved
- **1996:** RWHAP is reauthorized, with separate funding for the AIDS Drug Assistance Program (ADAP)

RWHAP and the HIV Timeline: 1997-2000

- **1997:** HIV/AIDS Bureau (HAB) is established to bring all RWHAP programs into one agency within the Health Resources and Services Administration (HRSA)
- **1997-99:** Congressional Black Caucus calls for action to address HIV-related health disparities, and the Minority AIDS Initiative (MAI) is launched
- **2000:** RWHAP is reauthorized and refined to increase access to care for individuals who know their status but are not receiving HIV-related medical care and to target resources to areas with the greatest need

RWHAP and the HIV Timeline: 2006-2010

- **2006:** RWHAP is reauthorized, with added focus on medical services, inclusion of MAI, and quality management, and Part A program eligibility redefined
- **2007:** Five new Part A programs are funded
- **2009:** RWHAP is reauthorized again, with added focus on finding individuals who do not know their status
- **2009:** A record 82.9 million adults are tested for HIV
- **2010:** National HIV/AIDS Strategy (NHAS) provides national goals to end the epidemic

RWHAP and the HIV Timeline: Recent

- **2011:** Research demonstrates “treatment as prevention,” showing that viral suppression prevents HIV transmission
- **2013:** HIV Care Continuum Initiative is launched to monitor and increase HIV testing, linkage to care, retention in care, and viral suppression
- **2013:** HIV/AIDS Bureau establishes a revised portfolio of care and treatment performance measures
- **2015:** HRSA reports on RWHAP client-level data, describing recipients, providers, clients, and services

Importance of RWHAP: Scope

- More than 1.1 million people in the U.S. are living with HIV
- About 1 in 7 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 – over 551,000 in 2016

Importance of RWHAP: Client Need

- RWHAP serves PLWH who are low-income and do not have insurance that covers their HIV care and medications – over 60% have incomes below the federal poverty line
- RWHAP is the payor of last resort – funds may not be used to pay for items or services that are eligible for coverage by other federal or state programs or private health insurance
- RWHAP is not an “entitlement” program: it must operate using the funds appropriated annually by Congress and awarded to recipients

Importance of RWHAP: Outcomes

- More than 80% of RWHAP clients in 2016 were retained in care – they had at least two outpatient ambulatory health services (OAHS) visits during the year, at least 90 days apart
- About 85% of clients receiving outpatient OAHS through RWHAP achieved viral suppression in 2016
 - Up from 69.5% in 2010
 - Far above the 49% viral suppression rate of all PLWH in the U.S. in 2014

Factors Affecting HIV Services

- The epidemic continues, especially among traditionally underserved and hard-to-reach populations – but new diagnoses have been declining since 2008
- Because of effective therapies, PLWH can live nearly normal life spans if they begin treatment early and stay in care
- Treatment is prevention – viral suppression prevents HIV transmission
- Changes in the larger health care system and financing have affected how RWHAP funds are used at the state and local levels

Tools for Ending the Epidemic

Recent tools include:

- National goals to end the epidemic, first developed through the National HIV/AIDS Strategy (NHAS)
- The HIV care continuum, which helps track the estimated number of people living with HIV, percent diagnosed, and percent who are linked to care, retained in care, and achieve viral suppression
- Performance measures developed by HRSA/HAB to assess quality of care and clinical outcomes of RWHAP-funded services

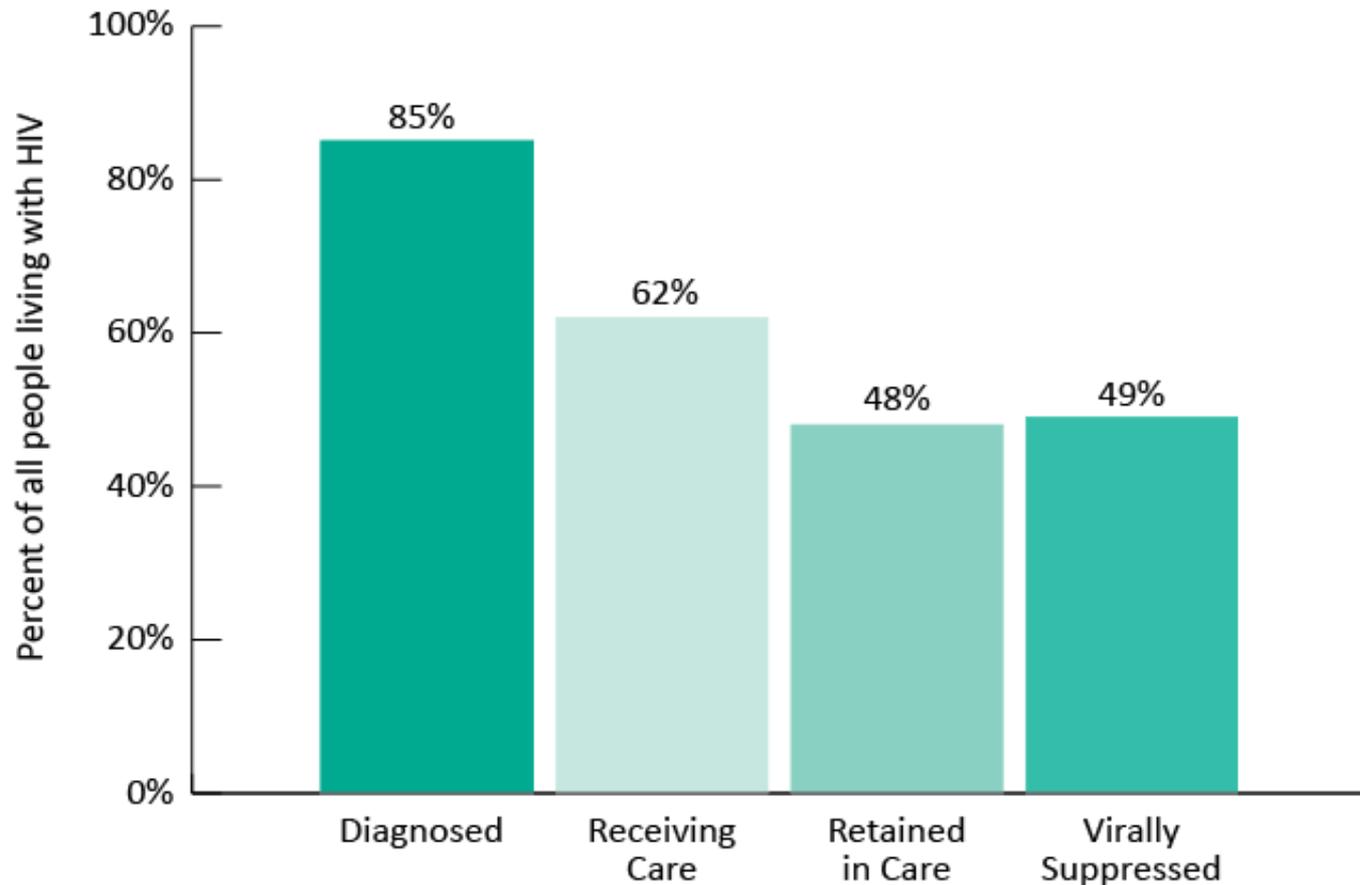
National Goals to End the Epidemic

2020 Goals:

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

HIV Care Continuum, United States, 2014

An estimated 1.1 million people are living with HIV in the U.S.



Performance Measures Portfolio

- Established in 2013
- Focus on critical areas of HIV care and treatment, including processes (like development of treatment plans) and outcomes (like viral suppression rates)
- Alignment with milestones along the HIV care continuum
- Can be used by individual providers or at a system of care level – by all RWHAP-funded providers in a service area

Overview of RWHAP Parts

The Ryan White HIV/AIDS Program

- Provides a comprehensive system of care for people living with HIV
- Most funds support primary medical care and other medical-related and support services
- Provides ongoing access to HIV medications
- Small amount of funds used for technical assistance, clinical training, and development of innovative models of care

The Ryan White HIV/AIDS Program (cont.)

- Includes 5 Parts: A, B, C, D, and F
- Administered by the HIV/AIDS Bureau (HAB), within the Health Resources and Services Administration (HRSA)
- RWHAP Parts designed to work together to ensure a comprehensive system of care in urban, suburban, and rural communities throughout the U.S.

RWHAP Part A

- Funding for areas hardest hit by the HIV epidemic
- Funding for two categories of metropolitan areas:
 - **Eligible Metropolitan Areas (EMAs)**, with at least 2,000 new cases of AIDS reported in the past 5 years and at least 3,000 people living with HIV
 - **Transitional Grant Areas (TGAs)**, with 1,000 – 1,999 new cases of AIDS reported in the past 5 years and at least 1,500 people living with HIV
- Funds are used to develop or enhance access to a comprehensive system of high quality community-based care for low-income PLWH

RWHAP Part B

- Funding to all 50 States, DC, Puerto Rico, U.S. territories and jurisdictions to improve the quality, availability, and organization of HIV health care and support services
- Provides funds for medical and support services
- Includes the AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications, through direct purchase and purchase of health insurance
- Also provides funds to emerging communities with a growing epidemic, reporting 500-999 new cases in the past 5 years

RWHAP Part C

- Funding to support “early intervention services”: comprehensive primary health care and support services for PLWH in an outpatient setting
- Competitive grants to local community-based organizations, community health centers, health departments, and hospitals
- Priority on services in rural areas and for traditionally underserved populations
- Capacity development grants provided to help public and nonprofit entities deliver HIV services more effectively

RWHAP Part D

- Funding to support family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV
- Competitive grants to local public and private health care entities, including hospitals, and public agencies
- Includes services designed to engage youth 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 F: Dental Services

Two types of dental programs:

- Dental Reimbursement Programs run by dental schools and other dental programs
- Community Based Dental Partnership Program, to provide dental services for PLWH while providing education and clinical training for dental care providers

RWHAP Part F: Minority AIDS Initiative (MAI)

- Funds used to improve access to HIV care and health outcomes for disproportionately affected racial and ethnic minorities
- Part A programs apply for MAI funds as part of the annual application and receive funds on a formula basis
- Formula is based on the number of racial and ethnic minority individuals with HIV/AIDS in the jurisdiction

RWHAP Part F: Special Project of National Significance (SPNS)

- Supports the development of innovative models of care to better serve PLWH and address emerging client needs
- Competitive funding
- Projects include a strong evaluation component
- Promising models are disseminated

RWHAP Part F: AIDS Education and Training Centers (AETCs)

- Supports a network of 8 regional centers that provide targeted, multidisciplinary education and training programs for health care providers serving PLWH
- Intended to increase the number of providers prepared and motivated to counsel, diagnose, treat, and medically manage PLWH
- AETC's National Clinician Consultation Center responds to questions from clinicians

Importance of Collaboration Across RWHAP Parts

- Representatives of all RWHAP Parts as members of Part A planning councils/planning bodies (PC/PBs)
- Coordination of needs assessment by all RWHAP Parts through the Statewide Coordinated Statement of Need (SCSN), led by Part B
- Collaboration in development of the HRSA/CDC Integrated HIV Prevention and Care Plans, submitted by RWHAP Parts A & B
- Coordination in targeting and use of resources

Coordination of Care Across Parts

A single RWHAP client living in an EMA or TGA might:

- Receive medications through RWHAP Part B ADAP
- Get oral health care from a RWHAP Part F-funded dental program
- Obtain other services funded through RWHAP Part A, Part C, and/or Part D
- Participate in a RWHAP Part F demonstration SPNS project

Understanding Part A

Ryan White HIV/AIDS Programs: Part A

- Funding for Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are severely & disproportionately affected by the HIV epidemic
- In 2018, 24 EMAs and 28 TGAs
- Service areas can include a single county or a multi-county area
- 11 programs have service areas that cross state boundaries

RWHAP Part A

- **Funds go to the Chief Elected Official (CEO)** of “the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS” [§2602(a)(1)]
- Recipient must establish an **Intergovernmental Agreement (IGA)** with any jurisdiction with at least 10% of the total number of reported cases of AIDS to establish a mechanism for allocating resources to address their service needs [§2602(a)(2)]

RWHAP Part A (cont. 1)

Legislative requirement for extensive community planning,
including participation of consumers of RWHAP Part A services

- EMAs required to have planning councils that decide how program funds will be used – they are not advisory
- TGAs strongly encouraged by HRSA/HAB to maintain planning councils
- TGAs that choose not to have planning councils encouraged to have planning bodies with roles, responsibilities and membership that are as much like planning councils as possible

RWHAP Part A (cont. 2)

RWHAP Part A programs receive both “formula” and “supplemental” funding:

- Part A formula funding is based on the number of living case of HIV and AIDS in the EMA or TGA
- Minority AIDS Initiative (MAI) formula funding is based on the number of minorities living with HIV and AIDS
- Supplemental funding is competitive, based on demonstration of additional need in the annual application

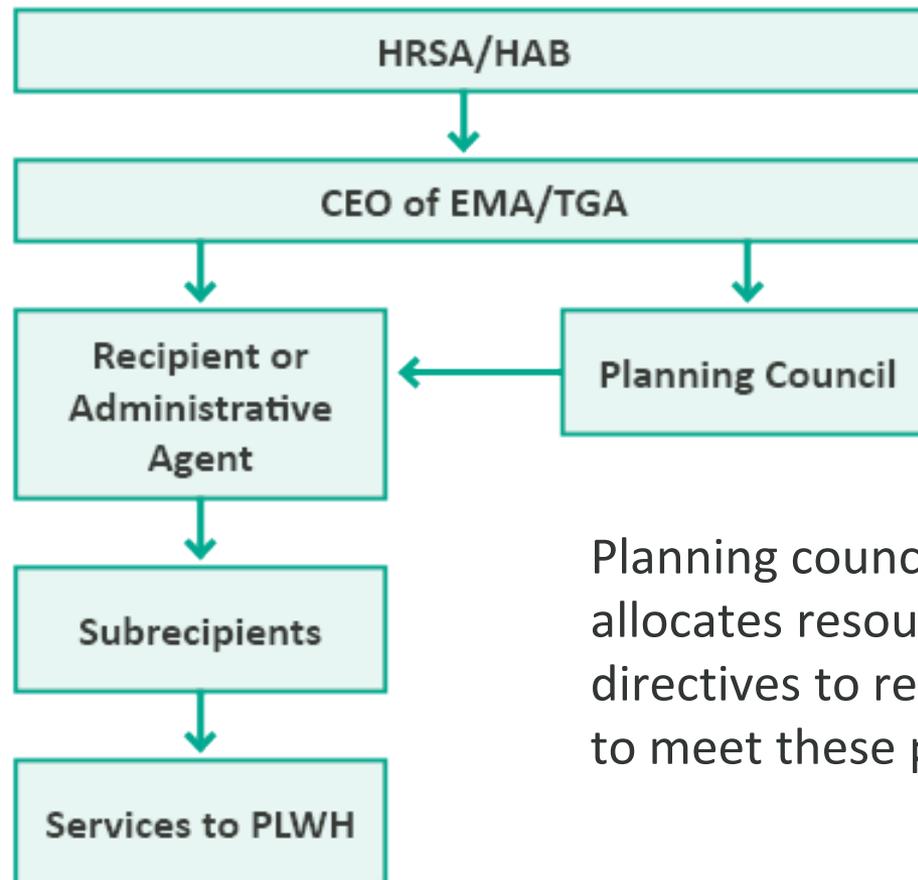
Services Fundable under RWHAP Part A

- **Core medical services** identified in the legislation
For example: Outpatient Ambulatory Health Services, Oral Health, Medical Case Management, Mental Health
- **Support services** needed so that PLWH can reach their medical outcomes
For example: Medical Transportation, Emergency Financial Assistance, Food Bank/Home-Delivered Meals
- HRSA/HAB provides service definitions and descriptions
Refinements to service categories and definitions in 2016 and 2018 [Policy Clarification Notice (PCN) #16-02]

Collaboration between Recipient and Planning Council/Planning Body

- Recipient receives and administers funds and is responsible for contracting with providers (subrecipients) who provide care and treatment
- Planning council/planning body (PC/PB) decides how best to use available funds to help support a community-based system of care for PLWH
- PC/PB and recipient work closely together, sharing responsibility for tasks like needs assessment and integrated/comprehensive planning

Flow of RWHAP Part A Decision Making & Funds



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

Similarities between RWHAP Part A and Part B

- Grants go to the CEO of a governmental jurisdiction – states and territories for Part B, cities and counties for Part A
- Funds may be used to support the same set of medical-related and support service categories
- Expectation is support of comprehensive outpatient health and support services for PLWH
- Structured community planning is required
- Programs must submit and periodically update an integrated/comprehensive plan

Similarities between RWHAP Part A and Part B (cont.)

- Majority of funds awarded under a formula based on the number of people living with HIV and AIDS in the service area
- At least 75% of service funds must be used for medical care and other medical-related services (such as oral health and medical case management)
- Up to 25% may be used for support services needed so clients can achieve positive medical outcomes
- Waiver can be requested if other resources are available and less funding is needed for medical services

Sum Up

- RWHAP plays a critical role in responding to the HIV epidemic
- The legislation has evolved to reflect changes in the epidemic, advances in treatments, and a focus on reaching PLWH with the greatest need for services
- Each RWHAP Part has a special role in overall HIV services – and all Parts need to collaborate to provide a seamless system of prevention and care
- RWHAP Part A plays a special role in HIV planning and services in metropolitan areas with a high rate of HIV

Optional Slides for Activities

Quick Activities to Apply Knowledge

Following are 3 quick activities to increase interaction during your presentation/lecture and help participants apply what they are learning to practical situations. Revise them if needed to fit your situation, and use them in small groups or pairs, or in the full group. Following is the title of each activity and where you may want to insert it:

- Insert Quick Scenario A: Importance of Serving on a RWHAP Part A PC/PB after slide 16
- Insert Quick Scenario B: Collaboration Across Parts after slide 33
- Insert Quick Discussion C: The RWHAP and HIV Community Planning after slide 39



Quick Scenario A: Importance of Serving on a RWHAP Part A PC/PB

You joined the PC/PB about 9 months ago. You serve on the Membership Committee and are doing outreach to recruit new consumer members. At a meeting with several consumers, one of them says: “You just told us that members have to attend a 2-hour PC/PB meeting every month, plus a committee meeting, and read a lot of materials. That’s a big time commitment. What could I accomplish as a member that makes it worth the time?”

- How do you respond?



Quick Scenario B:

Collaboration Across Parts

Your PC /PB's care strategies/system of care committee is concerned about recent data showing low rates of retention, treatment adherence, and viral suppression among young African American and Latino men who have sex with men. You are planning a “roundtable” to learn more about the situation and what might be done to improve outcomes. Besides Part A subrecipients and consumers, you aren't sure whom to invite. How could Part B, Part C, Part D, and Part F recipients or subrecipients contribute to this discussion – what might each of them bring?



Quick Discussion C: The RWHAP and HIV Community Planning

It is May and your PC/PB has 2 new members. They just received a quick orientation from the PC Support Manager and the Chair. Neither has prior HIV community planning experience. As a veteran member, you have agreed to mentor them. Your annual Priority Setting and Resource Allocation (PSRA) process begins next week with the Data Presentation.

- What 3-4 things do these new members most need to understand about the RWHAP and Part A in order to participate knowledgeably in the PSRA process?
- How can you best help prepare them?

Activity: Evolution of the RWHAP

- Work in a small group
- Choose a facilitator, recorder, and reporter
- Consider the question assigned to you
- Be prepared to share your work with the full group

Discussion Questions

Based on the discussion today and your own knowledge and experience:

- What are some important ways in which the RWHAP legislation and program have evolved based on changes in the epidemic?
- What are some important ways in which the RWHAP legislation and program have evolved based on changes in HIV prevention and treatment?

Activity: What's my RWHAP Part?

RWHAP Part A PC/PB Training Guide | Module 1: Understanding the Legislation



Activity 1.2: What's My RWHAP Part? Quiz

HANDOUT FOR PARTICIPANTS

Work individually. Indicate which Ryan White HIV/AIDS Program "Part," as described in the 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: RWHAP Parts

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

1. _____ Provides funds to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)
 2. _____ Special Projects of National Significance (SPNS)
 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 and Community Based Dental Partnerships
 5. _____ Competitive grants designed to improve Access to Care for Women, Infants, Children and Youth
 6. _____ Funding for Minority AIDS Initiative (MAI)
 7. _____ Improve access to quality HIV care and treatment
 8. _____ Entitlements that are the right of all people living with HIV
 9. _____ Includes the AIDS Drug Assistance Program (ADAP)
- _____ Communities grants to jurisdictions with a growing epidemic
_____ eligible for coverage

Quiz Key

Individually answer the 12 questions, 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

Roles and Responsibilities of RWHAP Part A Planning Councils/Bodies and Recipients

Slides for Module 2

Topic: Community Planning

Overview and Value of RWHAP Part A Community Planning

- Definition and Components of Community Health Planning
- Overview of RWHAP Part A HIV Community Planning Requirements
- Uniqueness and Value of RWHAP Part A PC/PBs

Training Objectives

Following the training, participants will be able to:

1. Define and describe key elements of “community health planning”
2. Describe HIV community planning requirements for RWHAP Part A jurisdictions
3. Explain the value and importance of PC/PBs in the RWHAP Part A program

Group Discussion

Consider this question individually for a minute, before discussion with the full group.

Question:

Why is it important for the RWHAP Part A program to include an HIV community planning process – what are the benefits?

What is “Community Health Planning” ?

- Community health planning is a deliberate effort to involve the members of a geographically defined community in an open public process designed to improve the availability, accessibility, and quality of healthcare services in their community as a means toward improving its health status
- That public process must provide broadly representative mechanisms for identifying community needs, assessing capacity to meet those needs, allocating resources, and resolving conflicts

Source: American Health Planning Association, John Steen, 2008

Legislative Requirements for RWHAP Part A HIV Planning

- CEO in an Eligible Metropolitan Area (EMA) must establish an “HIV health services planning council” [§2602(b)]
- In a Transitional Grant Area (TGA) established after 2006, CEO may choose a different process “to obtain community input (particularly from those with HIV) in the transitional area”
- TGAs established before 2006 not legislatively required to maintain planning councils after FY 2013, but have been “strongly encouraged to maintain that current structure” by HRSA/HAB

Overview of RWHAP Part A Planning

- 5-year Integrated HIV Prevention and Care Plan to serve as a blueprint
- Annual planning cycle to help support “a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV” in the EMA/TGA [Part A Manual]
- People living with HIV (PLWH) and community involvement, including “methods for obtaining input on community needs and priorities” [Legislation, §2602(b)(4)(G)]

Core Planning Tasks

- Determine service needs
- Establish “priorities for the allocation of funds”
- Provide guidance to the recipient on “how best to meet these priorities”
- Help ensure coordination of RWHAP and other services, including prevention
- Assess the efficiency of the recipient’s “administrative mechanism in rapidly allocating funds to the areas of greatest need”

Source: 2009 Legislation

HRSA/HAB Suggested Principles for RWHAP Planning

RWHAP Planning:

- Is community-based, including diverse stakeholders
- Requires consumer input to needs assessment and decision making
- Is a collaborative partnership between the planning body and the recipient
- Is designed to meet national goals for ending the epidemic and strengthen performance along the HIV Care Continuum
- Is an ongoing, cyclical process
- Requires data from multiple sources, gathered through varied methods
- Uses data-based decision making



Value and Importance of Planning in RWHAP Part A

- “PCs provide a significant and unique venue for the required involvement of and input from people living with HIV/AIDS”*
- Benefits include:
 - Capturing the community’s experience and voice through formalized opportunities for continuous community input
 - Providing multiple roles and opportunities for input and decision making for consumers and other PLWH
 - Allowing for a local system of HIV care that reflects documented jurisdictional needs and priorities

*Quotation from 12/3/13 Letter from Director of HAB Division of Metropolitan HIV/AIDS Programs (DMHAP), HRSA/HAB

Uniqueness of RWHAP Planning Councils

No other federal health/human services programs require such a body:

- Many programs require community planning, but planning bodies usually advisory rather than decision-making
- Federally funded nonprofits sometimes required to include consumers on their boards (for example, community health centers)
- Planning bodies may include consumers, but rarely require them to be such a high proportion of voting members (33%)
- Almost none have such specific legislative responsibilities – including decision-making about how service funds are allocated

Sum-Up

- HIV community planning is a broadly representative open process designed to improve HIV services
- RWHAP Part A planning councils provide a unique model of data-based community planning and decision making that includes strong consumer involvement
- EMAs are required to have planning councils; HRSA/HAB strongly urges TGAs with PCs to maintain them
- PCs carry out a set of legislative roles through an annual planning cycle, guided by a 5-year Integrated HIV Prevention and Care Plan

Post-Session Discussion in Small Groups

- 1. In your small group, brainstorm important things to know about HIV community planning, then agree together on those that are most important.*
- 2. Put your list on easel pad paper to share with the full group.*

Question:

If you wanted a potential PC/PB member without community planning experience to understand HIV community planning, what are the 3-5 most important things you would discuss with that person?

Roles and Responsibilities of RWHAP Part A Planning Councils/Bodies (PC/PBs) and Recipients

Slides for Module 2

Topic: Roles and Responsibilities

PC/PB and Recipient Roles and Responsibilities

- Evolution of Roles in the Legislation and HRSA/HAB Guidance
- PC/PB Roles and Responsibilities
- Recipient Roles and Responsibilities
- Boundaries and Separation of Roles
- Similarities and Differences between Roles of Planning Councils and Planning Bodies

Training Objectives

Following the roles and responsibilities training, participants will be able to:

1. Explain how the legislation and HRSA/HAB guidance together define and explain PC/PB and recipient responsibilities
2. List and explain the roles and responsibilities of RWHAP Part A PC/PBs
3. Describe and differentiate the roles and responsibilities of the recipient/administrative agency and those of the PC/PB
4. Ensure understanding of how PC/PB support staff and recipient staff work with PC/PBs
5. Identify 2 key similarities and 2 important differences between a RWHAP Part A planning council and a RWHAP Part A planning body

Legislation and Guidance

- **Legislation** specifies duties of RWHAP Part A planning councils and activities in which they must not be involved, to prevent conflict of interest [§2602(b)(4) and (5)]
- HRSA/HAB/DMHAP provides ongoing **guidance** to clarify PC/PB roles and responsibilities and how they fit into RWHAP Part A, through such means as:
 - The RWHAP Part A Manual
 - Policy Clarification Notices (PCNs) and Program Letters
 - Annual Notice of Funding Opportunity (NOFO)
 - Notice of Award (including Conditions of Award)
 - Project Officer calls and guidance
 - Training and technical assistance

Differences between Planning Councils and Planning Bodies

- RWHAP Part A planning councils have:
 - Clearly defined legislative roles and responsibilities
 - Legislatively required membership categories
 - Additional guidance from HRSA/HAB
- Other Part A planning bodies have:
 - A legislative requirement for obtaining “community input (particularly from those with HIV)...for formulating the overall plan for priority setting and allocating funds from the grant” [§2609(d)(1)(A)]
 - No legislatively required membership categories or responsibilities for appointment

Differences between Planning Councils and Planning Bodies (cont. 1)

- PCs decide how services are prioritized and how funding is allocated to those services
- PBs make recommendations to the recipient about priorities and allocations

Differences between Planning Councils and Planning Bodies (cont. 2)

In spite of these differences:

- HRSA/HAB strongly encourages PBs to look and act as much like PCs as possible, in terms of:
 - Membership
 - Roles and responsibilities
- TGAs with PBs must meet the same application requirements as those with PCs, including expectations for community planning and consumer input

Recipient and Planning Council Roles and Responsibilities

- Recipient and planning council are 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:
 - Frequent communications, information sharing, and collaboration between the recipient, planning council, and planning council support (PCS) staff
 - Ongoing consumer and community involvement

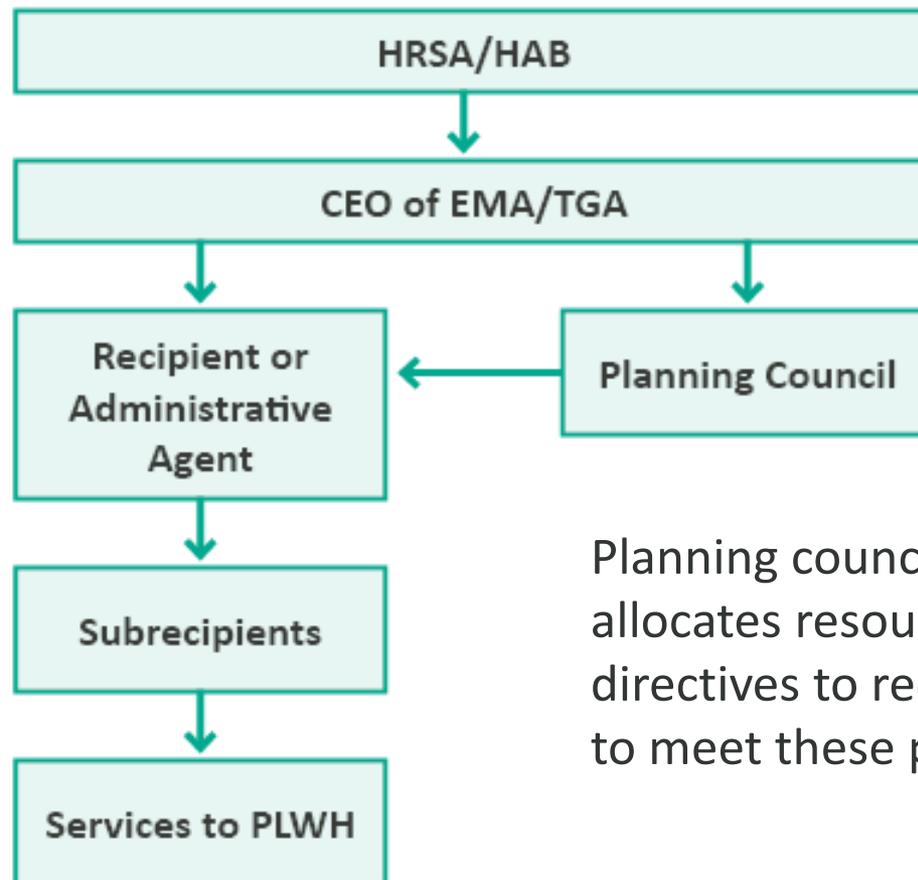
Planning Council/Planning Body, Recipient, & CEO Roles & Responsibilities¹

Task	CEO	Recipient	PC/PB
Establishment of Planning Council/Planning Body*	✓		
Appointment of PC/PB Members*	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting*			✓
Resource Allocation*			✓
Directives*			✓
Procurement of Services*		✓	
Contract Monitoring*		✓	
Coordination of Services		✓	✓
Evaluation of Services		✓	Optional
Development of Service Standards		✓	✓
Clinical Quality Management		✓	Contributes
Assessment of Efficiency of the Administrative Mechanism*			✓
PC/PB Operations & Support		✓	✓

*Sole responsibility of one entity

1: required for a PC; sound practice for a PB functioning like a PC

Flow of RWHAP Part A Decision Making & Funds



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

Planning Council Formation and Membership

- Chief Elected Official (CEO) establishes the PC/PB
- For a PC, CEO appoints all members from applicants provided through the PC's open nominations process
- Membership must meet legislative requirements:
 - Representation (legislatively required categories)
 - 33% unaffiliated consumers of RWHAP Part A services
 - Reflectiveness of the epidemic in the EMA/TGA
- Recipient not involved in membership selection
- Bylaws may call for a recipient representative on the PC/PB
- A PC may not be chaired solely by an employee of the recipient
- Varied approaches used for establishing and appointing PB members

Expectations: Needs Assessment

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

Components of Needs Assessment

- Epi profile of HIV and AIDS cases and trends
- Estimate & characteristics of PLWH with unmet need – PLWH who know their status but are not in care
- Estimate & characteristics of individuals with HIV who are unaware of their status
- Service needs & barriers for PLWH in and out of care
- Existing system of care including a resource inventory and profile of provider capacity & capability
- Assessment of service needs, gaps, and disparities in access to services, based on all needs assessment data

Needs Assessment

- PC has primary responsibility and “ownership” – design, direct work or oversight of consultants or volunteers
- Recipient provides support but not leadership – data, help in hiring a consultant if one is needed, staff assistance
- Active community involvement needed – especially consumers and providers
- Need a multi-year plan for assessing needs of PLWH in and out of care
- Presentation of findings in user-friendly formats as input to decision-making, especially priority setting and resource allocation

Integrated/Comprehensive Planning

- Legislation requires Ryan White Part A and Part B programs to prepare comprehensive plans that set goals and objectives and guide the annual planning cycle
- All RWHAP Parts expected to participate in the Statewide Coordinated Statement of Need (SCSN) process, which is led by Part B
- Part A and Part B recipients prepared 5-year HRSA/CDC Integrated HIV Prevention and Care Plans based on a combined guidance from CDC and HRSA
 - Plans for 2017-2022 submitted in September 2016

Integrated/Comprehensive Planning (cont.)

- Combined guidance designed to help reach the national goals to end the epidemic and improve performance along the HIV care continuum
- Programs expected to review Plan progress regularly and refine objectives and strategies as needed
- Collaborative plan implementation and monitoring by prevention and care (and between Part A and Part B) encouraged

Priority Setting and Resource Allocation (PSRA)

Most important legislative responsibility—planning councils decide, planning bodies recommend:

- **Priority setting:** determining what service categories are most important for PLWH in the EMA or TGA
- **Resource allocation:** specifying how much RWHAP Part A program funding should go to each prioritized service (best done in both dollars and percent)
- **Directives to the recipient** 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 to ensure that all funds are expended on needed services

Priority Setting

- Means determining what service categories are most important for PLWH in the EMA or TGA – unrelated to who provides the funding for these services
- Recipient provides information – especially service utilization data – and offers advice
- Requires a sound, fair process to ensure that priorities are data-based and address the needs of diverse PLWH
- All needed service categories should be prioritized even though some may not be funded, in case needs change or reallocation permits funds for a previously unfunded category during the program year

Directives

- Guidance to recipient on how best to meet the priorities and other factors to consider in procurement of services
- Often specify use of a particular service model, address geographic access to services or require services appropriate for specific PLWH subpopulations
- Must not limit procurement by making only a few providers eligible
- Recipient must follow PC directives in procurement and contracting (but cannot always guarantee full success)

Examples of Directives

- Funded outpatient ambulatory health services (OAHS) must offer services at least 1 evening a week or 1 weekend a month
- Medical case management must be offered at a site in a particular geographic area (e.g., an outlying county)
- At least one substance abuse treatment provider must offer services appropriate for pregnant women and mothers with young children

Resource Allocation

- **Planning council responsibility:** recipient provides data and advice, but has no decision-making role
- Process of deciding how much funding to allocate to each priority service category or sub-category
- At least 75% of service dollars must go to core services (unless program has a waiver from HRSA/HAB)
- Up to 25% of funds can be used for support services needed for achieving medical outcomes
- Need a fair, data-based process that manages conflict of interest
- Consider other funding streams, cost per client, plans for bringing people into care (some highly ranked service categories may receive little or no funding)

Reallocation

- **Planning council role:** must approve any reallocation of funds among service categories
- Recipient provides expenditure data by service category to PC, usually monthly
- Some recipients do regular “sweeps” or request reallocation permission at set times each year
- Rapid reallocations process needed to avoid unobligated (unused) funds and ensure available funds are used to address priority service needs

Coordination of Services

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

Procurement

- **Recipient role – no PC/PB involvement**
- Involves:
 - Publicizing the availability of funds
 - Writing Requests for Proposals (RFPs)
 - Using a fair and impartial review process to choose subrecipients (service providers)
 - Contracting with providers – and requiring that they follow service standards and meet reporting and clinical quality management (CQM) requirements
- Contract amounts and use of funds by service category or sub-category must be consistent with PC allocations and directives

Contract Monitoring

- **Recipient role – no PC/PB involvement**
- Involves site visits and document review for monitoring of:
 - **Program quality** and level of services
 - **Finances/fiscal management**, including expenditure patterns and adherence to HRSA/HAB and local regulations in use of funds
- Aggregate findings (by service category or across categories) shared with the PC/PB as input to decision making

Legislative Requirements to Prevent PC Conflict of Interest

- **Planning council:**
 - “May not be directly involved in the administration of a grant”
 - “May not designate (or otherwise be involved in the selection of) particular entities” as funded providers
- **Individual members** affiliated with an entity seeking funds may not “participate (directly or in an advisory capacity) in the process of selecting entities” for funding

[§2602(b)(5)]

Clinical Quality Management

- **Recipient responsibility** – some PC/PBs contribute
- Involves the coordination of activities aimed at improving service access, patient care, health outcomes, and patient satisfaction
- Used to ensure that:
 - Services meet clinical guidelines and local service standards
 - Supportive services are linked to positive medical outcomes
- Recipient monitors providers based on quality standards, and recommends improvements
- PC establishes service standards used in CQM and uses findings by or across service categories in decision making
- Sometimes consumers participate in CQM

Cost-Effectiveness and Outcomes Evaluation

- Recipient assesses performance, clinical outcomes, and cost effectiveness of services
- PC/PB has the option of assessing the effectiveness of services offered – usually best done in coordination with recipient
- Major focus on performance along the HIV care continuum
- Findings used by recipient in selecting and monitoring providers
- Findings used by PC/PB in priority setting, resource allocation, and improving service system

Assessment of the Efficiency of the Administrative Mechanism

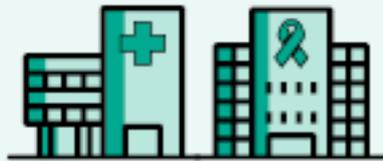
- PC must “assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area” [Legislation, §2602(b)(4)(E)]
- Done annually
- Assesses recipient procurement, disbursement of funds, support for the PC’s planning process, and adherence to PC priorities and allocations
- Written report goes to recipient, which indicates actions it will take to address any identified problem areas, and summarizes this in the annual application
- Planning bodies usually do not perform this role

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 currently
provided



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



PC/PB Operations

- Develop bylaws, policies and procedures to ensure fair, efficient operations
- Establish grievance procedures
- Manage conflict of interest
- Major attention to new member recruitment including an open nominations process, orientation, and training
- PCs expected to provide training for members at least annually
- Much of PC/PB's work is done in committees
- Assistance from PC/PB support staff

Role of PC/PB Support Staff

- Help the PC/PB carry out its responsibilities and operate effectively
- Typical roles:
 - Staff committees and full meetings
 - Provide expert advice on RWHAP legislative requirements and HRSA/HAB regulations & expectations
 - Oversee a training program for members
 - Encourage member involvement and retention, with special focus on consumers
 - Serve as liaison with the recipient
 - Help the PC/PB manage its budget
- PBs may have assigned staff or be staffed by recipient

Recipient Staff Roles with PC/PBs

- Typical roles with PC:
 - Attend and make a recipient report at meetings
 - Regularly provide agreed-upon reports and data (e.g., costs and service utilization, CQM performance data)
 - 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
- Roles with PBs similar, but with more staff leadership and direction since PB is advisory

Separation of PC/PB and Recipient Roles

- Division of roles between recipient and PC/PB helps prevent actual or perceived conflict of interest
- Recipient chooses and manages RWHAP Part A service providers with no PC/PB involvement
- Data on subrecipients – e.g., funding, expenditures, performance – provided to PC/PB by service category only, without provider names
- PC/PB should not discuss individual providers or refer to funded providers by name names in its work – focus should be on services and service categories

Recipient and PC/PB as Partners

- Joint efforts of PC and recipient necessary to provide needed care and maximize positive clinical outcomes for PLWH
- PC should work closely with the recipient but as an independent body with its own staff, structure, & roles
- Recipient provides information and advice to the PC while supporting its decision-making role
- HRSA/HAB encourages use of a **Memorandum of Understanding (MOU)** to clarify roles, relationship, and data sharing
- Ideally, relationship of recipient and non-PC planning body is similar to PC-recipient relationship

Sum-Up

- Planning councils are decision-making bodies; planning bodies are advisory
- PC roles are determined by the legislation, with additional guidance from HRSA/HAB/DMHAP
- PBs encouraged to look and act as much like PCs as possible
- Many tasks shared with the recipient
- Legislation forbids PC involvement in activities related to procurement and contract administration/monitoring
- Programs and clients benefit when PC and recipient work together as mutually respectful partners

Optional Slides for Activities

Quick Activities to Apply Knowledge

Following are 4 quick scenarios and discussions to increase interaction during your presentation/lecture and help participants apply what they are learning to practical situations. Revise them if needed to fit your situation, and use them in small groups or pairs, or in the full group. Following is the title of each activity and where you may want to insert it:

- Insert Scenario A: Needs Assessment after slide 14
- Insert Discussion B: Integrated/Comprehensive Planning after slide 16
- Insert Scenario C: Reallocation after slide 22
- Insert Scenario D: Boundaries after slide 35

Quick Scenario A: Needs Assessment

Your PC/PB has done a lot of needs assessment activities, but not a comprehensive needs assessment, including all components. Several members of the Committee want to do a comprehensive needs assessment with every component next program year, to “catch up,” then begin a multi-year cycle. Others say no, it is best to just start a three-year cycle next year.

- Which is the better idea? Why?
- Is there another approach you think would work better than these options? If so, explain.

Quick Discussion B:

Integrated/Comprehensive Planning

Discuss the following, asking PC/PB leadership or support staff for any needed background information:

1. What kind of integrated/comprehensive plan did your EMA/TGA submit last time – did it include just Part A and CDC prevention, or was it a joint plan with Part B?
2. What are some specific ways in which this kind of 5-year plan can help improve HIV services and outcomes and move the EMA/TGA toward ending the epidemic?
3. What do you see as the greatest challenges of developing an integrated plan with prevention and with Part B?
4. What are the challenges of implementing an integrated plan?

Quick Scenario C: Reallocation

Your PC/PB has clear procedures for PSRA, but not for reallocation. The new Executive Committee suggests the following as steps to improve reallocation decisions:

1. During resource allocation, identify and document service categories the PC/PB would like to see receive more funds
 2. Identify proposed directives not adopted because of the costs of implementation and ask the recipient to estimate those costs
 3. Have the responsible committee carefully review expenditure data with the recipient each month
 4. Work with the recipient on a thorough review of utilization data for the first quarter to identify service issues that might be addressed through reallocation
- Are these appropriate approaches?
 - What other steps might the PC/PB take to improve reallocation?

Quick Scenario D: Boundaries

A PC/PB member who runs a subrecipient agency that also has Part C funding reports to the PC/PB each month about Part C activities. He also discusses why his agency needs more funding, complains about the amount of time it takes to prepare for Part A and HRSA/HAB Part C monitoring visits, and talks about late reimbursements or other challenges the agency is facing. PC/PB members sometimes ask questions that lead to more of this.

You are a PC/PB Co-Chair, and you know that the PC/PB should not discuss contracting or monitoring issues or issues related to a specific agency, but you aren't sure how to deal with this situation, since the members like the updates.

- What should be done? How can the PC/PB receive useful information about Part C without overstepping boundaries?

Pre-Training Quiz

- Please complete the quiz individually
- Circle the number of any questions you can't answer or aren't sure you answered correctly
- Keep the quiz for use at the end of the session

Post-Training Quiz

- Please take out your quiz as completed before the training
- Review your answers
- Add and revise your answers based on what you learned during the training
- Count the number of answers you added or revised
- Identify any questions that you still aren't sure how to answer
- Be ready to discuss the quiz with other participants

Scenarios on PC/PB Roles and Responsibilities

- Work in your small group, choosing a **facilitator, recorder, and reporter**
- Assume you are members of the PC/PB or a specific committee, and need to decide how to address your assigned scenario – you have 15 minutes
- Have your recorder summarize your work on easel pad paper for sharing
- If you have time, read the scenarios assigned to other groups
- Your reporter will share your work, focusing on what you recommend and why

Review of Matrix

As a review of the training on the roles and responsibilities of the CEO, recipient, and PC/PB:

- Using the blank *Roles and Responsibilities Matrix* provided, fill in the duties of each entity
- Indicate which roles are shared, and which are the responsibility of just one entity
- Be prepared to discuss the Matrix

Planning Council/Planning Body, Recipient, & CEO Roles & Responsibilities¹ Matrix

Task	CEO	Recipient	PC/PB
Establishment of Planning Council/Planning Body*			
Appointment of PC/PB Members*			
Needs Assessment			
Integrated/Comprehensive Planning			
Priority Setting*			
Resource Allocation*			
Directives*			
Procurement of Services*			
Contract Monitoring*			
Coordination of Services			
Evaluation of Services			
Development of Service Standards			
Clinical Quality Management			
Assessment of Efficiency of the Administrative Mechanism*			
PC/PB Operations & Support			

*Sole responsibility of one entity

1: required for a PC; sound practice for a PB functioning like a PC