MEETING AGENDA

Wednesday, January 23, 2019
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Moment of Silence/Introductions

Approval of Agenda

Approval of Minutes

Special Presentation:

- CLUB 1509 – *Antar Bush, AACO*

Report of Co-Chairs

Report of Staff

Prevention Services Initiatives

Discussion Items:

- Planning Council Mission, Vision, and Values
- Priority Setting
- Training and Presentation Requests

PrEP Workgroup Update

Old Business

New Business

Announcements

Adjournment

PREVENTION COMMITTEE

Please contact the office at least 5 days in advance if you require special assistance.

The next Prevention Committee meeting will be held on
Wednesday, February 27, 2019 from 2:30 - 4:30p.m. at
the Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, November 28, 2018
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Katelyn Baron, Keith Carter, Dave Gana, Gus Gannon, Lorett Matus, Erica Rand, Joseph Roderick, Clint Steib.

Excused: none.

Absent: Mark Coleman, Janice Horan, Nhakia Outland, Eran Sargent, Zora Wesley.

Guests: C. Conyngham (AACO), B. Rowley, R. Woodhouse.

Staff: Nicole Johns, Briana Morgan, Mari Ross Russell

Call to Order: C. Steib called the meeting to order at 2:44 p.m. and apologized for the late start.

Welcome/Moment of Silence/Introductions: C. Steib welcomed Prevention Committee members and guests. A moment of silence followed.

Approval of Agenda: C. Steib presented the agenda for approval. **Motion**: D. Gana moved, G. Gannon seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*October 31, 2018*): C. Steib presented the minutes for approval. **Motion**: D. Gana moved, G. Gannon seconded to approve the October 31, 2018 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
L. Matus reported that before the meeting co-chairs and representatives from the AIDS Activities Coordinating Office (AACO) met to discuss the PrEP workgroup. A PrEP workplan will be presented to the PrEP workgroup in January and the Prevention Committee will receive it shortly after. The workgroup will have the opportunity to provide feedback on the PrEP workplan before the plan comes to the Prevention Committee. The workgroup may change in structure or purpose after that the workplan is completed. L. Matus reported one takeaway from this meeting is that the committee should focus on MSM of color, in recruiting for the committee and the activities it pursues.

Report of Staff:
B. Morgan reported that the US Prevention Task Force recommended a Grade A for PrEP for many groups, including sex workers and PWID. Comments are being accepted now. If the full recommendation goes forward, insurance companies will be required to cover

PrEP. C. Conyngham explained that cost-sharing would go away for PrEP, because patients wouldn't have to pay towards deductible for PrEP. There will be several months until the recommendations go through to full approval. M. Ross-Russell explained that staff will forward the link to the committee so they can make public comments.

M. Ross-Russell reported that OHP staff will discuss HIPC meeting structure at the next Executive Committee. Changes to structure may include extending the meeting by an hour and including a standing training on planning activities. More will be reported after the Executive Committee discussion.

N. Johns reported that the November Comprehensive Planning Committee meeting was cancelled due to weather so the December committee meeting will cover the intersection of the Opioid and HIV epidemics. All are encouraged to attend.

Prevention Services Initiatives:
C. Conyngham reported that AACO is recruiting for the DEXIS (Demonstrated Expanded Interventional Surveillance) Project Coordinator position. It is the project to look at missed opportunities and challenges in prevention systems related to young people, trans persons, gay and bisexual and other men who have sex with men of color under CDC Component B. She said the job announcement would be shared with the committee so they can forward to their contacts.

C. Conyngham reported on PDPH's response to the recent increase in HIV diagnoses in People who Inject Drugs (PWID). She shared that PDPH has been increasing the data reporting on programs who have been funded to test for those populations. The providers have been reporting back data quickly and efficiently. There are data submissions every week to the Health Commissioner. She explained that progress on the response is reported weekly by the Mayor's Resilience Project[1]. As of the last report, Nov 1-14, 232 tests were conducted in the city and 40% were among PWID. There were 114 tests conducted in Kensington and 65% of those were among PWID. 2 new cases of HIV were identified in that time period and they both were linked to care. L. Matus asked if those cases were from the PWID testing initiative or surveillance. C. Conyngham said she would have to follow up with that information.

C. Conyngham elaborated that AACO is pulling specific site data and looking at which sites were productive, which sites had high volume, which sites to keep or not, which sites had positive results. There will be a meeting of the programs in this initiative for data reporting and best practice sharing. She further explained that all the one-stop-shops in the initiatives have the community alerts in English and Spanish.

G. Gannon asked C. Conyngham if there was any data back from the Medical Examiner concerning recent HIV infections. C. Conyngham reported no.

[1] https://www.phila.gov/programs/combating-the-opioid-epidemic/the-citys-response/the-philadelphia-resilience-project/

Discussion Items:

Review of Goal 4 Baseline Data

B. Morgan reviewed the strategies and activities under goal 4 of the integrated plan. This has the fewest quantifiable activities of all the goals in the plan, so there really isn't much to discuss. She reviewed each strategy and activity with the committee (see handout for details).

B. Morgan asked the committee for any comments or questions and there were none. L. Matus asked when the committee would be looking at the baseline data again. B. Morgan said when there is more data to review, not for some time.

Committee Work Plan

B. Morgan stated that the committee is now done with the review of the plan. It is now time to plan activities for the coming year. She pointed the committee to the blank work plan and the slides from C. Terrell's presentation from the HIPC meeting which outlines prevention activities, in the handouts. B. Morgan suggested that the PrEP workgroup plan will need to be discussed in this committee, at least within one or two months. L. Matus suggested January would be the earliest for the committee to get a report on the PrEP workplan. C. Conyngham asked G. Gannon if he thought there would be some time after the PrEP work group receives the plan to provide feedback and make any changes. G. Gannon said that he and E. Aaron discussed that the work product will be presented along with the primary data, and other work that has been done on PrEP, so he thought it would probably be March for the Prevention Committee to receive the updated workplan and any recommendations from the PrEP workgroup. The committee decided to add the PrEP workplan discussion to March.

B. Morgan explained that this will be the first priority setting process since the HIPC integration so a presentation on that process would make sense for this committee, in order to help them participate. The committee agreed to add that discussion in January.

B. Morgan reminded the committee that another item the committee has discussed is learning more about how community-based and routine testing are working in the PA counties. The committee talked about having a panel discussion with representatives from each PA county. C. Steib said that February would be a good time to have the panel. G. Gannon asked if this was specifically the PA counties or also included the NJ counties. B. Morgan explained that PA counties were the focus because of the high concurrence (of AIDS diagnosis at time of HIV diagnosis) rates that had been discussed at previous meetings. L. Matus suggested that it might make sense to have NJ on a separate day. G. Gannon recommended that it might be worth it to compare and contrast the practices between jurisdictions. M. Ross Russell offered that it would might make sense to include Philadelphia as well, if there is going to be a comparison. The HIPC's jurisdiction is Philadelphia only under prevention activities. G. Gannon asked if it would make sense to have PA counties and then follow up with a more comprehensive meeting to look at NJ and Philadelphia to see if there are solutions/ideas from other jurisdictions. C. Conyngham asked about the process for this body to make recommendations. Would this committee make recommendations in HIPC and then take it to PA HPG? The HIPC and

AACO have no jurisdiction over any testing outside of Philadelphia. M. Ross Russell agreed and added that OHP/HIPC share information with the NJ and PA HPGs. She elaborated that the purpose of this discussion is to share with the providers locally as well improve service provision. The purpose of this meeting is to try to understand why the concurrence rates in PA counties are so much higher than the other two regions in the EMA and how that might impact the care continuum and disparities in the EMA. C. Steib reported that there was some pushback about the discrepancies in the data at the be PA HPG meeting and there may be other data available now. B. Morgan offered that within Ryan White there is Early Intervention Services which is an example of something that the HIPC could do to address concerns about testing and linkage in the suburban counties. B. Morgan suggested the group add the comprehensive testing discussion to April. The committee agreed.

B. Morgan asked what else the committee might want to work on and pointed them to the presentation slides in the handouts for ideas. C. Steib asked about a report on Club 1509. C. Conyngham said that the project is in the final year. Presently, the project is conducting focus groups with clients who use the services and people who are not engaged in prevention services. She recommended that the committee might like to hear those results as well. She suggested January could be a good time to get an update on Club 1509. She said that there are local data on year 1-3 because CDC data will not be available until a couple years after the project ends. The committee added that discussion to the January meeting.

L. Matus asked if the committee could have an update on Do You Philly website and condom ordering. C. Conyngham said that she can report more regularly on the project. L. Matus asked for quarterly reports. C. Conyngham asked if the committee would like data about test kits and condoms orders and basic web traffic data. They agreed. L. Matus asked if they are looking to translate the website into other languages. C. Conyngham reported she didn't know but could report back.

L. Matus asked if the committee wants to meet in December. By general consensus the group decided not to meet in December.

L Matus suggested that the committee schedule time to make sure they are targeting MSM communities. C. Conyngham said that testing is not reaching that group, disproportionately. She clarified targeted testing is reaching older heterosexuals. She said she could bring the data to show that about 65% of the testing is with heterosexuals. She suggested the larger question is what is happening that is preventing the impacted groups from getting tested or PrEP and other services. L. Matus asked for testing data to seperate community-based and clinical settings.

K. Carter suggested that it might be the location of testing because of stigma concerns, if young people are afraid to be 'outed'. C. Steib asked if there could be time spent mapping where infections are, where testing is happening, and see what changes might be made to improve outcomes.

M. Ross Russell suggested that J. Peters from the DASH project at the school district might be a helpful stakeholder to bring to a discussion. She added that AIDS United released the Ending the Epidemic Roadmap and it has recommendations around testing in specific populations and that can be a potential resource for ideas.

K. Carter asked if there were incentives for testing. C. Conyngham replied that some places do provide incentives like socks, tokens, small amount gift cards, but most places are not doing high value incentives. She further explained that community-based targeting testing is rapid testing and individuals get their results right away. C. Steib said that there is a number for people who are tested in ER and discharged before they get results, but that they are given a number to call to get their results. If they do not call then they are considered lost to care and DIS is triggered to engage with them. R. Woodhouse stated people who are incarcerated may not get their results before they are released. C. Conyngham replied that PDPH will follow up with those who are released or discharged before they get their results. G. Gannon said that the new bail guidelines might impact when/if people get their HIV test results.

K. Carter asked if there was community-based Hepatitis C testing too. C. Conyngham said that some places do both, however, Hep C antibody positivity rate is high in many populations and the test that you need to get a true viral load is not a rapid test. She further explained that you really want to get people in a care setting to get an accurate result and linking to healthcare in community settings, including PrEP or HEP C testing/treatment is a priority. She clarified that PDPH doesn't fund Hepatitis C tests for community settings. G. Gannon added that giving results to a Hepatitis C test is a lot more complicated than an HIV test, because of the difference in antibody testing and viral load testing.

M. Ross-Russell offered a suggestion that the committee schedule some time to think about recommendations for regional allocations in the summer. For example, if the committee wanted to talk about populations to target with services there are a few ways to fund prevention within a Ryan White environment. She added that the committee might also have recommendations for activities in the integrated plan. C. Steib asked when it would make sense to schedule this conversation. M. Ross-Russell replied that allocations meetings are generally in June or July. B. Morgan suggested that the committee schedule this conversation for May so they have time to develop any recommendations. M. Ross Russell further explained that instructions to the Recipient can be geographically, population or service specific so there are options for the committee to consider in how they approach recommendations. B. Morgan suggested that June can be kept open to see what the committee needs to do.

She asked for additions to the calendar. There were none.

PrEP Work Group Update
No further report.

Old Business: None.

New Business: None.

Announcements:.
D. Gana announced the Red Ribbon Awards on Friday, November 30th from 4 to 7pm at 440 N. Broad Street.

G. Gannon offered two updates on harm reduction. The syringe exchange in Charleston in WV was shut down by the county. Yesterday a judge lodged an injunction in Orange County, CA against the needle access program. C. Conyngham added that Denver city council voted to approve safe injection facilities.

The committee discussed the local efforts to have a safe injection facility, including federal and state officials coming out against the safe consumption sites. The committee discussed having medical marijuana programs come to present on access and use. M. Ross-Russell said the PA HPG had a presentation on the dispensary network and process to gain access. She will see what other information she can get to share with the committee and possibly schedule a presentation.

Adjournment: The meeting was adjourned by general consensus at 3:57p.m.

Respectfully submitted by,

Nicole D. Johns, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from October 31, 2018
- 2019 Planning Calendar
- Slides from C. Terrell's HIV Prevention Update form September 2018 HIPC meeting
- Meeting Calendar
- OHP Calendar

INTRODUCTION

MISSION STATEMENT

The mission of the Philadelphia EMA Ryan White Part A Planning Council is to be responsive to the EMA's consumers' needs through proactive planning of an efficient, high quality continuum of care.

SHARED VALUES

Until the HIV epidemic is over, the Planning Council believes our work should guide continuous improvement in the Philadelphia EMA service system standards and functions. To this end, the Planning Council embraces these shared values to further develop this road map of our EMA's continuum of care:

- Ensure all people with HIV disease have fair, equitable and appropriate access to all care and prevention services;
- Improve all care, prevention and support services to the highest standard of quality;
- Provide services that skillfully accommodate and respect the individual needs of each person with HIV disease;
- Maximize the meaningful participation of people with HIV disease (or at high risk of acquiring HIV) in all levels of the design, delivery and evaluation of services;
- Diminish perceived or actual barriers to care and provide high-quality services thereby attracting people with HIV disease, who are not receiving HIV-related services, to seek appropriate and needed care;
- Provide high quality, culturally competent, and inclusive services that address the needs of people living with HIV who are/are not currently in a system of care and,
- Maximize the quality of life of people with HIV.

Vision Statement

We envision that every person with HIV disease will have fair, equitable and inclusive access to healthcare, support services, and information. Furthermore, this planning body actively prepares for the day when all services will ensure the best possible health and quality of life for people with HIV disease.

Priority Setting and Resource Allocations

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

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

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

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

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

ELIGIBLE RWHAP PART A & PART B SERVICES

Core medical-related services, including:

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

Support services, including:

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

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

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

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

HIV Integrated Planning Council Quick Reference: Legislative Requirements for Planning Councils/Bodies, with HRSA/HAB Definitions, Clarifications, and Expectations[1]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
Establishment of a Planning Council or Body		
Establishment of a Planning Council	CEO "shall establish an HIV health services planning council" [Section 2602(b)(2)(A)(ii)]	All EMAs must have planning councils that meet legislative requirements.
Planning Council/Body Membership		
Representation: Membership Categories	Section 2602(b)(2): "REPRESENTATION.—The HIV health services planning council shall include representatives of— (A) health care providers, including federally qualified health centers; (B) community-based organizations serving affected populations and AIDS service organizations; (C) social service providers, including providers of housing and homeless services; (D) mental health and substance abuse providers; (E) local public health agencies; (F) hospital planning agencies or health care planning agencies; (G) affected communities, including people with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations;	▪ "Representation is the extent to which the planning council includes individuals from the legislatively defined categories of membership." [p 110] ▪ The category of grantees under Category L, other Federal HIV programs "is to include, at a minimum, a representative from each of the following:" - Federally-funded HIV prevention services. A grantee funded under Part F's SPNS, AETC, and/or Ryan White Dental Programs. - Housing Opportunities for Persons With AIDS (HOPWA). - Other Federal programs that provide HIV/AIDS treatment such as the Veterans Health Administration. [p 110] - "The planning council must include at least one member to separately represent each of the designated membership categories (unless no entity from that category exists in the EMA/TGA)....*Separate representation means that each planning council member can fill only one legislatively required*

[1] Prepared in March 2017 for DMHAP based on Ryan White HIV/AIDS Treatment Extension Act of 2009. Prepared under Task Order TA003111 through MSCG/Ryan White Technical Assistance Contract.

From: Compendium of Materials for Planning Council Support Staff. EGM Consulting, LLC. 2018.

Available at: www.targetHIV.org/planning-chatt/pcs-compendium

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
	(H)nonelected community leaders; (I)State government (including the State Medicaid agency and the agency administering the program under part B); (J) grantees under subpart II of part C; (K) grantees under section 2671 [Part D], or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area; (L) grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services; and (M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV/AIDS as of the date on which the individuals were so released."	*membership category at any given time, even if qualified to fill more than one."* [p 110] ▪ There are 3 exceptions, in which a single person can represent multiple categories: - Both substance abuse and mental health provider categories "if his/her agency provides both types of services and the person is familiar with both programs." - "Both the Ryan White Part B program and the State Medicaid agency if that person is in a position of responsibility for both programs." - Any combination of Ryan White Part F grantees (SPNS, AETCs, and Dental Programs) and HOPWA, if the agency represented by the member receives grants from some combination of those four funding streams...and the individual is familiar with all these programs." [p 110]
Consumer Members	▪ "Not less than 33 percent of the council shall be individuals who are receiving HIV-related services [under RWHAP Part A], are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV/AIDS" ▪ Includes parents or caregivers of children with HIV [Section 2602(b)(5)(C)(i)]	"DMHAP and its predecessor, the Division Service Systems (DSS), have consistently emphasized that planning councils can be truly effective in meeting their legislated responsibilities only if they have well-supported consumer participation and membership reflective of the local demographics of the HIV/AIDS epidemic." [p 109]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
Reflectiveness	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)]	▪ **"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]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
Open Nominations	"Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria." [Section 2602(b)(1)]	HAB/DMHAP expects that: ▪ The open nominations process will be "described and announced before the nominations process begins," will "specify clear criteria on the planning council composition being sought," will be publicized, allow people to "apply for membership or be nominated by others," and use a "standardized, plain-language application form." ▪ "The CEO will approve and/or appoint as planning council members only individuals who have gone through the open nominations process." [p 118]
Roles and Responsibilities		
Duties	"(4) DUTIES — The planning council) shall— (A) determine the size and demographics of the population of individuals with HIV/AIDS; (B) determine the needs of such population...; (C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant...; (D) develop a comprehensive plan for the organization and delivery of health and support services...; (E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs; (F) participate in the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under part B;	▪ *Extensive guidance on key duties in RWHAP Part A Manual, with separate chapters on Needs Assessment, Comprehensive Planning, Priority Setting and Resource Allocations, and the Statewide Coordinated Statement of Need RWHAP Part A Manual, Section XI. Planning and Planning Bodies, Chapters 3-6]* ▪ Legislatively required tasks include: - "Conduct an assessment of local community needs. - Develop a comprehensive service plan, compatible with existing State and local plans. - Allocate funds according to service priorities set by the planning council. - Participate along with other Ryan White partners in the development a Statewide Coordinated Statement of Need (SCSN) to enhance coordination among Ryan White HIV/AIDS programs in addressing key HIV/AIDS care issues. - Coordinate with Federal, State, and locally funded grantees providing HIV-related services. - Assess the efficient administration of funds." [p 80]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
	(G) establish methods for obtaining input on community needs and priorities which may include public meetings..., conducting focus groups, and convening ad-hoc panels; and (H) coordinate with Federal grantees that provide HIV-related services within the eligible area." [Section 2602(b)(4)]	
Conflict of Interest and Grievance Procedures		
Conflict of Interest: Planning Council	A planning council: ▪ "May not be directly involved in the administration of a grant" under RWHAP Part A. ▪ "May not designate (or otherwise be involved in the selection of) particular entities as recipients" of RWHAP Part A funds. [Section 2602(b)(5)(A)]	▪ "Planning councils are strictly prohibited from involvement in the selection of particular entities to receive [RWHAP] Part A funding." [p 191] ▪ "As part of their responsibility to determine how best to meet stated priorities, planning councils may stipulate what provider characteristics the grantee should look for in its procurement process (e.g., community-based AIDS service providers, multi-service organizations or public agencies that provide a specific service or target a specific population). They may also specify that providers should be sought in specific parts of the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA)." [p 191] ▪ "While the legislation prohibits planning councils from participating or otherwise being involved in selecting particular entities for funding, they may be involved in selecting particular entities and individuals to carry out activities directly related to planning council functions and responsibilities" such as general planning council administrative duties, needs assessments, planning activities such as writing the comprehensive plan, assessment of the administrative mechanism, technical assistance, and program evaluation. [p 145]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations *[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]*
Conflict of Interest: Individual Members	An individual planning council member who has a financial interest, is an employee, or is a member of an entity that is seeking RWHAP Part A funds: ▪ will not "participate (directly or in an advisory capacity) in the process of selecting entities" for RWHAP Part A funding. [Section 2602(b)(5)(B)]	▪ "Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. To illustrate, conflict of interest occurs when a planning council member has a monetary, personal, or professional interest in a planning council decision or vote. Any group making funding decisions for a Ryan White program should be free from conflicts of interest." [p 143] ▪ "As appropriate, the definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child." [p 147] ▪ "HAB/DMHAP expects planning councils to employ a variety of strategies to minimize conflict of interest and its potential adverse effects, such as keeping members self-aware of the potential for conflict of interest and using procedures that can minimize or address conflicts." Of particular importance are adoption of COI policies and procedures "and their routine and consistent application in planning council deliberations and decision making." [p 150] ▪ "Because of an individual member's relationship to the planning council, sound practice is not to have them serve on external review panels for the selection of [RWHAP] Part A providers." [p 144]
Grievance Procedures	▪ A planning council "(1) shall develop procedures for addressing grievances with respect to funding under this subpart, including procedures for submitting grievances that cannot be resolved to binding arbitration. ▪ "Such procedures shall be described in the by-laws of the planning council and be consistent with the requirements of subsection (c)" *[which call for model grievance procedure to be provided by the Secretary of HHS and planning council grievance procedures to be*	▪ "The Ryan White HIV/AIDS Program requires [RWHAP]Part A planning councils to establish procedures to address grievances related to funding. At local discretion, grievance procedures can also address other types of disputes faced by planning councils." [p 134] ▪ "HAB/DMHAP has developed model grievance procedures to guide local efforts in adequately addressing potential grievances....There should be periodic local review of grievance procedures and their implementation to ensure that legislative

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	reviewed by the Secretary]. [Section 3602(b)(6)]	requirements are being met and grievances are being resolved in a timely and appropriate manner. Any revisions in these grievances should be sent to the HAB/DMHAP project officer to be approved and kept on file." [p 134]
Planning Council Support and Operations		
Support/Funding	Among the allowable uses of administrative funds, which are capped at 10% of the total grant, are "all activities associated with the grantee's contract award procedures, including the activities carried out by the HIV health services planning council…" [Section 2604(h)(3)(B)]	▪ "The planning council needs funding to carry out its responsibilities. HAB/ DMHAP refers to these funds as 'planning council support.' Planning Council Support funds are part of the 10 percent administrative funds available to the grantee for managing the [RWHAP] Part A program." [p 104] ▪ "The grantee must also ensure adequate funding for PC mandated functions within the administrative line item." [p 31] ▪ "The planning council must negotiate the size of the planning council support budget with the grantee and is then responsible for developing and managing that budget within the grantee's grants management structure." [p 104] ▪ "Planning council support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need, sometimes with the help of consultants, conducting planning activities, holding meetings, and assuring PLWHA participation." [p 104]
Officers	"The council may not be chaired solely by an employee of the grantee" [Section 2602(b)(7)(A)]	"The planning council needs a chair or co-chairs. The legislation does not permit an employee of the [RWHAP]Part A grantee to serve as the chair of a planning council. An employee of the grantee may serve as a co-chair, provided the bylaws of the planning council permit or specify that arrangement. Bylaws should specify whether there is to be a chair or co-chairs and how they are selected. They may specify that the chair is to be appointed by the CEO or elected by the Planning Council. Often, if the chair is appointed by the CEO or is an employee of the

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		grantee, bylaws require that the planning council elect the co-chair. Sometimes bylaws require that one co-chair be a PLWHA." [p 100]
Member Training and Materials	"The Secretary shall provide to each chief elected official receiving a grant under [RWHAP Part A] guidelines and materials for training members of the planning council…regarding the duties of the council." [Section 2602(e)]	▪ "Members must be trained to enable them to fulfill their responsibilities, in accordance with guidance from" DMHAP. [p 80] ▪ "PC or planning body members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision making." [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 22] ▪ Letter from PC/B included in the RWHAP Part A application must address "that ongoing, and at least annual membership training took place, including the date(s)." [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 24]
Public Deliberations/ Open Meetings	"(i) The meetings of the council shall be open to the public and shall be held only after adequate notice to the public. (ii) The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location. (iii) Detailed minutes of each meeting of the council shall be kept…." [Section 2602(b)(7)]	"To comply with legislative requirements around open meetings and public access to minutes and other planning council documents, planning councils must: ▪ Ensure that meetings are open to all members of the general public and maintain a system that provides for public written notice of all council meetings. This includes publication of the meeting notices in local print media and through other forums accessible to the disabled (*i.e.*, the hearing- or speech-impaired). Meeting times and locations should be announced on the planning council or health department website and on other appropriate online media. ▪ Have a summary of the minutes that has been approved by the planning council and certified by the chair of the planning council available for public inspection. Both the minutes and other documents or materials made available to or prepared for the planning council should be available to the public within six weeks after the meeting date.

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		▪ Have a publicly accessible location where minutes and other legislatively required information can be inspected and copied if requested. It is important that detailed minutes are required….Minutes need to be able to show how the Council arrived at their funding decisions, especially if there is a grievance." ▪ …"Make available for public inspection records of the recommendations made by committees or other subgroups to the planning council, as well as the subsequent actions taken by the planning council. A sound practice to implement this requirement is to post approved planning council and committee minutes on the planning council website. ▪ Where local, county, or State regulations, ordinances, or statutes are more stringent than Ryan White requirements, follow these more stringent requirements. For example, many States and municipalities have open meeting laws that have very specific public notice or other requirements. Planning councils must adhere to these requirements, and planning council members and support staff should receive information and training about these requirements." [pp 100-101]
Public Disclosure of Member Status	"The requirement for public deliberations "does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters." [Section 2602(b)(7)] *[Legislation does not address public disclosure of status by consumer members]*	▪ At least two of the unaligned consumer representatives must publicly disclose their HIV status. [p 109] ▪ The planning council must "take appropriate steps to guard against disclosure of personal information that would constitute an invasion of privacy. For example, minutes should not indicate the HIV status of planning council members unless they are publicly disclosed, and should never provide medical or health status information about a member." [p 101]