Meeting Agenda

Thursday, March 14, 2019
2:00 p.m. – 4:30 p.m.

Call to Order

Welcome and Introductions

Approval of Agenda

Approval of Minutes (*February 14, 2019)*

Report of Co-Chairs

Report of Staff

Public Comment

Discussion Items

- Reallocations
- Allocations Material Process

Presentation

- Roles and Responsibilities

Old Business

New Business

Announcements

Adjournment

HIV Integrated Planning Council

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

The next HIV Integrated Planning Council meeting is scheduled for
Thursday, April 11, 2019 from 2:00 – 4:00 p.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

HIV Integrated Planning Council
Thursday, February 14, 2019
2:00 p.m. – 4:00 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Baron, Michael Cappuccilli, Keith Carter, Mark Coleman, Maisaloon Dias, Lupe Diaz, Tiffany Dominique, David Gana, Sharee Heaven, Janice Horan, Peter Houle, La'Seana Jones, Gerry Keys, Lorett Matus, Nicole Miller, Jeanette Murdock, Nhakia Outland, Christine Quimby, Erica Rand, Samuel Romero, Eran Sargent, Jason Simmons, Clint Steib, Coleman Terrell (AACO), Adam Thompson, Jacquelyn Whitfield

Excused: Juan Baez, Alan Edelstein, Pamela Gorman, Gus Grannan, Gloria Taylor

Absent: Henry Bennett, Johnnie Bradley, George Matthews, Dorothy McBride-Wesley, Joseph Roderick, Terry Smith-Flores, Gail Thomas, Lorrita Wellington, Zora Wesley, Melvin White, Steven Zick

Guests: Kathleen Brady (AACO), Caitlyn Conyngham (AACO), Ameenah McCann-Woods (AACO), Vanessa Graves, Evette Colon-Street, Julio Jackson, Kelli Sebastian, Nicole Reiser, Dena Lewis-Salley, Janielle Bryan.

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan

Call to Order S. Heaven called the meeting to order at 2:04 p.m. Those present then introduced themselves and participated in an ice breaker activity which included their names, location, and preferred pronouns.

Approval of agenda

L. Diaz asked for an approval of the agenda.
Motion: M. Cappuccillli moved, J. Whitefield seconded to approve the agenda. **Motion Passed by general consensus**

Approval of minutes

L. Diaz asked for an approval of the meeting minutes from January 10, 2019. **Motion:** K. Carter moved, J. Whitefield seconded to approve the minutes for January 10, 2019. **Motion Passed by general consensus.**

Report of Chair

C. Terrell announced that the EMA had received the Ryan White Part A grant award with about a 1% increase, something the council would discuss in detail later. The EMA received a score of 97 on the application. He shared that President Trump announced the End the Epidemic initiative[1] during the State of the Union address earlier that week. He explained that the little that was known at the time and it was not much new from what is currently happening in the EMA. He explained that the initiative focuses on 47 counties with the most HIV, of which Philadelphia is one of them. He stated more information will be presented when it's available.

PrEP Campaign

C. Conyngham announced the launched the Philadelphia PrEP campaign- Philly Keep on Loving[2]. It's a bilingual campaign – English and Spanish. She explained that advertisements will be on buses, bus

[1] https://www.hiv.gov/ending-hiv-epidemic
[2] https://www.phillykeeponloving.com/

stops, in social media and location-based apps, and various physical locations throughout Philadelphia. She reviewed the website content with the audience.

C. Conyngham demonstrated a quiz that helps people determine if PrEP is right for them. She explained that there is a provider locator map on the page which is searchable by zip code. She clarified that all the providers are vetted by PDPH. She explained that information about insurance taken and how to contact an office are included on that map. M. Cappuccilli asked how a provider becomes part of the network. C. Conyngham explained that they can become part of the network through receiving some kind of technical assistance from PDPH. PDPH also does quality assurance calls to make sure the proper information about PrEP is given to callers. All the listed providers are in Philadelphia and some in surrounding counties. She further explained that site visitors can get a home test for chlamydia and gonorrhea through the sight. Visitors can also download an FAQ to take to the provider to help people talk to providers. E. Rand asked when the campaign was launched. C. Conyngham said that everything was launched that day, February 14th, but it may take a few days to see it. She clarified that social media ads should be running immediately, and different audiences may see different ads. The campaign will run through the summer.

Report of Staff

M. Ross Russell explained that Dr. Kathleen Brady is the first presentation to HIPC in preparation for priority setting and allocations processes. The next month's training will be on roles and responsibilities. She asked for ideas for things posted in the conference room to help people remember what they need to know to do the HIPC work. She announced that B. Morgan created a quiz on common acronyms that is on the OHP website. Quizzes will be posted on different topics from time to time. It can be found under 'Test Your Knowledge' on hivphilly.org. B. Morgan asked for ideas and recommendations for similar content. She reminded the group that the OHP newsletter was sent out yesterday with a lot of good content. She explained there is a HIPC recruitment video shareable on Facebook and Twitter.

Special Presentation: Epidemiological Update (Dr. Kathleen Brady)

L. Diaz introduced Dr. Brady. K. Brady explained that she has some EMA data, most is Philadelphia specific. She explained that she will give big picture analysis, but the specifics are in the slides[3]. She shared that there are nearly 27,000 people who are diagnosed with HIV in the EMA, and there are some who don't know their status. She explained that 1.2% of PLWH in the EMA are transgender. She explained PA doesn't collect information on transgender individuals, Philadelphia does, and NJ does to some extent. She pointed out that 54% of PLWH are over 50 years old and this brings up different needs and challenges for individuals and the service delivery system.

K. Brady shared the nine county EMA map that showed PLWH by zip code. There are some areas outside of Philadelphia, like Chester and Camden where there are more PLWH. She noted that for Philadelphia, f there are census tracts with 10 or more PLWH are marked on the map, there are many tracts marked. HIV affects every neighborhood in Philadelphia.

She reviewed that over 19,000 of PLWH in the EMA live in Philadelphia. In Philadelphia, HIV is an epidemic of persons color and 52% are over 50. She reviewed a graph from AACO's surveillance report that shows AIDS cases over time which shows the EMA is at an all-time low. Overall there has

[3] Dr. Brady's slides as well as many other presentations can be found here: https://www.slideshare.net/HIVPhilly

been decreases in diagnoses. A lot of the deaths occur in PLWH are not HIV-related, but things that the general population dies from.

K. Brady reviewed data about those newly diagnosed in 2017 in the EMA. There were 716 new diagnoses. Of those, 77% were male, 1.7% transgender. 22% among those aged 13-24. In Philadelphia 2.2% of the newly diagnosed people identify as transgender. Over a quarter of the new diagnoses are among 13-24 year olds in Philadelphia. She shared that according to local estimates: 260 MSM were infected in 2016 and 30 people who inject drugs. She explained that she expects the PWID numbers to be higher once all the reporting is done.

She reviewed data of those who are unaware of their HIV+ status. 9.3% of PLWH in Philadelphia are unaware of their HIV status, which is less than national rates. People who do not know they are HIV+ are more likely to be male, persons of color, MSM and heterosexuals, persons under 35 years of age. Half of 13-24 year old PLWH are unaware of their status. L. Diaz asked how these percentages are estimated. K. Brady explained that the CDC comes up with formulas to figure out these numbers using surveillance data. A jurisdiction needs to have complete CD4 data to do these numbers, only Philadelphia has the data. NJ and PA do not have complete CD4. A guest asked if these infections in youth are perinatal infections. K. Brady explained no, the number of perinatal infections is very small. There have not been transmissions in the last two years and in the last five years there have only been one transmission in Philadelphia. She presented concurrent AIDS data. The four PA counties have the highest rate in concurrent AIDS diagnosis, and there has been no real change in PA counties over time. She explained that this may show that there are not routine testing in primary care settings.

K. Brady showed care continuum data for only Philadelphia. She said that she is not showing care continuum data for PA and NJ because of reporting delays and incomplete data. She noted that Philadelphia falls behind in retention and viral suppression. E. Sargent asked where the viral suppression numbers are for national and local. K. Brady explained they are almost the same, 51%. We should be doing better considering the context of Philadelphia's resources for HIV treatment. She shared the data for Philadelphia care continuum by subpopulations. She noted that disparities are mostly in youth in retention and virally suppression, mostly due to them not knowing their status.

She explained that in Philadelphia there is a status neutral attitude in HIV testing. People get appropriate services no matter their status. She shared NHBS data on testing in MSM, PWID and heterosexuals. 80% of MSM had a test in the last 12 months, 63% of PWID, and 44% of heterosexuals. K. Brady explained that there is no difference between racial groups in MSM. She explained that the PWID cycle just finished in December and the data isn't ready. In the last NHBS MSM cycle, prevalence rates among MSM: 37% were HIV infected, 21% were unaware. In the previous NHBS cycle, 43% of PWID were unaware of their HIV positive status.

A guest asked for the average time from diagnosis to treatment. K. Brady explained that she did not have that data on-hand but PDPH can look at time of diagnosis and viral suppression. She said that she will run the data.

K. Brady reviewed PrEP estimates by difference risk groups and race/ethnicity. She noted this data came from the AACO 2017 surveillance report. She noted that it is estimated that 8,287 MSM in Philadelphia that have indication for PrEP. A guest asked what is being done to get people information to prevent infections. K. Brady explained that one key thing is the PrEP campaign launched today. The

PrEP monitoring and evaluation plan is still under development and the outline is shared here. She explained that AACO is working on pulling together baseline data for most populations very soon.

K. Brady reviewed some data from the data-to-care initiative. She explained that some unretained people are virally suppressed but most are not. 9,749 of 12,789 who have been in care are retained in care. She encouraged people to check out CDC website to find out more about the data to care initiative[4]. It is required by the CDC prevention grant. PA is also funding data to care from RW rebate dollars. The program is a collaborative confidential data exchange between HIV medical providers and AACP to identify people out of care. Eligible patients are referred to disease intervention specialists for assistance in re-engaging in HIV care. She added that AACO participated in a study with this data that will be reported at CROI in March. The data show that the program works to re-engage people over all and more quickly. She explained that they use a patient-centered approach and helps understand mitigating factors that prevent people from getting care. She explained that the intervention reduces costs and avoids unnecessary and inappropriate referrals. She noted that they collect barriers to care: time management and organization, SES factors, challenges with medical facility, attitude/perception about HIV, mental health, insurance and access to care. People who feel well don't go to the doctor and people who feel too sick don't go to care. People also don't know about Ryan White and don't know they can get care for free. She offered that it is a mix of needs and each person needs to be treated individually. All people in the program are referred to Medical Case Management (MCM) because they are often lost to that as well. She stated that MCM is important to long term success of people. She clarified that very few people say stigma is the reason they are not in care.

K. Brady reviewed demographics of the NHBS PWID sample. Of that sample 31% say they are only using sterile needles. She offered that there is a lot of work to do with this population. She further explained that almost a quarter of the participants have gotten syringes from pharmacy, and 76% report buying syringes off the street. She also shared that transactional sex is common, especially in women. For the sample, 40% had heard about PrEP and 11% had talked about PrEP with provider. She explained that this is much lower than in MSM but not as low in heterosexuals. HIV prevalence is 6.5% and going up. She explained there is a 58% increase in diagnoses among PWID. She noted that Philadelphia has an ongoing outbreak in this population.

M. Coleman asked about harm reduction. K. Brady explained that harm reduction for people who inject drugs. It is a way to get people clean syringes, not to get them to stop using drugs. She further explained that for men who have sex with men, it would be getting them PrEP, rather than changing behaviors that might put them at risk. T. Dominique asked if there were location data about where people get syringes. K. Brady said only at the zip code data but not corner level. T. Dominique said she is doing interviews with PWID. She said people in the interviews were only getting syringes from the syringe exchange program. She asked if where you interview people has an effect on if/where people have access to syringes. K. Brady said that it varies, even among people who live in the neighborhood of Kensington. She offered that if people miss the exchange, they will find another source. K. Carter said that some pharmacies won't sell syringes to people they suspect of using drugs. K. Brady said that there is a standing order to buy syringes in PA, however the state cannot force the pharmacies to sell syringes. There is nothing illegal in refusing to sell them to people.

[4] https://effectiveinterventions.cdc.gov/data-to-care/group-1/data-to-care

Action Items:

FY 2019 Allocations

D. Gana explained that the EMA received the RW Part A award for 2019 with a 1.7% increase over last year. Finance Committee reviewed the spreadsheets in the package and ask the HIPC to approve the allocations for FY2019 as outlined. He explained that the committee looked at the whole EMA. They recommend the increase is spread throughout all the funded categories proportionately because it is a small amount of increased funding overall. He directed the group to review the spreadsheets.
M. Ross-Russell explained the spreadsheet columns: first column is the budget from FY2018 and the second column is the level funding budget with shift in regional portions according to the shifts in the epidemic between the 3 regions. Rather than following the 5% increase budget voted on by HIPC in August, Finance Committee choose to look at what was proposed for the level funding budget rather because the 5% increase budget was for a larger amount of money. She noted that from the discussion in the PA allocations meeting, the increase was divided between transportation and substance use treatment. She further explained that in the Philadelphia allocations substance use treatment was increased by $250,000 and mental health services were left at 2018 levels, and then the difference between 2018 and 2019 level funding totals was taken from core services.

She explained that in the NJ region the plan was to increase proportionately across all funded services, except food bank and home-delivered meals. All of these things are reflected in the spreadsheets in the handouts. Finally, M. Ross-Russell directed everyone to the EMA-wide budget to see that the Minority AIDS Initiative funds were included and lost about $5,000 over all.

D. Gana asked for any more questions. No further questions.
Motion: From Finance Committee, to approve allocation for FY2019 as presented in the regional spreadsheets. **Motion passed**: 19 for, 0 opposed. 6 abstentions.

Extending HIPC Meeting Times

L. Diaz reported this action item is coming from the Executive Committee as a motion.
M. Ross-Russell explained that the Executive Committee met to discuss HIPC meeting times. She explained that because of trainings and presentations in the last several months, HIPC meetings have been running past 4pm. She stated the proposal is to change the scheduled meeting time to 2:00 to 4:30pm to ensure there is time for training and leadership development of HIPC. She said that the council may leave earlier than that, and HIPC would only use the time when needed. She clarified that this is in response to HIPC members asking for more information and greater understanding of their role. M. Cappuccilli said that the priority is keeping people as HIPC members. He noted that the planning process is very complicated and this is a way to get people informed and comfortable faster so they can be successful members.

E. Sargent asked how the time would be managed. She noted that they would be adding activities to meetings that are already running overtime. M. Ross-Russell explained that the reason the meetings were running over was because of trying to fit in training and presentations. She noted that HIPC leadership and OHP staff will be working on streamlining other parts of the meeting. K. Carter asked when this will take place. M. Ross-Russell said if it is approved it will start in March. C. Steib asked how the training will fall in the agenda. M. Ross-Russell that it will depend on where they logically fit, probably not at the end so that there is balance in the flow of the meeting.

Motion: Coming from the Executive Committee to extend HIPC general meeting from 2:00 to 4:30pm.
Motion passed: All in favor 20, opposed 0, abstentions 4.

Public Comment None.

Discussion Items:

Third Quarterly Underspending Report

A. McCann presented the third quarter underspending report for consideration. She explained that there is a nine percent underspending of total award of $1,432,614 (which includes Minority AIDS Initiative funds). She explained that service categories underspending is 29% or $410,235 and systemwide allocations underspending is about $1,024,154 or 71%. She explained that these figures are based on invoices processed for March 2018-November 2018. She offered that there are often delays in invoicing from sub-recipients.

A. McCann started with Philadelphia region report. She explained that there is overspending in Ambulatory/Outpatient Care and that will likely level out in the last quarter. She noted that the underspending in MCM was due to staff vacancies. DEFA was overspent due to high utilization. She explained that reallocations are underway because the HIPC approved them in December 2018. She explained that transportation is overspent due to high utilization. M. Coleman asked about delays in invoicing. A. McCann said that AACO has processed through what was received as of November 2018. The largest delays are from hospitals and fiduciary organization. T. Dominque asked about ambulatory care if it was under or overspent. A. McCann explained that it is overspent. K. Baron asked about the parenthesis, whether it denotes over- or underspent. A. McCann explained that this has been a problem and it will be corrected to show parenthesis for underspending. S. Heaven asked if there was a due date for invoices in the subrecipient contracts. A. McCann answered that invoices are due at the 10th of the month. C. Terrell explained that AACO is constantly and continuously monitoring underspending at the end of the year through conversations with providers even if it hasn't hit the books, so to speak. He explained that the AACO program analysts work with providers to identify and reallocate funds as it becomes apparent there are some. A. McCann reminded the group that last year the EMA did really well with reducing underspending and the hope is to do the same this year. C. Terrell explained that the EFA drug assistance underspending happened because of switch to two weeks instead of 30 days for prescriptions and it has helped people and saved money. A. McCann explained that there are two weeks left in contract year, things will look a lot different at the end of the fiscal year, February 28th.

A. McCann directed the group to the spreadsheet for the PA counties. She explained that Mental Health is utilized differently according to the season. She explained that service utilization is different for some subrecipients and Medicaid covers some of the need. She also offered that when people need more service than can be offered by a RW subrecipient people get referred out. She went on to explain that the overspending in DEFA was due to high demand. Housing was overspent due to utilization and will likely level out. She noted that spending in Transportation was being reviewed. She noted that suburban providers might be using more cost-effective methods of transportation like ride shares and MTP.

A. McCann directed the group to the New Jersey region. She explained that in NJ MCM was underspent due to vacancies. She noted that the mental health provider hadn't invoiced for this contract period. She explained that oral health will level out although overspent. A. McCann explained that AACO is investigating transportation use in NJ, particularly use for support groups. She explained that AACO wants to make sure people have access to MCM and medical appointments. C. Terrell said that the overspending NJ should be looked at by HIPC during allocations this year, because transportation is important and the council should consider what types of services transportation should cover. A.

McCann explained that the systemwide underspending was likely due to late invoicing. She closed by reminding the group that underspending will be rerouted to direct services as soon as identified.

Committee Reports

Positive Committee K. Carter reported that the committee is starting a quarterly newsletter. The newsletter will include: profiles, events, resources and Positive Committee news. He asked for events to be included in the newsletter. He reported that their next meeting is March 14th at noon.

Nominations Committee M. Cappucilli reported that the committee is reviewing new applications and renewing members. He noted that some members need to reapply and the deadline is coming up quickly. He explained that the committee is looking for young men of color and PLWH from PA counties. He shared that on May 9th after the HIPC meeting there will be a social at OHP. He noted that the Nominations Committee is supplying the food and will ask for sign-ups. The purpose is to allow members to meet each other and invite guests to introduce them to the council. He noted that HIPC members are encouraged to bring store bought desserts.

Finance Committee No further report

Prevention Committee C. Steib reported that the PrEP workgroup was presented a report from AACO of the group's discussions. At the next Prevention Committee meeting they will review the report to make comments and recommendations. Those recommendations will be brought back to HIPC for final approval. He encouraged members to attend the Prevention Committee meeting in March.

Comprehensive Planning Committee N. Johns reported that the committee is working on the priority setting process and will bring their final decisions to the HIPC for approval. She also noted that there was an announcement about the Racial Equity Workgroup in the handouts. She encouraged the group to contact her if there were interested in being a member of the workgroup.

Executive Committee M. Cappacilli reported that the committee meets quarterly and they will set a regular meeting date soon. A email will be sent to committee co-chairs to help pick that regular meeting time.

Old Business. None.

New Business. None.

Announcements.

A guest announced that Gilead was hosting a dinner on February 20th to talk about PrEP implementation among local medical providers. He noted there are limited seats and people must register with him. He also noted that Gilead wants to help providers get same-day treatment for people living with HIV. He asked anyone interested in learning more to contact him about resources available.

T. Dominique announced that HHS was having a listening session on February 22nd in Washington D.C. about the President's Ending the Epidemic plan.

Adjournment

L. Diaz asked for motion to adjourn. Meeting adjourned at 4:04 by general consensus.

Respectfully submitted by,
Nicole D. Johns, staff

Handouts distributed at the meeting:

- Meeting agenda
- Meeting minutes for January 10, 2019
- OHP calendar
- Philadelphia EMA FY 2019-2020 Allocations examples
- Recipient FY2018-2019 Third Quarter Underspending Report, February 14, 2019
- Racial Equity Workgroup Purpose and Scope

Department of Public Health
CITY OF PHILADELPHIA

Office of HIV Planning

HIV Integrated Planning Council

Ryan White Part A FY 2019-2020

Philadelphia Region and Pennsylvania Counties Reallocation Request

March 14, 2019

Just prior to the conclusion of the 2017-2018 contract year, the Recipient noticed a considerable uptick in the funds utilized for the EFA-Pharma service category. To mitigate significant overspending, the Recipient imposed a 14-day prescription fill limitation. This imposition resulted in no negative impact for the clients who benefitted from this service. Moving forward, it is the Recipient's assessment that the 14-day fills should continue.

The Recipient has done a full assessment to determine the appropriate funding levels that results in no negative systemic impact. Below is a snapshot of the current fiscal year allocations:

EFA-Pharma (Philadelphia Region)

- Current Allocation - $643,585
- Allocation to meet need - $550,000
- Excess Allocation - $93,585

EFA-Pharma (PA Counties)

- Current Allocation - $215,909
- Allocation to meet need - $120,000
- Excess Allocation - $95,909

The Recipient is requesting that the HIV Integrated Planning Council: Finance Committee determine reallocations for the current FY 2019-2020 to other service categories.

Decisions from the 2019-2020 Allocations Process

PA counties Level-Funding Budget:

Motion Passed. The Planning Council members present moved to allocate $60,107 into transportation and substance abuse treatment equally. Other categories will remain at the level of the original level funding budget.

PA counties 5% increase Budget:

Motion Passed. To allocate 50% to substance abuse, 25% to DEFA, and 25% to the food bank and keep the rest of the categories at the approved level funding budget.

Philadelphia Level-Funding Budget:

Motion Passed. The Planning Council moved to allocate an additional $250,000 to substance abuse services to support Medication Assisted Treatment (MAT). To fund the allocation the $250,000 would be taken proportionally out of core services besides mental health. The supportive services would be kept at original level funding budget level.

Philadelphia 5% increase Budget:

Motion passed. To propose a $100,000 allocation into psychosocial support, and then a proportional increase across all other categories from the new level funding budget.

In February the HIPC voted to use the level funding budget scenario.

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

Slides for Module 2 Adapted from the Planning CHATT Modules on TargetHIV

Topic: Section 1 - 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

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

- The CEO (the Mayor of Philadelphia) in an Eligible Metropolitan Area (EMA) must establish an "HIV health services planning council" [§2602(b)] (More than 2,000 new cases in the last five years and a population greater than 50,000.)
- 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" (An area with a population of at least 50,000 and reported at least 1,000 but fewer than 2,000 new AIDS cases in the last five years.)

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"
- Allocation of funds
- Provide guidance to the recipient on "how best to meet these priorities" through Instructions to the Recipient
- 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

Questions

1. Section 1 - Community Planning

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

Slides for Module 2 Adapted from the Planning CHATT Modules on TargetHIV

Topic: Section 2 Roles and Responsibilities

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 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

Recipient and Planning Council Roles and Responsibilities

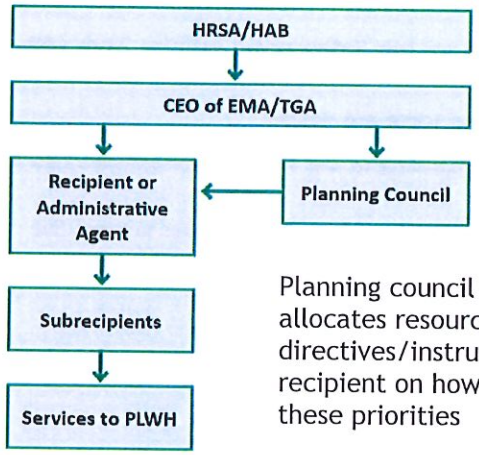
- The recipient and planning council are two independent entities, both with legislative authority and roles
- Some roles belong to one entity and some are shared
- Effectiveness requires clear understanding of the roles and responsibilities of each entity, plus:
  - Frequent communications, information 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 & Responsibilities[1]

Task	CEO	Recipient	PC
Establishment of Planning Council/Planning Body*	✓		
Appointment of PC 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 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/instructions to recipient on how best to meet these priorities

Planning Council Formation and Membership

- Chief Elected Official (CEO) establishes the PC
- For a PC, the 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
- A PC may not be chaired solely by an employee of the recipient
- Varied approaches used for establishing and appointing PC 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
  - What five services are routinely identified by PLWH almost every year (excluding medical care and case management)?

Needs Assessment

- 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/Instructions 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/Instructions

- 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/Instructions

- 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, in our case of 10%
- 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**
- 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 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-Request For Proposal (RFP)

- **Recipient role - no PC 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 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 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 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 and/or recipient 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 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 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

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 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's work is done in committees
- Assistance from PC support staff

Role of PC Support Staff

- Help the PC 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 manage its budget
- Complete needs assessments
- Complete various documents

Recipient Staff Roles with PC

- 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

Separation of PC and Recipient Roles

- Division of roles between recipient and PC helps prevent actual or perceived conflict of interest
- Recipient chooses and manages RWHAP Part A service providers with no PC involvement
- Data on subrecipients - e.g., funding, expenditures, performance - provided to PC by service category only, without provider names
- PC 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 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

Sum-Up

- Planning councils are decision-making bodies
- PC roles are determined by the legislation, with additional guidance from HRSA/HAB/DMHAP
- 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

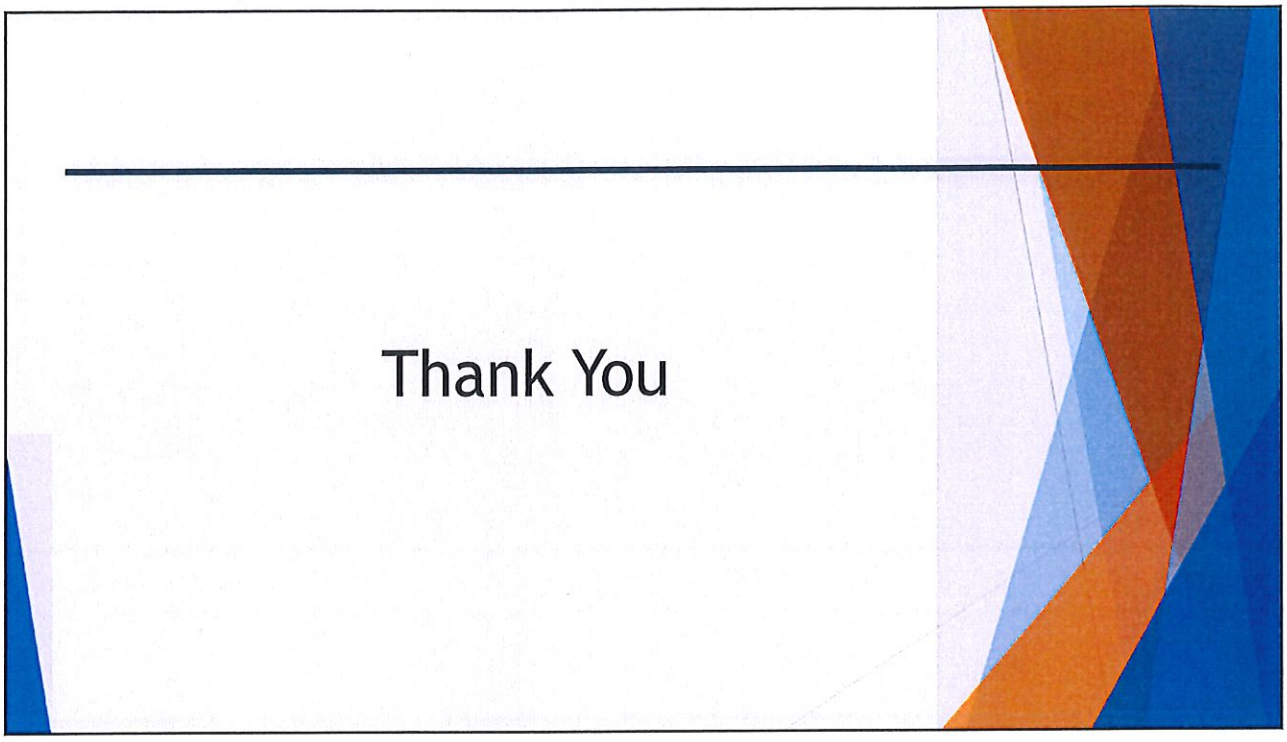
Post-Training Quiz

- Please take the quiz to completed after the training
- Review of the correct answers
- Count the number of answers that were correct
- Identify any questions that you still aren't sure how to answer

Planning Council, Recipient, & CEO

Task	CEO	Recipient	PC
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


Thank You

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

Indicate whether each of the following is TRUE or FALSE.

True or False:

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

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

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

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

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

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

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

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

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

Activity 2.4: Review of Roles and Responsibilities Matrix[1]

HANDOUT FOR PARTICIPANTS

For each task, indicate with a checkmark the responsible entity or entities.

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

[1] Roles and responsibilities that are requirements for a Part A planning council (PC) and sound practice for a Part A TGA planning body functioning like a planning council