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Section I: Overview of the Ryan White HIV/AIDS Program

I. Ch 1. Overview

The HIV epidemic has taken an enormous toll since its onset in the early 1980s. Approximately 619,400 Americans with an AIDS diagnosis have died, and many others are living with HIV-related illness and disability, or are caring for people with the disease.\(^1\) An estimated 50,000 Americans become infected with HIV each year.\(^2\) Today, more than 1.1 million Americans are living with HIV disease.\(^3\) The epidemic has hit hardest among populations who are poor, lack health insurance, have limited or no access to health care, and are from communities of color.


The Ryan White HIV/AIDS Program reaches an estimated 529,000 people each year.\(^4\) People living with HIV (PLWH) are, on average, poorer than the general population. By statute, the programs funded under the Ryan White legislation are the “payer of last resort,” meaning that the Ryan White HIV/AIDS Program grant funds may not be used for any item or service for which payment has been made, or can reasonably be expected to be made by any other payer. In 2008, more than 70 percent of Ryan White HIV/AIDS Program clients self-identified as members of racial or ethnic minority groups. In the same year, 67 percent of Program clients were male, and 33 percent were female. The FY 2012 funding for the Ryan White HIV/AIDS Program is $2.35 billion.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

I. Ch 2. Ryan White HIV/AIDS Program Legislation

The Ryan White HIV/AIDS Program is authorized and funded under Title XXVI of the Public Health Services Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). The legislation was first enacted in 1990 as the

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The Ryan White legislation has been adjusted with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas. The legislation provides a flexible structure through which the Ryan White HIV/AIDS Program can address HIV/AIDS care needs on the basis of:

- Different geographic areas (large metropolitan areas, States, and communities across the Nation).
- Varying populations hit hardest by the epidemic.
- Availability and access to HIV-AIDS-related services.
- Service system needs (e.g., technical assistance for programs, training of clinicians, research on innovative models of care).

Legislative provisions (called Sections) address, for example, planning and decision-making, type of grants that are available, what funds may be used for, requirements for entities submitting applications for funding, and available technical assistance to help programs run more effectively.

I. Ch 3. Ryan White HIV/AIDS Program Structure

The Ryan White HIV/AIDS Program is divided into several “Parts,” outlined in the authorizing legislation.

Part A – Eligible Metropolitan Areas (EMAs)

Part A provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)—population centers that are the most severely affected by the HIV/AIDS epidemic. EMA eligibility requires an area to report more than 2,000 AIDS cases in the most recent 5 years and to have a population of at least 50,000. To be eligible as a TGA, an area must have 1,000 to 1,999 reported new AIDS cases in the most recent 5 years.

Ryan White Part B – States and Territories

Ryan White Part B provides grants to States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Ryan White Part B grants include a base grant for core medical and support services; the AIDS Drug Assistance Program (ADAP) award; the ADAP Supplemental Drug Treatment Program for eligible entities; and supplemental grants to States with “emerging communities,” defined as jurisdictions reporting between 500 and 999 cumulative AIDS cases over the most recent 5 years. Congress designates a portion of the Ryan White Part B appropriation for ADAP; the ADAP earmark is now the largest portion of the Ryan White Part B appropriation. Five percent of the ADAP earmark is set aside for the ADAP Supplemental Drug Treatment Program to assist States needing additional ADAP funds.
Part C – Community-Based Programs

Part C supports outpatient HIV early intervention services and ambulatory care. Part C grants are awarded directly to service providers, such as ambulatory medical clinics. Part C also funds planning grants, which help organizations more effectively deliver HIV/AIDS care and services.

Part D – Women, Infants, Children, and Youth with HIV/AIDS and Their Families

Part D grants provide family centered comprehensive care to children, youth, and women and their families and help improve access to clinical trials and research.

Part F – Special Projects of National Significance (SPNS)—Research Models

Part F grants support several research, technical assistance, and access-to-care programs, as described below:

**The Special Projects of National Significance (SPNS) Program** supports the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations. SPNS also provides funds to help grantees develop standard electronic client information data systems.

**The AIDS Education and Training Centers (AETC) Program** supports education and training of health care providers through a network of 11 regional and 4 national centers.

**The Minority AIDS Initiative (MAI)** was established in FY 1999 through Congressional appropriations to improve access to HIV/AIDS care and health outcomes for disproportionately affected minority populations. MAI-funded services under Parts A, C, and D were consistent with their “base” programs, whereas the Ryan White Part B MAI focused on education and outreach to improve minority access to medication assistance programs, including ADAP. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 made the Part A and B MAI separate, competitive grant programs for EMA/TGAs and States, respectively. Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, however, Congress directed that Part A and B funding be returned to a formula grant basis and synchronized with the Part A and B grant awards, similar to the Part C and D MAI.

All Ryan White HIV/AIDS Program Parts can support the provision of oral health services. Two Part F programs, however, focus on funding oral health care for people with HIV:

**The HIV/AIDS Dental Reimbursement Program** reimburses dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for a portion of uncompensated costs incurred in providing oral health treatment to patients with HIV disease.
The Community-Based Dental Partnership Program supports increased access to oral health care services for people who are HIV positive while providing education and clinical training for dental care providers, especially those practicing in community-based settings.

Learn more at http://hab.hrsa.gov/abouthab/aboutprogram.html.

I. Ch 4. Ryan White HIV/AIDS Program Administration

As noted, HRSA HAB administers the Ryan White HIV/AIDS Program. HRSA’s Office of the Associate Administrator for HAB manages the bureau; provides leadership and direction for HRSA’s HIV/AIDS programs and activities, including the Ryan White HIV/AIDS Program; and oversees collaboration with other national health programs.

The HIV/AIDS Bureau Mission and Vision


Mission: Provide leadership and resources to assure access to and retention in high quality, integrated care and treatment services for vulnerable people living with HIV/AIDS and their families.

The HIV/AIDS Bureau Organizational Chart

Please see the following page for the organizational chart.
Figure 1: HIV/AIDS Bureau Organizational Chart
HAB Offices and Divisions
HAB has six additional offices and divisions:


The Division of Community HIV/AIDS Programs (DCHAP) administers Parts C and D, the Community HIV/AIDS Dental Partnership Program, and the HIV/AIDS Dental Reimbursement Program.

The Division of HIV/AIDS Training and Capacity Development administers planning, training, and technical assistance activities for Ryan White HIV/AIDS Program grantees and the AIDS Education and Training Centers (AETC) Program. The division also administers the Global Program as well as the Special Projects of National Significance Program, which develops, implements, and evaluates innovative models of HIV/AIDS care delivery and supports the development of standard electronic client information data systems by Ryan White HIV/AIDS Program grantees.

The Division of Policy and Data serves as HAB’s focal point for program data collection and evaluation, coordination of program performance activities, development of policy guidance, coordination of technical assistance activities, and development of analyses and reports to support HIV/AIDS decision making.

The Office of Operations and Management provides administrative and fiscal guidance and support for HAB and is responsible for all budget execution tasks, personnel actions, contracting services, and facility management.

Learn more at http://hab.hrsa.gov/abouthab/programfactsheets.html.

I. Ch 5. Overview of the Ryan White Part B Program

Ryan White Part B: Grants to States and Territories

Ryan White Part B under Title XXVI of the Public Health Services Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides grants to States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Ryan White Part B grants include a base grant for core medical and support services; the ADAP award; the ADAP Supplemental Drug Treatment Program for eligible entities; and supplemental grants to States with “emerging communities,” defined as jurisdictions reporting between 500 and 999 cumulative AIDS cases over the most recent 5
years. Congress designates a portion of the Ryan White Part B appropriation for ADAP; the ADAP earmark is now the largest portion of the Ryan White Part B appropriation. Five percent of the ADAP earmark is set aside for the ADAP Supplemental Drug Treatment Program to assist States needing additional ADAP funds.

**Eligibility**

All 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the six U.S. Pacific Territories/Associated jurisdictions are eligible for funding. Emerging Communities are defined as those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years. The grant awards are accepted by the Governor or CEO of the jurisdiction and designated to the State Health Department or another State/Territory agency that implements and manages the Ryan White HIV/AIDS Program funds.

**Services**

Section 2612(b)(3) of as defined by Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) defines the following core medical services:

- Outpatient and ambulatory health services
- ADAP
- AIDS pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premium and cost-sharing assistance
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services
- Mental health services
- Outpatient substance abuse care
- Medical case management, including treatment adherence services

Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for health care and other support services, case management, and residential substance abuse treatment services.

Unless approved for a waiver, grantees are required to spend at least 75 percent of their Ryan White Part B grant funds on core medical services and no more than 25 percent on support services.
Implementation

The State Health Department or State administering agency may either provide core medical or support services directly to eligible individuals in their jurisdiction or may establish contracts/MOs with service providers to deliver the core medical or support services. These providers may include public or nonprofit entities. For-profit entities are eligible only if they are the sole available providers of quality HIV care in the area. Some States may subcontract with HIV Care Consortia, which are associations of public and nonprofit health-care and support service providers and community-based organizations that plan, develop, and deliver services for PLWH. Services provided through a consortium are considered support services.

Grantees and Administrative and National Policy Requirements

Grantees must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Sub-awards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Grant Award).

Federal regulations require grantees to oversee their service providers. In April 2011 HRSA compiled existing requirements into a comprehensive document called the National Monitoring Standards. The standards are designed to help Ryan White Part A and Ryan White Part B grantees meet Federal requirements for program and financial management, and to improve program efficiency.


Ryan White Part B Funding

Ryan White Part B funding is available through several forms: the formula grant (i.e., Ryan White Part B base award, MAI and ADAP Earmark award for HIV/AIDS-related medications); the ADAP Supplemental award; the Part B Supplemental and the Emerging Communities award.

*Formula Grants*

Ryan White Part B base and ADAP earmark funding are distributed using a funding formula process.

- The Ryan White Part B formula/base award, the ADAP awards, and Emerging Communities awards are formula awards in that they are based on the number of reported
living cases of HIV/AIDS cases in the State or Territory in the most recent calendar year as confirmed by CDC.

- ADAP funds are “earmarked” and distributed using a formula process as well to provide HIV-related medications. Fundable services include treatment adherence as well as health insurance continuation for plans that fit the Ryan White HIV/AIDS Program criteria under Ryan White legislation (Section 2615).
- Similarly, Minority AIDS Initiative (MAI) formula awards are based on the number of reported and confirmed living minority cases of HIV/AIDS for the most recent calendar year and code-based HIV data submitted to HRSA.
- Base Ryan White Part B grants are awarded using a formula based on reported living cases of HIV/AIDS in the State or Territory. States with more than 1 percent of total HIV/AIDS cases reported in the United States during the previous 2 years must provide matching funds with their own resources using a formula outlined in the legislation.

Supplemental Grants
Ryan White Part B Supplemental Grants are awarded to States demonstrating the severity of the HIV/AIDS epidemic.

- The funds are intended to supplement the services otherwise provided by the State. The funding is made available to States and Territories based on an Objective Review Committee.
- Supplemental funds are awarded based on the quantifiable data on HIV epidemiology, co-morbidities, cost of care, the service needs of emerging populations, unmet need for core medical services, and unique service delivery challenges provided by States/territories.
- ADAP Supplemental Grants are awarded to States and Territories demonstrating severe need for medications. Section 2618(a)(2)(F)(ii) of the Ryan White legislation states that five percent of the ADAP appropriation will be reserved as funding to purchase medications.

I. Ch 6. The Division of State HIV/AIDS Programs


DSHAP Project Officers (PO)

The PO is the HRSA official responsible for working with grantees to ensure compliance with the legislative programmatic and technical aspects of the Ryan White Part B grants and to provide technical assistance resources to the State to ensure a comprehensive HIV service delivery system. POs are supervised by HAB Division of State HIV/AIDS Program (DSHAP) branch chiefs, who are responsible for ensuring that POs are meeting their responsibilities. The PO works with the HRSA Office of Financial Assistance Management’s grants management
specialists (GMSs). GMSs are responsible for providing non-programmatic administrative assistance to grantees, including assistance in interpreting provisions of grants administration, law, regulation and policy. These provisions include how grantees can drawdown grant funds and how grantees are to administer and close out grants. GMSs are supervised by Grants Management Officers. Additionally, within the Office of Federal Assistance Management, staff in the Division of Financial Integrity (DFI) provides technical assistance to the POs and GMSs on audit issues.

Specifically, the DSHAP PO is:

- To be the primary contact between grantees and DSHAP.
- To facilitate the exchange of information needed by grantees, planning bodies (includes consortia, statewide planning groups, and prevention/care planning groups) or other representatives that directly affect the implementation and administration of Ryan White Part B programs. This information may relate directly to grantee roles and responsibilities, planning bodies roles and mandated functions, and service provider issues such as reporting requirements.
- To monitor and document programmatic performance to ensure compliance with legislative requirements through monthly calls with the grantee; conducting site visits; reviewing grantee specific submissions such as grant applications, conditions of award, carry-over requests, needs assessments, the Statewide Comprehensive Statement of Need, and comprehensive plans.
- To understand and track the health care service delivery system in the jurisdiction.
- To identify and respond to specific technical assistance needs of grantees and entities within the jurisdiction. The project officer is the point of contact to coordinate the request to begin technical assistance.
- To maintain a summary of major grantee key program accomplishments and challenges.
- To represent the concerns/perspectives of grantees in HRSA/HAB initiatives.

I. Ch 7. Technical Assistance for the Ryan White Community

The legislation authorizes technical assistance (TA) to help programs comply with Ryan White requirements. Ryan White Part B grantees can obtain TA from HAB through their assigned Project Officer. Assistance focuses on implementing legislative and programmatic requirements in order to improve health care access and quality of life for PLWH.

I. Ch 8. References, Links, and Resources

For More Information


Section II: HIV Service Delivery System

II. Ch 1. Overview

The largest component of the Federal AIDS budget is health care services and treatment for PLWHA in the United States, totaling $15.6 billion in the FY 2013 budget request. This represents a 6-percent increase over FY 2012, primarily due to increased mandatory spending for Medicaid and Medicare, but also to increases in the Ryan White Program.5

The Ryan White HIV/AIDS Program, under Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87 October 2009), is the single largest Federal program designed specifically for people with HIV in the United States, estimated to reach more than half a million people with HIV each year. It is also the third largest source of domestic funding for HIV care.5 First enacted in 1990, it provides care and support services to individuals and families affected by the disease, functioning as the “payer of last resort” by filling the gaps for those who have no other source of coverage or face coverage limits.

The Ryan White HIV/AIDS Program requires States and territories to develop coordinated service delivery systems of care for people living with HIV/AIDS (PLWHA). A comprehensive continuum of HIV/AIDS care requires grantees to develop collaborative, partnering and coordinating relationships between multiple sources of HIV testing, treatment, care and prevention service provider agencies on the State and local levels.

The Ryan White Part B Program grantees are expected to reflect these in their HIV comprehensive plan and community-based needs assessment and planning processes. Ryan White grantees must integrate the National HIV/AIDS Strategy (NHAS) goals and Early Identification of Individuals living with HIV/AIDS (EIIHA) strategies in addressing the service needs of newly affected and underserved populations.

II. Ch 2. Legislative Background

The Ryan White HIV/AIDS Program under Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 2009) includes formula and supplemental grants to assist States and territories in developing HIV/AIDS service delivery systems that reflect a comprehensive continuum of care that include essential core medical services and appropriate support services that assist PLWHA in accessing treatment for HIV/AIDS infection.

Ryan White Part B of the Ryan White legislation, under Section 2612(b)(3), requires that 75 percent of grant funds, unless a waiver is exercised, to be used for core services after grantees reserve amounts of grants for administrative services. In addition, essential core medical services are identified under Section 2612(b) and include early intervention services as defined in Section 2612(d).

In addition to core services, key supportive services needed to achieve medical outcomes are fundable under Ryan White. These are described in Section 2612(c) as services,” that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).”

Section 2617(b)(5) of the Ryan White legislation describes the requirement for grantees to develop a comprehensive planning that establishes priorities for fund allocation, includes a strategy that: identifies individuals who know their HIV status and are not receiving such services; coordinates the provision of such services; and describes the services and activities to be provided will be implemented to maximize quality and coordinated with available resources.

In addition, Section 2617(b)(5)(F) and 2617(b)(6) address the Ryan White Part B Statewide Coordinated Statement of Need (SCSN) that:

“(F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title; and

(G) includes key outcomes to be measured by all entities in the State receiving assistance under this title”

Section 2612(b)(6) and (7) address the importance of full participation by key entities in the HIV/AIDS care and treatment service delivery process, by way of the Statewide Coordinated Statement of Need (SCSN).and public hearing processes by requiring:

“(6) an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need;

(7) an assurance by the State that—

(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (6), and the types of entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (5) and commenting on the implementation of such plan”
In addition, Section 2617(b)(7)(G) of the Ryan White legislation speaks to the important points of access and components of a health care system for PLWHA.

“(7) an assurance by the State that—

(G) entities within areas in which activities under the grant are carried out will maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2612(c) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care”

II. Ch 3. Ryan White Core Medical Services

Introduction

As of 2006 Ryan White legislation requires that that not less than 75 percent of the funds be used to provide core medical services that are needed in the State for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Core medical services are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. The HIV care continuum and service delivery coordination efforts are dependent on the availability of core services through Ryan White funding and other payers. Core Services are part of the monitoring expectations for Ryan White Part A and included in the National Monitoring Standards.

Defined Core Medical Services

As stated in the Ryan White legislation, the term “core medical services,” with respect to an individual infected with HIV/AIDS (including the co-occurring conditions of the individual) means the following 13 core medical services are fundable:

(A) Outpatient and ambulatory health services.
(B) AIDS Drug Assistance Program treatments in accordance with section 2616.
(C) AIDS pharmaceutical assistance.
(D) Oral health care.
(E) Early intervention services described in subsection (d).
(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.
(G) Home health care.
(H) Medical nutrition therapy.
(I) Hospice services.
(J) Home and community-based health services as defined under section 2614(c).
(K) Mental health services.
(L) Substance abuse outpatient care.
(M) Medical case management, including treatment adherence services.

The most recent service definitions can be found in the Ryan White Services Report Instructions Manual that is available online at: http://hab.hrsa.gov/manageyourgrant/files/rsrmanual.pdf.

Waiver to Core Medical Services Requirement

Applicants seeking a waiver to the core medical services requirement must submit a waiver request with this grant application in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 73, No. 113, dated Wednesday June 11, 2008, and may be found at http://www.gpo.gov/fdsys/pkg/FR-2008-06-11/html/E8-13102.htm.

Core Medical Services and the Coordination of Services

The Ryan White HIV/AIDS Program requires services to be provided in a coordinated, cost-effective manner that ensures that Ryan White HIV/AIDS Program Part A funds is the payer of last resort for HIV/AIDS services. Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication. Grantees are required to participate in established HIV community-based continuum of care if such continuum exists within the area and maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

II. Ch 4. Ryan White Support Services

Introduction

As of the 2006 Ryan White legislation requires that that no more than 25 percent of service dollars to be spent on support services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Services funded must be needed in order for PLWH to achieve medical outcomes—defined as "outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS." The HIV care continuum and service delivery coordination efforts are dependent on the availability of core services through Ryan White funding and other payers. HIV Support Services are part of the monitoring expectations for Ryan White Part A and included in the National Monitoring Standards.

Defined Support Services

A total of 16 support services approved for funding by the Secretary of HHS based on the legislation:

1. Case management (non-medical)
2. Child care services
3. Emergency financial assistance
4. Food bank/home-delivered meals
5. Health education/risk reduction
6. Housing services
7. Legal services
8. Linguistics services (interpretation and translation)
9. Medical transportation services
10. Outreach services
11. Psychosocial support services
12. Referral for health care/supportive services
13. Rehabilitation services
14. Respite care
15. Substance abuse services—residential
16. Treatment adherence counseling

The most recent service definitions can be found in the Ryan White Services Report Instructions Manual that is available online at: [http://hab.hrsa.gov/manageyourgrant/files/rsrmanual.pdf](http://hab.hrsa.gov/manageyourgrant/files/rsrmanual.pdf).

**HIV Support Services and the Coordination of Services**

The Ryan White HIV/AIDS Program requires services to be provided in a coordinated, cost-effective manner that ensures that Ryan White HIV/AIDS Program Part A funds is the payer of last resort for HIV/AIDS services. Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication. Grantees are required to participate in established HIV community-based continuum of care if such continuum exists within the area and maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

**II. Ch 5. HIV Care Continuum**

An HIV Continuum of Care is an integrated service network that guides and tracks HIV clients over time through a comprehensive array of clinical, mental, and social services in order to maximize access and effectiveness. The characteristics of a continuum include:

- Coordination among provider treatment activities.
- Seamless transition across levels of care.
- Coordination of present and past treatment.
A comprehensive continuum of care includes primary medical care and supportive services, which aim to promote health and enhance quality of life. The Ryan White HIV/AIDS Program requires States and territories under Ryan White Part B to develop a comprehensive continuum of HIV/AIDS care accessible to eligible PLWHA. The system of care should address the service needs of newly affected and underserved populations—including disproportionately impacted communities of color and emerging populations. The HIV/AIDS care should be consistent with HRSA’s goals of increasing access to services and decreasing HIV/AIDS health disparities among affected subpopulations and historically underserved communities. A continuum of HIV prevention and care services should be designed to address the needs of PLWHA across all life stages, from those unaware of his/her HIV status, through HIV counseling and testing, early intervention and linkage to care, to retention in care and treatment adherence.

Grantees’ comprehensive planning and State Coordinated Statement of Need processes must reflect full participation of entities within the jurisdiction that constitute key points of access to the health care system for individuals with HIV/AIDS including those that facilitate early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care.

II. Ch 6. Coordination of Services and Funding Streams

Partnerships and Collaboration

In a continuum of care, the Ryan White HIV/AIDS Program expects to see collaboration, partnering and coordination between multiple sources of treatment, care and HIV testing, and HIV prevention service providers. In a mature continuum of care, collaboration between HIV testing sites, non-Ryan White Program providers, all Ryan White Program Parts (A, B, C, D,
and F), Medicaid, and VA should be established and maintained in the planning and implementation of services.

Ryan White Part B grantee planning and service delivery efforts be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication. Other Federal and local sources, including other Ryan White HIV/AIDS Programs must be taken into consideration in planning for the continuum of HIV/AIDS care. Sources may include but are not limited to:

- Medicaid.
- Medicare, including Medicare Part D.
- Children’s Health Insurance Program (CHIP).
- Veterans Affairs.
- Housing Opportunities for Persons With HIV/AIDS Programs (HOPWA).
- CDC Prevention.
- Services for Women and Children (e.g., Special Supplemental Food Program for Women, Infants, and Children (WIC) Program ,and Substance Abuse Treatment Programs for Pregnant Women).
- Other State and local Social Service Programs (e.g., General Assistance, Vocational Rehabilitation).
- Local, State, and Federal Public Health programs.
- Local and Federal funds for Substance Abuse/Mental Health Treatment Services.
- Other Ryan White HIV/AIDS Program Funding (Parts B, C, D and F).

II. Ch 7. Collaborative Planning Processes

Ryan White Comprehensive Plan

HAB has required Ryan White Part B grantees to submit an updated Comprehensive Plan every three years. The purpose of this multi-year plan is to assist grantees in the development of a comprehensive and responsive system of care that addresses service delivery gaps and resource needs. The Comprehensive Plan is a living document that serves as a roadmap for the grantee and should be continually updated as needed. The comprehensive plan should also reflect input from area stakeholders on how best to plan, prioritize, and deliver HIV/AIDS services, particularly in the light of available Federal, State, and local resources. The Comprehensive Plan must be compatible with existing plans including the Statewide Coordinated Statement of Need (SCSN) and the CDC required HIV Prevention Comprehensive Plan.

In addition, Ryan White grantees must discuss how their comprehensive plan will address the goals of the National HIV/AIDS Strategy, as well as identify the specific goals being addressed, including:

1. Reducing new HIV infections.
2. Increasing access to care and improving health outcomes for PLWH.

The Comprehensive Plan should also discuss how the Healthy People 2020 objectives will be addressed.

**Statewide Coordinated Statement of Need**

The Statewide Coordinated Statement of Need (SCSN) is a collaborative process and must be developed with input from all Ryan White HIV/AIDS Programs Parts. The Ryan White Part B grantee is responsible for periodically convening a meeting for the purpose of developing a SCSN. The mechanism for developing a SCSN may be a statewide meeting or some other input process. All Ryan White Parts are equally responsible for the development of the process, participation in the process, and the development and approval of a SCSN. The Early Identification of Individuals living with HIV/AIDS (EIHA) is a legislative requirement that focuses on individuals who are unaware of their HIV status, how best to bring HIV positive individuals into care, and how to refer HIV negative individuals into services that are going to keep them HIV negative. An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status.

**II. Ch 8. References, Links, and Resources**

**For More Information**

Department of Health and Human Services: [http://www.aids.gov](http://www.aids.gov)

Kaiser Family Foundation: [http://www.kff.org](http://www.kff.org)
Section III. AIDS Drug Assistance Program

III. Ch 1. Overview

A. Introduction

AIDS Drug Assistance Programs (ADAPs) are authorized under Ryan White Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111–87) which provides grants to States and U.S. Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Ryan White Part B grants include a base grant; the ADAP award; ADAP Supplemental Drug Treatment Program funds; and supplemental grants to States with “emerging communities,” defined as jurisdictions reporting between 500 and 999 cumulative AIDS cases over the most recent 5 years.

Congress designates, or “earmarks,” a portion of the Ryan White HIV/AIDS Program Ryan White Part B appropriation for ADAP. This distinction is important, because other Ryan White Part B resource allocation decisions are made locally. Five percent of the total earmark, however, is reserved for supplemental grants to States and Territories that have demonstrated severe need that prevents them from providing medications consistent with Public Health Service guidelines.

A formula based on the number of reported living HIV/AIDS cases in the State or Territory in the most recent calendar year is used to award ADAP funds. Before the 2006 reauthorization, the estimated number of living cases of AIDS was used in determining the formula, and 3 percent was reserved for supplemental grants.

All States and territories are eligible for ADAP. These include all 50 States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the five U.S. Pacific Territories or Associated Jurisdictions. Each funded State or territory is responsible for:

- Establishing ADAP eligibility.
- Determining the type, amount, duration and scope of services.
- Developing a list of covered drugs on its formulary.
- Covering each class of drug on its formulary.
- Administering the program.

Grantees are State departments of health or other State entities that implement and manage State public health programs. Grantees establish their own ADAP eligibility criteria, but all grantees are required to implement an ADAP recertification process at least every 6 months to ensure that only eligible clients are served.

The ADAP in each State and Territory is unique in that it decides which medications will be included in its formulary and how those medications will be distributed. However, current legislation requires that each grantee must cover all classes of approved HIV antiretrovirals on their ADAP formulary.

ADAPs provide life-saving HIV treatments to low income, uninsured, and
underinsured individuals living with HIV/AIDS. In addition, some ADAPs provide insurance continuation and Medicare Part D and Medicaid wrap-around services to eligible individuals.

**B. History of AIDS Drug Assistance Programs**

ADAP started as a HRSA demonstration project to provide zidovudine (AZT), the first drug approved by the Food and Drug Administration (FDA) to treat HIV disease, to low-income PLWA. The annual cost of this drug—about $10,000 per year per person—placed it out of reach for many people. Congress responded by approving $30 million in funding under a public health emergency provision, and later enacted Public Law 100-71 authorizing the establishment of an ADAP program nationwide.

As HIV treatment advances occurred and as resources permitted, States expanded their programs to cover drugs in addition to AZT. States added therapeutics beneficial in the treatment of many of the opportunistic infections that occur in PLWH. When ADAP became part of the newly enacted CARE Act, States had the option to cover any FDA-approved drug that treats HIV disease or prevents the deterioration of health due to HIV.

ADAPs have expanded considerably since 1991 (when Congress first appropriated funds for CARE Act programs), both in terms of numbers of enrolled clients and in program resources. As a result of the dramatic increase in the cost of pharmaceutical treatment and the growing number of PLWHA, the ADAP earmark is now the largest portion of Ryan White Part B spending.

Total ADAP spending is even higher than the ADAP earmark, however, because State ADAPs also receive money from their respective States, from other Ryan White HIV/AIDS Program components, and through cost-saving strategies. Many clients are enrolled in ADAP temporarily while they await acceptance into other insurance programs, such as Medicaid.

Since 2010 when the Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) was signed into law, ADAPs have been working to implement and preparing for areas of the law that directly impact them. Portions of health reform that may impact ADAPs include:

- Medicaid eligibility expansion in 2014 and the expansion of the CMS Section 1115 Waiver.
- Increase in the number of individuals covered by private insurance plans through health marketplaces in 2014.
- ADAPs’ Medicare Part D expenditures counting toward True Out Of Pocket (TrOOP) expenditures.
- 340B pricing transparency.

III. Ch 2. 340B Drug Pricing Program

A. Introduction

Purpose

Ryan White Program Ryan White Part B/AIDS Drug Assistance (ADAP) grantees are required to use every means at their disposal to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds. The 340B Drug Pricing Program permits Ryan White Programs (Parts A, B, C, and D) to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

States and U.S. Territories eligible for ADAP under Ryan White Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111–87) include all 50 States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and the five U.S. Pacific Territories or Associated Jurisdictions. ADAPs are “covered entities” certified by HHS as eligible to receive access to reduced price prescription drugs through the 340B Drug Pricing Program. (See Ryan White HIV/AIDS Program Ryan White Part B Manual: Section III. AIDS Drug Assistance Program for additional information.)

Legislation

The 340B Drug Pricing Program was created through the Veterans Health Care Act (VHCA) of 1992 and codified as Section 340B of the Public Health Service Act. The VHCA extends discount pricing to specific Public Health Service (PHS) grantees, including State ADAPs, to access the same discounts as Medicaid programs. In addition, the 340B Program exempts entities that take advantage of these discounts, called “eligible entities,” from inclusion in the BP calculation. In essence, manufacturers were required to offer Medicaid discounts to certain federally funded programs outside Medicaid; however, the discounts would not cause a reduction in the BP and therefore would not trigger larger discounts to Medicaid programs.

The 340B Drug Pricing Program was developed in response to unintended consequences stemming from the Medicaid Drug Rebate program that began in 1990. Under that program, drug manufacturers were required to enter into a rebate agreement with HHS to provide drugs to State Medicaid programs.

Under the 340B Drug Pricing Program, drug manufacturers that participate in the Medicaid Drug Rebate program must also provide a reduced 340B price for covered outpatient drugs to select safety net providers that choose to participate in the program. The 340B discount is the same discount that manufacturers are required to provide to State Medicaid agencies.

Since 2010 when the Patient Protection and Affordable Care Act (PPACA) (Public Law 111–148) was signed into law, ADAPs have been working to implement and preparing for areas of the law that directly impact them. Portions of health reform that impact ADAPs and the 340B Drug Pricing Program include:
- Medicaid eligibility expansion in 2014 and the expansion of the CMS Section 1115 Waiver.
- Increase in the number of individuals covered by insurance plans, including health exchanges in 2014, and the current PCIPs.
- ADAPs’ Medicare Part D expenditures counting toward True Out Of Pocket expenditures.
- Narrowing and closing of the Medicare Part D “doughnut hole.”
- An increase in the Medicaid rebate amount for purchased drugs.
- 340B pricing transparency.
- Annual recertification for all entities.
- New guidance on the definition of a 340B patient

For additional information on insurance coordination, see Ryan White HIV/AIDS Program Ryan White Part B Manual: Section III. AIDS Drug Assistance Program and Section IX. Insurance Programs.

B. Office of Pharmacy Affairs and Its Programs

Office of Pharmacy Affairs

The Office of Pharmacy Affairs (OPA) has three primary functions: 1) administer the 340B program, 2) develop innovative pharmacy delivery models and provide technical assistance, and 3) act as a Federal resource for pharmacy issues.

In all of its activities, OPA emphasizes the importance of comprehensive pharmacy services being an integral part of primary health care. The 340B Drug Pricing Program helps eligible safety net organizations ensure medication access, a key component of clinical pharmacy services and the continuum of care. Comprehensive pharmacy services include patient access to affordable pharmaceuticals, application of “best practices” and efficient pharmacy management, and the application of systems that improve patient outcomes through safe and effective medication use.

OPA funds the Pharmacy Services Support Center (PSSC) to provide free technical assistance for the 340B Drug Pricing Program. Additional discounts on some products are negotiated through 340B’s Prime Vendor Program (PVP) which leverages public health entities’ collective purchasing power to negotiate sub-340B discounts.

Pharmacy Services Support Center

PSSC is a resource established by HRSA through a contract to help 340B entities optimize the use of the program. The Pharmacy Services Support Center (PSSC) assists health centers and other eligible entities in enrolling and using the program. PSSC’s mission is to provide information, education, and policy analysis to help eligible entities optimize the value of the 340B program and provide clinically and cost effective pharmacy services that improve medication use and advance patient care.
340B Prime Vendor Program

As part of the original 340B legislation, the government was required to establish a 340B Prime Vendor Program (PVP). The 340B PVP is managed by Apexus through a contract awarded by the OPA. As the contractor to the 340B Prime Vendor, Apexus is responsible for negotiating pharmaceutical pricing below the 340B price as well as improving access to affordable medications by establishing a distribution network for pharmaceuticals to covered entities.

If ADAPs choose to use the 340B program, they may purchase drugs from manufacturers either through the direct purchase option, receiving the 340B price up front, or through the 340B rebate option, paying full price and receiving a rebate later. A covered entity does not have to join the PVP in order to participate in the 340B program and may negotiate sub-ceiling discounts on its own through direct purchase. However, because the PVP can negotiate prices on behalf of a large number of 340B purchasers, it has been able to negotiate favorable prices and develop a national distribution system that may not be possible for some covered entities to obtain individually.

The Prime Vendor Program serves participants in three primary roles:

1. Negotiates sub-ceiling 340B pricing on branded and generic pharmaceuticals.
2. Establishes distribution solutions and networks that improve access to affordable medications.
3. Provides other value-added pharmacy related products and services to its participants.

The PVP enables hospitals, community health centers, clinics and other safety net providers to purchase outpatient pharmaceuticals at discounted pricing, thereby expanding access to care to low-income and vulnerable segments of the population. The program is a free Federal benefit to all eligible entities and requires registration with Apexus to have access to the sub-ceiling pricing.


III. Ch 3. References, Links, and Resources

3. HRSA: Eligibility and Registration: http://www.hrsa.gov/opa/eligibilityandregistration/
4. HRSA Office of Pharmacy Affairs: http://opanet.hrsa.gov/OPA/


Section IV: National HIV/AIDS Strategy and Ryan White Legislation

IV. Ch 1. Overview
On July 13, 2010 the White House released the National HIV/AIDS Strategy (NHAS) for the United States, with an accompanying Federal Implementation Plan. The vision of the NHAS calls for the United States to “become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance will have unfettered access to high-quality, life extending care, free from stigma and discrimination.” The NHAS is the nation’s first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015.

Background

HHS, along with five other “lead Federal agencies” (i.e., the Departments of Justice, Labor, Housing and Urban Development, and Veterans Affairs, and the Social Security Administration), were called upon to develop and submit operational plans to the Office of National AIDS Policy (ONAP) and the Office of Management and Budget (OMB) “within 150 days” of the Strategy’s release date and the issuance of a Presidential Memorandum for the heads of Executive departments and agencies. The Memorandum directed that the operational plans include “appropriate actions to advance the Strategy,” as well as “steps to strengthen coordination in planning, budgeting for, and evaluating domestic HIV/AIDS programs within and across agencies.”

1. Reduce new HIV infections.
   - Lower the annual number of new infections by 25%.
   - Reduce HIV transmission by 30%.
   - Increase the percentage of people living with HIV who know their serostatus from 79% to 90%.

2. Increase access to care and improve health outcomes for people living with HIV.
   - Increase the proportion of newly diagnosed patients linked to clinical care from 65% to 85%.
   - Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%.
   - Increase the number of Ryan White clients with permanent housing from 82% to 86%.

3. Reduce HIV-related health disparities.
   - Improve access to prevention and care services for all Americans.
- Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%.
- Increase the proportion of HIV-diagnosed Blacks with undetectable viral load by 20%.
- Increase the proportion of HIV-diagnosed Latinos with undetectable viral load by 20%.

**IV. Ch 2. Goals for the National HIV/AIDS Strategy**

The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for PLWH to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against PLWH. By 2015, the NHAS goals and outcomes will achieve the following:

**IV. Ch 3. NHAS and Ryan White Part B Program**

To the extent possible, Ryan White Program activities should strive to support the three primary goals of the NHAS. To ensure success, the NHAS requires the Federal Government and State, tribal and local governments to increase collaboration, efficiency, and innovation.

HAB recognizes that States/Territories have used Ryan White Part B grant funds to develop and/or expand systems of care to meet the needs of PLWHA. This includes HAB and grantee efforts to estimate and assess Unmet Need and the number of individuals who are unaware of their HIV/AIDS status and to ensure that essential core medical services have been adequately addressed when setting priorities and allocating funds. At the same time, the CDC has ongoing initiatives that may identify significant new numbers of PLWHA that will be seeking services. This requires ongoing assessment of how States/Territories will ensure access to primary care and medications as well as the provision of critical support services necessary to maintain individuals in systems of care.

The NHAS also calls for improved Federal coordination of HIV/AIDS programs, as evidenced by streamlining and standardizing data collection and reducing reporting requirements for grantees. In 2012, the Office of HIV/AIDS and Infectious Disease Policy in HHS worked with a group of Federal agencies, national partners and grantees to identify indicators, data systems, and elements used across HHS programs to monitor HIV prevention, treatment, care services. A set of common indicators is being catalogued within 7 domains: 1) HIV testing, 2) Late HIV diagnosis, 3) Initial linkage to HIV medical care, 4) Retention/engagement in HIV medical care, 5) ARV Therapy, 6) Viral Load suppression, and 7) Housing Status. A subset of these indicators are included in the Ryan White HIV/AIDS Program Services Report (RSR) that grantees and
service providers report to HRSA on an annual basis, and thus HRSA/HAB will be positioned to calculate and report on most indicators.

IV. Ch 4. References, Links, and Resources


For More Information

Please refer to http://aids.gov.
Section V: Data and Reporting Requirements

V. Ch 1. Overview

Introduction
All grantees receiving Federal funds are required to report fiscal and program information to the agency designated to administer the particular grant program. For Ryan White HIV/AIDS Program Ryan White Part B grantees, that agency is the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

In general, reports are required for one or more of the following reasons:

- To assure grantee compliance with requirements mandated by Congress on the use of Ryan White Part B funds. Such requirements are called Conditions of Award because they set criteria or limits on how grant funds may be used.
- To monitor the fiscal and programmatic integrity of the grant program, as required by the HHS Grants Policy Statement. For example, recipients of grants administered by HRSA usually must submit a revised program budget after receiving their notice of grant award, along with a narrative justification. Similarly, grantees are required to submit information about subcontracts. Examples of this type of report include the Ryan White Part B Consolidated List of Contractors report and the Contract Review Certification.
- To monitor program accomplishments, prepare HRSA reports on program trends, and respond to information requests from Congress, OMB, the media, and the public at large. As the agency responsible for the fiscal and program integrity of Ryan White Part B programs, HRSA must be able to monitor and report on the grantees’ fiscal status, services provided, clients served, program accomplishments, and technical assistance needs. HRSA also relies on information routinely reported by grantees to respond to inquiries from various parties such as the Congress.

Legislative Background
Grantees must provide progress and data reports in accordance with applicable provisions of the general regulations 45 CFR Part 92, Sub-part C, “Monitoring and Reporting Program Performance” and provisions of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).

Submission of progress reports is one of the Conditions of Award for Ryan White Part B grantees. Failure to comply with any of the Conditions of Award by the specified due date may result in suspension of a grantee’s ability to drawdown funds and/or the disallowance of funds.

Submitting Reports
In an effort to increase the efficiency and effectiveness of its management of grantee records, HRSA has developed an electronic record keeping system. The HRSA Electronic Handbook (EHB) system provides a one-stop Grants Management Online tool for Project Officers as well grantees. The EHB makes accessible online Funding Opportunities Announcements, Grant applications, Notices of Award (NoA), Non-competing continuation applications, progress
reports and other types of post-award reports and requests. EHB allows grantees and project officers to view award history, view past NoAs, monitor report activity as well as deadlines, and access reports such as the ADAP Quarterly/Data report and the Ryan White Program Services Reports.

Any information and data required from the grantee, such as applications, drawdown restriction requests, reports, waivers, must be submitted using the format provided by HRSA, as outlined in the Electronic Handbook. The HRSA EHB reporting formats help to assure that correct information is reported across all Ryan White HIV/AIDS program grantees. This in turn allows HRSA to track and report national program trends, identify technical assistance needs, and prepare aggregate summary reports to Congress, grantees, and the public at large.

In order to access its grant portfolio (grants the grantee can access) a grantee must register in the EHB. Before registering it is advisable that the grantee access the system information which provides the system Internet and software requirements for access.

The Project Director of the grant (listed on the NoA) and the Authorizing Official of the grantee organization are required to register within HRSA’s EHBs. The registration portal must be accessed and the following instructions followed:

1. Create a User Account (6-20 characters).
2. Password (8 characters—case sensitive).
3. Subordinate the account to the Organizations—use the 10 digit grant number to search for the organization and add the Project Director’s name and title to the organization even if the online address of the organization is incorrect.
4. Project Director’s identity is verified against NoA issue date and 18 characters CRSEIN.
5. Once the first one or two users have privileges with the system the Project Director has to approve other users.
6. Grantees having problems accessing the EHB or the Web data entry system, please contact the HRSA Call Center at:

   **Toll-Free Help Line:** 1-877-464-4772  
   **Hours:** Monday - Friday 9AM - 5:30PM EST  
   **E-mail:** CallCenter@HRSA.gov

**Data Submission EHB**

1. To submit data the registered user must:
   a. Login to the EHBs.
   b. Click “Open Grant Handbook.”
   c. Select “View Portfolio.”
   d. Select from the list of tasks (e.g., Here to work on non-financial grant reporting)
   e. Click request permission from the Project Director.
   f. Select from the grant list that appears for your organization the grant by number that you wish to access.
Reporting Deadlines

In establishing the deadline for a report, HRSA/HAB takes into consideration the:

- Purpose of the report.
- Grant program’s fiscal year.
- Application/award process and schedule.
- Any mandated timeframes for reporting specific information to the Congress or OMB.
- Program monitoring and reporting standards set by PHS Grants Management Policy.
- Feedback from grantees on reporting issues specific to the program.

For the precise date, refer to the Condition of Award and/or EHB dateline instructions issued each year by HRSA/HAB through the Notice of Grant Award. To meet the deadline, the information must be in the EHB by close of business (5:00 p.m. EST) on the due date. Grantees are expected to comply with all reporting deadlines. Once the dateline expires the EHB will close submission access and the grantee must request the Project Officer or Grants Manager to open the file. If late reports persist it may result in a special Condition of Award.

To use the system access https://grants.hrsa.gov/webexternal/login.asp and additional help is available online and/or from the HRSA Call center at 877-Go4-HRSA/877-464-4772. Time: 9:00 a.m. to 5:30 p.m. EST, Monday through Friday. Email: CallCenter@HRSA.GOV

V. Ch 2. Program and Fiscal Reports

A. Introduction

Grantees are required as a Condition of Award to provide certain program budget and fiscal reports. HRSA requirements for submitting Ryan White Part B, program and fiscal reports are guided by grants policies established by HHS, Public Health Service (PHS), and Office of Management and Budget (OMB) Circulars.

B. Overview of HRSA/HAB Reports

Below is a description of these reports, their purpose, and a chart of reporting deadlines for each.

ADAP Quarterly Report (starting with the period ending 7/29 of each year—first quarter)
Grantees are required to submit an ADAP Quarterly Report for each three month reporting period within the grant year. The report provides HRSA with aggregate data on the grantees direct medication program. Collection of data for a new report the ADAP Data Report (ADR) will begin in October of 2012. Grantees will continue to collect the AQR data until HRSA retires the report which will be sometime in 2013.

ADAP Data Report (ADR) (two six month periods starting April 1 of each year)
To address the limitation provided by the aggregate data collected in the ADAP Quarterly Report HRSA is requiring the grantees to collect client base data for its ADAP programs starting
Currently HAB requires that all ADAP’s report quarterly aggregate (AQR). Aggregate data limits HAB’s ability to respond to inquiries from Congress and other stakeholders regarding the ADAP program. To correct this limitation HAB requested ADAP programs collect client-level data starting October 1, 2012. This will provide HAB with a demographic profile of the clients served, with enough service and expense data to evaluate the impact of the program nationwide, and with information about the services being use and its cost effectiveness.

For more information about the ADAP Data Report (ADR) download the ADAP DATA Report Instructional Manual from HAB’s target center (http://www.careacttarget.org). The report is to be submitted in the EHB manual.

**Grantee Program Terms Report**
The Program Terms Report is to be submitted via the HRSA EHBs, consistent with reporting guidelines, instructions, and reporting template provided separately. The report must include the following items:

a. *The Ryan White Part B and MAI Planned Allocation* is a projection of the current grant year funding priorities. The report is a table that indicates in the categories and priority areas (core and support service categories) established by the Grantee for the current grant year and the funding (dollar amount).

b. *The revised SF-424 budget and narrative justification* for the current grant year. This report is a revision of the planned Ryan White Part B budget submitted by the grantee with the grant application, before Congress has appropriated funds for the Ryan White Part B program that fiscal year. The actual grant amount awarded to each State depends upon the appropriation level each year. Therefore, it is necessary for grantees to revise their planned budget to reflect the actual amount of funds awarded and the program priorities established by the planning body for that fiscal year.

c. *Implementation Plan* that reflects access to a comprehensive continuum of HIV/AIDS care. It must include each service category and amounts for all Ryan White Part B funding sources to include Ryan White Part B Formula funding, ADAP, Minority AIDS Initiative, ADAP Supplemental (if applicable, and Emerging Communities, if applicable, that will be allocated for each service category in the current grant year). All priorities and core and support services provided in this plan must be consistent with the Ryan White Part B and MAI planned allocations report.

d. *The Ryan White Part B: Consolidated List of Contracts (CLC)* identifies each Ryan White Part B funded contract provider, the contract amount, and the service/activity to be provided under that contract. This summary information helps HRSA monitor and track the use of grant funds for compliance with program and grants policies and requirements.

e. *Consolidated Review Certification*. Grantees are required to certify for HRSA all direct service contracts, Ryan White Part B and MAI.

**Progress Reports (Mid-Year and Final)**
The grantee is to report the Ryan White Part B program accomplishments and challenges in meeting established goals and objectives twice during the grant year. The Mid-Year Progress
Report covers the period of April 1 to September 30. The Final Progress Report covers the grant year April 1 to March 31.

**Mid-Year Progress Report**

The Mid-Year Progress Report chronicles accomplishments, challenges or resolution of previously reported challenges for the first six months of the grant year (April 1 to September 31). In the report the grantee must:

- Document progress made in reaching the service goals in all funded program areas using the most recent Ryan White Part B Implementation Plan. This includes services funded under Base, ADAP Earmark, MAI, ADAP Supplemental, and Emerging Community (EC).
- Provide an update on the Early Identification of Individuals with HIV/AIDS (EIIHA) projections (e.g., number individual test as of the need of the reporting period).
- Provide a brief update in narrative form on the services added or deleted; new access points; contract monitoring activities; involvement in addressing the Deficit Reduction Act (DRA) mandate and accomplishments that were not covered under the Implementation plan.
- Compare by funding category (Ryan White Part B, ADAP Earmark; Supplemental; Emerging Communities; MAI) expenditures for the six month reporting period with the total amount allocated.
- Identify challenges experienced in the six month reporting period and technical assistance needs.

The Mid-Year and Final Progress Reports, with all items listed above must be submitted through the HRSA Electronic Handbook on or before the dateline.

**Final Progress Report**

The Final Progress Report chronicles accomplishments and challenges for the twelve-month grant year (April 1 to March 31). As in the Mid-Year Progress Report the grantee must update the Ryan White Part B Implementation Plan, the EIIHA projections, and the narrative report. In addition the Final Progress Report must:

- Update the Match report provided with the application by including not only the dollar amount but describing the activities that were supported with the matching funds.
- Document and certify the actual aggregate administrative expenditures of subgrantees/contractors.
- Document the evaluation activities performed to measure the impact of Ryan White Part B funds in meeting emerging needs: ensuring access to care, coordinating with other health-care delivery systems, and evaluating the impact of Ryan White Program funds.
- Provide information in the Clinical Quality Management activities.
- Submit the annual WICY report (refer to the instructions and template sent annually by HAB.
- Describe any specific HRSA sponsored technical assistance activity received during the year.
Maintenance of Effort Report
Requirements are described in this manual in the Grants Administration section.

MAI Annual Report
The MAI Annual Report is a table and a narrative that documents the use of Ryan White Part B MAI funds during the grant year. The report is submitted to HRSA through the EHB. Guidelines and instructions for submission of the table and narrative are provided in the EHB and through the HRSA HAB Project Officer.

Ryan White Part B and MAI Final Expenditure Table
The table must be submitted using the format provided in the EHBs.

Interim Federal Financial Report (FFR)
Using form SF-425, the grantee is to report for the current budget period the amount of Ryan White Part B funds that have been obligated (contracted) and made available for expenditure by August 1. The grantee is required to substantiate that 75% of the funds were obligated and can be used for the provision of services.

Final Federal Financial Report
Using form SF-425 provided in the EHB the grantee is to report the cumulative expenses within the project period. The final FFR must not include un-liquidated obligations and must agree with the Payment Management System report of disbursements and advances for the budget period being reported and identified by the document number.

The FFR will not be accepted unless the grantee completes the required attachment providing a breakout of the awarded amounts, any approved carryover, and the respective expenditures for each of the following:

- Base
- Emerging Communities
- ADAP
- MAI
- Carryover amount from the prior year

The report must also include State Matching Funds in the “remarks” section the ADAP Earmark funds. The Earmark funds report must include the Outlays, Un-liquidated Obligations, Total Federal Share and Unobligated Balance. The HAB Policy Notice 12-02 specifies that UOB provisions do not apply to funds from drug rebates under Ryan White Part B. Rebate funds should never be recorded as an unobligated balance on any FFR. Rebate funds should be tracked and the total amount reported in the FFR under line 12 “Remarks,” with attachments as necessary. If the State is indicating that the UOB is a result of the drug rebate funds and therefore the UOB penalty does not apply, that must be indicated in the “Remarks.”

If the grantee has an unobligated balance, they must:
- Upload the carryover request within the EHBs Prior Approval module.
• Indicate in their FFR their intent to submit a carryover request separately and submit the request via the Prior Approval Module within 30 days of the FFR submission.  
• Indicate on the FFR their intention to not submit any carryover request.

See: HAB Policy Notice 12-02:  

### Unobligated Balance Estimate

January 31: Grantee submits current grant year waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.

### Ryan White HIV/AIDS Program Services Data Report (RSR)

This report is addressed in more detail later in Chapter 3.

### C. Reporting Deadlines—Chart

<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAP Quarterly Report</td>
<td>7/29-10/31-1/31-4/30</td>
</tr>
<tr>
<td>ADAP Data Report (ADR)</td>
<td>Replaces ADAP quarterly report on April 1, 2013 due dates pending</td>
</tr>
<tr>
<td>Grantee Program Terms Report</td>
<td>90 days of Award Issue Date</td>
</tr>
<tr>
<td>Every Mid-Year Progress Report</td>
<td>October</td>
</tr>
<tr>
<td>Final Progress Report</td>
<td>August</td>
</tr>
<tr>
<td>Maintenance of Effort Report</td>
<td>90 days of Award Issue Date</td>
</tr>
<tr>
<td>MAI Annual Report</td>
<td>August</td>
</tr>
<tr>
<td>Ryan White Part B and MAI Final</td>
<td>August</td>
</tr>
<tr>
<td>Expenditure Table</td>
<td></td>
</tr>
<tr>
<td>Interim Federal Financial Report</td>
<td>August</td>
</tr>
<tr>
<td>Final Financial Report (FSR on SF 269)</td>
<td>150 days after the end of the fiscal grant year</td>
</tr>
<tr>
<td>Unobligated Balance Estimate</td>
<td>60 days before end of each grant year</td>
</tr>
<tr>
<td>Ryan White Part B MAI Annual Plan</td>
<td>October</td>
</tr>
</tbody>
</table>

Table 1: Reporting Deadlines—Chart

### D. Budget and Budget Narrative Guidelines

A categorical one-year Final Program Budget must be submitted for each Ryan White Part B award of the NoA. It must be based on priorities established by the grantee in the comprehensive plan and SCSN and reflect the amount of Ryan White Part B funds awarded to the State for that
fiscal year (FY) only, and be prepared using applicable Cost Principles and HAB program policies.

There are two components in a Final Program Budget:

**Standard Form (SF) 424-A.** Budget Information—Non-construction Programs. This form must be revised and resubmitted with the Final Ryan White Part B Program Budget to reflect budget allocations based on the actual amount of funds awarded to the State with respect to the following four major program budget categories:

1. **Administration:** This column should include all funds allocated to the following grant activities: grantee administration, planning and evaluation, and clinical quality management.
2. **ADAP:** This column should include all funds allocated to the following grant activities: ADAP.
3. **Consortia:** This column should include all funds allocated to consortia and emerging communities.
4. **Direct Services:** This column should include all funds allocated to the following grant activities: state direct services, home and community-based care, MAI, and health insurance continuation.

**Budget Justification.** A categorical budget and narrative justification is required for the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant must submit one-year budgets for each of the subsequent budget periods within the requested project period.

The budget narrative is the descriptive information used to explain and justify the amounts budgeted within each program budget category. It must include specific information—the “who, what, where, when, and why.” All costs identified in Section B of SF 424-A of the budget must be described and justified, including those listed in the “other” category.

**Instructions for Preparing SF 424-A and Narrative Justification**

This information supplements instructions that accompany the SF 424-A: Budget Information—Non-construction Programs. It provides guidance on preparing the categorical budget and narrative justification for each program budget category, and guidance on the types of cost (called “Object Class Categories”) within each budget category.

**SF 424-A:** This form has two sections, which must be completed for a one-year budget period.

a. Section A is used to report summary budget information.

b. Section B is used to provide a detailed breakdown of budget costs in “Object Class Categories” for each program budget category. Allowable costs and how those costs may be allocated by States and local governments receiving PHS grants is set forth in 45 CFR Part 92. Cost principles prescribed for grant recipients are contained in OMB Circular A-87 for State and local governments.
c. Because there are five major program budget categories, grantees will need to complete two pages of the SF 424-A. Page one should be used to report the amounts budgeted for Grantee Administration, Clinical Quality Management, ADAP, and Planning and Evaluation activities in the four columns listed in Section B. Page two should be used to report in Section B the amounts budgeted for consortia, home- and community-based care, health insurance continuity, ADAP from Ryan White Part B Base, and State Direct Services that will be provided to clients and program budget totals in column 5.

**Guidance on Program Budget Categories**

A budget and narrative must be included for funds allocated to Grantee Administration, Quality Management, ADAP, and Planning and Evaluation, including a line-item breakout of the budget detailing the amount of funds budgeted for each item or activity within the category.

**a. Grantee Administrative Costs.** These are funds to be used by the grantee for routine grant administration and monitoring activities and cannot exceed 10 percent. Such activities include development of the Ryan White Part B application, receipt and disbursement of program funds, the development and establishment of reimbursement and accounting systems, preparation of routine programmatic and financial reports, and costs associated with assuring compliance with grant conditions and audit requirements. Reminder: Administrative and planning evaluation costs together cannot exceed 15 percent. (See Section VI. Grantee and Sub-Grantee Monitoring.)

**b. Planning and Evaluation Costs.** These costs may not exceed 10 percent of the grantee’s award. Reminder: Administrative and planning evaluation costs together cannot exceed 15 percent. (See Section VI. Grantee and Sub-Grantee Monitoring.)

**c. Grantee Clinical Quality Management Activities.** The grantee may allocate a portion of Ryan White Part B funds awarded to the State to support Clinical Quality Management programs that assist direct-service medical providers in assuring that funded services adhere to established HIV clinical practice standards and HHS Guidelines.

Clinical Quality Management programs must ensure that strategies for improvements to quality medical care include health-related supportive services and that available demographic, clinical, and health care utilization information is used to monitor HIV-related illnesses and trends in the local epidemic.

Grantees are allowed to allocate up to 5 percent of the total grant award or $3 million (whichever is less) for quality management activities.

**d. Service Costs.** Service costs are the proposed expenditures for services to be provided to clients need to be prioritized based upon the need established in the Comprehensive Plan and Statement of Need. The total amount to be awarded for services through sub-grants, contracts, sub-contracts and any memoranda of understanding or other agreements should be entered on line 6f of column 1 on page 2 of the SF 424-A. Further contract information is not needed with the Final Program Budget, but will be submitted later with the Consolidated List of Contractors and Contractor Budget Packages described in Subsections B and C of this chapter.
e. **ADAP.** Costs associated with the ADAP program.

**Ryan White Part B Funding Restrictions**

Ryan White Part B funds are subject to certain requirements, restrictions, and limitations as described in the FOA and NoA, and also based on the Ryan White legislative requirements. (See Section VI. Grantee and Sub-Grantee Monitoring.)

The key documents that specify conditions, restrictions, and requirements of entities receiving Federal grants include:

- The NoA sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant’s Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date.

- Administrative and National Policy Requirements: Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Sub-awards to Institutions of Higher HRSA Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

- HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at [http://www.hrsa.gov/grants/hhsgrantspolicy.pdf](http://www.hrsa.gov/grants/hhsgrantspolicy.pdf). The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

**V. Ch 3. Ryan White Services Report**

**Introduction**

All providers funded by Ryan White grantees, with the exception of ADAP programs, are required to submit a completed RSR annually. It is the responsibility of each grantee to collect one RSR from each of the providers with which it contracts to provide Ryan White services or program support. Ryan White Part B consortia also must submit one RSR for each of the providers with which they contract. ADAP programs will submit a different client-level report beginning in 2013 and will continue to submit a quarterly aggregated report until otherwise specified.

The purpose of the RSR is to collect information on all clients who receive at least one Ryan White eligible service during a calendar year. RSR client-level data provides information on the
number and characteristics of grantee, providers and the clients served, the types of services funded and provided, and the number of clients receiving each service.

All client-level data is collected via a unique encrypted unique identifier to ensure that all measures have been taken on the part of HAB to protect the data as well collect only the necessary variables required for the RSR report. The data collected is recognized by HAB as the property of the grantees and will not be shared among other grantees without permission.

Data reported in the RSR are used to broadly assess the impact and quality of Ryan White programs as grantees and their providers strive to serve the vulnerable and underserved populations most severely impacted by the HIV/AIDS epidemic. The Government Performance and Results Act (GPRA) requires all Federal programs to document progress towards specific measurable objectives. RSR data are used to demonstrate program effectiveness and quality under GPRA. RSR also provides comprehensive Ryan White program information to respond to public inquiries regarding the Ryan White HIV/AIDS Program funded service delivery and client demographics.

The following is a brief summary description of the RSR; instructions for completing the report can be found on the HRSA/HAB website.

**A. Description of the Ryan White Services Report**

The RSR replaces the former annual data report, the Ryan White Data Report (RDR). The RSR and instructions for completing the report can be found on the TARGET Center website: [https://careacttarget.org](https://careacttarget.org). Unlike the RDR, which collected and reported aggregated data from all Parts, the RSR is a client-based report. The RSR is includes three main phases that include the completion and reporting of:

- Grantee Report
- Provider Report
- Client Report

Each section is to be answered by the appropriate Part, grantee and provider. Not all sections require a response; some sections are specific to the funded services. Entities completing the RSR should carefully review their roles and responsibilities for reporting.

**B. Grantee and Provider Responsibilities**

**Grantee Responsibilities**

**Regarding Data Reporting**
Title 45 CFR 92.40, monitoring and reporting program performance; monitoring by grantees:

*Grantees are responsible for managing the day-to-day operations of grant and sub-grant supported activities. Grantees must monitor grant and sub-grant supported activities to assure*
compliance with applicable Federal requirements, and that performance goals are being achieved. Grantee monitoring must cover each program, function, or activity.

Title 45 CFR 74.51, monitoring and reporting program performance:

Recipients are responsible for managing and monitoring each project, program, sub-award, function or activity supported by the award. Recipients shall monitor sub-awards to ensure that sub-recipients have met the audit requirements as set forth in §74.26.

All Ryan White grantees are responsible for training their service providers and any other reporting entities on collecting and reporting data for the annual RSR. Grantees are also responsible for:

- Ensuring that contract providers annually complete the RSR.
- Reviewing their providers’ reports to ensure accuracy prior to submitting them to HAB.
- Submitting completed RSRs to HAB by the HRSA deadline provided.
- Cooperating in the verification of their data following submission.

C. Provider Responsibilities

All providers must complete a Provider Report and, if it provides core medical or support services, upload client-level data.

A grantee-provider is a service provider that also is a grantee. They must complete a Grantee Report and a Provider Report. If the grantee-provider offers core medical or support services must also submit a Client Report.

All service providers funded by Ryan White grantees are responsible for:

- Establishing and maintaining a client-level data collection system that permits the compilation of all data needed to complete the RSR.
- Collecting complete data from all subcontractors.
- Submitting a completed RSR to their grantee of record by a locally established due date to permit review by the grantee.

D. RSR Data Submission Process

The RSR eliminates Parts-specific reporting. Therefore, service providers should complete one annual report that includes all Ryan White services provided and all clients served during the calendar year, regardless of which Part funded the services. The provider then submits a copy of the completed report to its grantee(s) of record. The grantee of record then submits the same report to the HAB data contractor.

The RSR is to be submitted electronically to HAB’s data contractor. The web-based system includes built-in validations and warnings to assure that the data will be internally consistent.

E. RSR Training and Technical Assistance
HAB designated division(s) and subcontractors are responsible for training Ryan White grantees on the implementation and use of the RSR, and in turn, grantees are responsible for training their service providers. HAB makes available the RSR and detailed instructions; these are available on the HAB website.

HAB also provides the software package CAREWare (for free) for use in collecting and reporting client-level data necessary for completion of the RSR. Use of CAREWare is not required. However, grantees and service providers can use CAREWare to generate their annual report for submission to HAB. HAB staff are responsible for offering CAREWare training on an as-needed basis.

HAB also provides the following training and technical assistance:

- A data-related technical assistance found at the Target Center website.
- A telephone helpline for assistance with completing the annual report.
- A CAREWare telephone helpline for assistance in implementing the use of CAREWare at a grantee or service provider’s site.
- Upon request, on-site data-related technical assistance from HAB’s data contractor.

V. Ch 4. AIDS Drug Assistance Program Data Report

A. Description of the ADR Report

The ADR is a HAB required data report for all ADAPs and a condition of the Ryan White Part B grant award. The ADR is comprised of two following components that are expected to be completed by ADAPs:

- Grantee Report
- Client Report (client-level data)

The purpose of the ADR is to assist HAB with evaluating the impact of the ADAP program on a national scale by describing the demographics of the individuals who access the program, by identifying the services funded and utilized, and quantifying all costs associated with these services.

ADAP programs currently provide to HAB, on a quarterly basis, aggregated data collected and submitted through the ADAP Quarterly Report (AQR). The aggregated data reported in the AQR report limits the ability for HAB to properly evaluate the quality of the ADAP program therefore the ADR has been designed to capture more specific information regarding the ADAP programs. The AQR will continue to be utilized on a quarterly basis until the ADR is fully matured and will then be retired.

The ADR will begin to collect data beginning with the first reporting period of October 2012 and will be submitted beginning in 2013. The ADR will have two reporting periods: April 1 to September 30 and October 1 to March 31 and the due dates are the 3rd Monday in June (includes the Grantee Programmatic Summary; Annual Submission and client-level data file) and the 3rd...
Monday in December (includes the second Programmatic Summary and the second client-level data file). All client-level reports must be submitted as an .xml file to HAB.

**B. Grantee Responsibilities**

The ADR is a requirement of the Ryan White Part B conditions of award, therefore all Ryan White Part B grantees of record are required to submit both components of the ADR to HAB twice a year.

**V. Ch 5. Data Support and Technical Assistance Links and Resources**

<table>
<thead>
<tr>
<th>Report</th>
<th>Report Content or Submission Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan White HIV/AIDS Program Services Report</td>
<td>Questions related to program guidance, such as funding or grant-related questions, should be addressed to the officer appropriate to your project(s). If you are unable to get in touch with your project officer or need immediate assistance, contact WRMA/CSR Data Support at</td>
</tr>
</tbody>
</table>
| ADAP Data Report                      | Toll-free Help Line: 1-888-640-9356  
**Hours:** Monday–Friday 9AM–5:30PM EST  
**E-mail:** [Ryan White Data Support](mailto:info@hivhaweb.org)  
**Learn More Online:** [RSR Home Page](http://www.rsrprogram.org) |
<table>
<thead>
<tr>
<th>Report</th>
<th>Report Content or Submission Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ADAP Quarterly Report</td>
<td>For questions pertaining to the RDR report itself or questions about submitting your report, contact WRMA/CSR Data Support at:</td>
</tr>
<tr>
<td></td>
<td><strong>Toll-Free Help Line:</strong> 1-888-640-9356</td>
</tr>
<tr>
<td></td>
<td><strong>Hours:</strong> Monday–Friday 9AM–5:30PM EST</td>
</tr>
<tr>
<td>Part A MAI Report</td>
<td><strong>E-mail:</strong> Ryan White Data Support at wrma@csrin incorporation.com</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> When calling the toll-free help line, please provide your Grantee-of-Record name to the TA Specialist. When submitting a request via e-mail, be sure to include your Grantee-of-Record name and your position within the organization in the message text.</td>
</tr>
<tr>
<td></td>
<td><strong>Web Technical Support:</strong></td>
</tr>
<tr>
<td></td>
<td>For questions pertaining to HRSA Electronic Handbooks (EHBs) or the Web data entry system, please contact the HRSA Call Center at:</td>
</tr>
<tr>
<td></td>
<td><strong>Toll-Free Help Line:</strong> 1-877-464-4772</td>
</tr>
<tr>
<td></td>
<td><strong>Hours:</strong> Monday–Friday 9AM–5:30PM EST</td>
</tr>
<tr>
<td></td>
<td><strong>E-mail:</strong> <a href="mailto:CallCenter@HRSA.gov">CallCenter@HRSA.gov</a></td>
</tr>
<tr>
<td>CAREWare</td>
<td>Questions related to program guidance, such as funding or grant-related questions, should be addressed to the HAB project officer appropriate to your project(s).</td>
</tr>
<tr>
<td></td>
<td>For questions pertaining to CAREWare, please contact the CAREWare Help Desk at:</td>
</tr>
<tr>
<td></td>
<td><strong>Toll-Free Help Line:</strong> 1-877-294-3571</td>
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<tr>
<td></td>
<td><strong>Hours:</strong> Monday–Friday 1:00–4:00 PM EST</td>
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<td><strong>E-mail:</strong> <a href="mailto:cwhelp@jprog.com">cwhelp@jprog.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Learn More Online:</strong> CAREWare Home Page</td>
</tr>
</tbody>
</table>
### Allocation and Expenditure Reports (A&E Reports)

Questions related to the allocation and expenditure reports should be addressed to the HAB project officer appropriate to your project(s).

<table>
<thead>
<tr>
<th>Report</th>
<th>Report Content or Submission Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation and Expenditure Reports (A&amp;E Reports)</td>
<td>Questions related to the allocation and expenditure reports should be addressed to the HAB project officer appropriate to your project(s).</td>
</tr>
</tbody>
</table>

**Table 2: Data Support and Technical Assistance Links and Resources**

#### V. Ch 6. ADR Training and Technical Assistance

HAB designated division(s) and subcontractors are responsible for training Ryan White Part B grantees on the implementation and use of the ADR. HAB makes available the ADR and detailed instructions in the earlier chapter.

HAB also provides the software package CAREWare (for free) for use in collecting and reporting client-level data necessary for completion of the ADR. Use of CAREWare is not required. However, grantees and service providers can use CAREWare to generate their annual report for submission to HAB. HAB staff are responsible for offering CAREWare training on an as-needed basis.

HAB also provides the following training and technical assistance:

- A data-related technical assistance at the Target Center website.
- A telephone helpline for assistance with completing the annual report.
- A CAREWare telephone helpline for assistance in implementing the use of CAREWare at a grantee or service provider’s site.
- Upon request, on-site data-related technical assistance from HAB’s data contractor.

#### V. Ch 7. References, Links, and Resources

4. Information and instructions on the SF-424 budget forms can be found at [http://www.grants.gov/assets/InstructionsSF424A.pdf](http://www.grants.gov/assets/InstructionsSF424A.pdf)

**For More Information**

Please refer to the HAB Target Center at [https://careacttarget.org](https://careacttarget.org).
Section VI: Grantee and Sub-grantee Monitoring

VI. Ch 1. Overview

Monitoring is a HRSA requirement that applies to any project program sub-award, function or activity supported by the Ryan White Part B award (Base formula, Ryan White Part B supplemental, ADAP earmark, ADAP supplemental, emerging communities, and MAI). Therefore, monitoring applies to grantees, sub-grantees of the State, lead agencies, fiduciaries and/or consortia sub-grantees/contractors. Monitoring includes both program monitoring and fiscal monitoring but is not limited to the need for: 1) Performance Reports, 2) comparison of projected goals and objectives with actual outcomes, 3) evaluation of funded activities, and 4) site visits.

VI. Ch 2. Legislative Background

Section 2618(b)(3) of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), describes grantee and sub-grantee monitoring and related activity as an administrative activity as follows:

“(3) ADMINISTRATION.—

(A) IN GENERAL—Subject to paragraph (4), and except as provided in paragraph (5), a State may not use more than 10 percent of amounts received under a grant awarded under section 2611 for administration.

(B) ALLOCATIONS—In the case of entities and subcontractors to which a State allocates amounts received by the State under a grant under section 2611, the State shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

(C) ADMINISTRATIVE ACTIVITIES—For the purposes of subparagraph (A), amounts may be used for administrative activities that include routine grant administration and monitoring activities, including a clinical quality management program under subparagraph (E).

(D) SUBCONTRACTOR ADMINISTRATIVE COSTS—For the purposes of this paragraph, subcontractor administrative activities include—

(i) usual and recognized overhead, including established indirect rates for agencies;  
(ii) management oversight of specific programs funded under this title; and  
(iii) other types of program support such as quality assurance, quality control, and related activities.”

In the Circulars Federal Regulations 74 CFR 74.51 & 45 CFR 92.40 and 2 CFR 215.51 it States:
“Recipients are responsible for managing and monitoring each project program sub-award, function activities supported by the award. Monitoring includes a need for:

- Performance Reports
- Comparison actual accomplishment with goals and objectives
- Analysis and explanation cost overrun
- Report development significant impact on the award supported activities
- Site visit.”


The National Monitoring Standards for the Ryan White HIV/AIDS (the Standards) Part A and B grantees were developed by HRSA/HAB in response to several Office of Inspector General (OIG) and Government Accountability Office (GAO) reports. The reports identified a need for HRSA/HAB to provide clear guidance to grantees regarding monitoring expectations of sub-grantees and grantees. The Standards define a series of fiscal and program criteria to be monitored for compliance by consolidating the expectations of the following grant management documents:

1. Title XXVI of the Public Health Service Act, 42 U.S.C. 300ff-11, Sections 2611-23 (as amended by Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).
4. HHS and PHS grantee management policies.
5. HRSA/HAB policy notices, letters and guidelines.
7. Notices of Grant Award and Conditions of Award.
8. OIG reports and recommendations.
9. Manual and Guides issued by HRSA/HAB.

The Standards are part of the terms of the Notice of Grant Award and Ryan White Part B grantees are expected to comply with the Ryan White Part B Fiscal and Program Standards as well as the Universal standards (applies to both Parts A and B). The National Monitoring Standards can be accessed at the following link: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

- Fiscal Monitoring Standards: Part A (PDF - 492 KB) & Ryan White Part B (PDF - 301 KB)
- Program Monitoring Standards: Part A (PDF - 428 KB) & Ryan White Part B (PDF - 492 KB)
- Universal Monitoring Standards: Part A & B (PDF - 117 KB)

Frequently Asked Questions (FAQs) (PDF - 161 KB)
VI. Ch 4. Monitoring Program

A. Monitoring Grantees

HRSA is responsible for overseeing the Ryan White Part B programs and conducting routine monitoring of grantees’ performance and compliance with statutory requirements, regulations, and guidance. Routine monitoring of grantees includes regularly scheduled monthly monitoring calls, reviews of grantee reports, and the provision of technical assistance to grantees.

The monitoring of grantees is based upon OMB circulars and the Code of Federal Regulations (CFR) as well as Ryan White HIV/AIDS Program legislation and policy guidance. The Grantee and sub-grantee assessments include adherence with PHS treatment guidelines, the extent to which grantees are providing coordinated systems of care, and adherence with programmatic and fiscal requirements.

The monitoring of grantees includes the provision of technical assistance assessments which may be requested by project officers or by grantees. Technical assistance can be provided using a range of modalities, including on-site visit, tool and resource development, telephone consultation, and webinar. If a grantee does not correct legislative and programmatic non-compliance findings in a timely manner, and does not request technical assistance to correct such deficiencies, more intensive monitoring will result. This can include a conditions of award which is a way of repeating obligations set forth in the original monitoring report. The conditions include a clear statement of the obligations that are not being met and a timetable for making a correction.

B. Monitoring Sub-Grantees

The grantee retains ultimate accountability to HRSA for all contracts awarded through its Ryan White Part B Program. For example, in the case of an OIG visit that results in repayment of Federal dollars the State or territory not the sub-grantee is responsible for repaying the debt out of non-Federal dollars. Grantees should use the monitoring process to reinforce and underscore mutual obligations between funder and provider. The grantee should designate a person or team to review fiscal and program reports, conduct site visits, interact on an ongoing basis with contracted providers, and implement remedial steps or corrective action plans if necessary. A grantee may distribute monitoring functions across its organization. For example, fiscal monitoring activities are frequently handled by a different person, team, or even division within a health department than program monitoring activities.

The grantee should have a process to monitor sub-grantees as well as assure that lead agencies (fiduciary-consortia) have in place a process to monitor their sub grantees that includes annual site visits. Grantees should require lead agencies to submit annually their sub-grantees A-133 audits, sub-grantee monitoring reports and/or corrective action plans. When problems with a subcontractor become apparent, grantees or lead agencies must undertake some form of corrective action; grantees or a lead agency generally releases a report of the findings or areas of improvement. The report is discussed with the subcontractor staff and includes legislative and program noncompliance issues. Indicators for corrective action include noncompliance with:
• Missing or incomplete client records.
• Accessibility problems.
• Lack of a clinical quality management plan.
• Delivering core and support services in accordance with HRSA/HAB expectations as defined in the policy notices.
• Lack of appropriate licensure by staff or facility.
• Program income maximized, tracked or reported (providers with billable services only).
• Improper budget and expense allocation:
  o Administrative expenses exceed contracted limit
  o Unallowable expenses
  o No approved budget
• Tracking, monitoring caps on charges, sliding fee scale, (providers with billable services only).
• Payer of last resort.
• Eligibility recipients.
• Grantees with full-time positions listed on the Ryan White Part B budget that does not provide full time services to HIV/AIDS patients.
• Consumer involvement.
• Fiscal policy and procedures were not reflective of the actual operations:
  o Ryan White Part B funds being used to fund personnel that do not support the HIV program
  o No documentation of Time and Effort Financial reports
  o Late audit reports
  o Grantee does not receive regular financial reports
• HIPAA regulations require that a patient bill of rights and responsibilities posted in healthcare facilities.
• HIPAA patient confidentiality violations (patient lab results, no identifying information, medical chart file cabinets are not locked, patient conversations easily heard, releasing patient information to third parties, and invoices).
• Americans with Disabilities Act of 1990 violations.
• OSHA violations.
• Lack of Consumer input for the HIV program planning or service delivery.
• Noncompliance with culturally competencies.
• Noncompliance with cost principles/standards.
• Noncompliance with the annual A-133 audit.
• Noncompliance with salary limitations.

If any of the above occurs, grantees’ lead agency and consortia should have in place a corrective action plan that provides the sub-grantee with a number of mechanisms to resolve the compliance issues. This should include but not be limited to technical assistance by grantees, lead agencies, consortia, consultants or HRSA/HAB. If informal efforts fail and formal mechanisms are necessary, a graduated problem-solving approach should be used before termination of the contract is necessary.
Creating and operating a monitoring program requires understanding of the following:

1. How program and fiscal monitoring activities as stated in the standards differ from evaluation or auditing:

   Single audits (A-133 audits) are performed by independent auditors in accordance with Government Auditing Standards (GAS) who emit an opinion on the agency’s financial statements and based on samples on compliance with major Federal programs. Evaluation focuses on documentation of program accomplishments and outcomes. Monitoring activities differ from both in that the activities review and test compliance with applicable laws, regulations, assesses efficiency of operations, and effectiveness in achieving program results. If warranted, the monitoring process makes recommendations to enhance agency operations, promote economy, efficiency and compliance with Federal and programmatic requirements.

2. What to have in place before a monitoring program begins:

   A monitoring manual can assist in providing a standardized and transparent process for in-house processes such as desk compliance audits, analysis of performance reports, scope of work, staff and sub-grantee training, and other required program and fiscal reports. In addition, the manual should describe and outline the process to be followed prior, during and after a monitoring site visit.

   There should be two set of site visit tools: one that measures fiscal standards, and the other that measures program, including standards of care, and universal standards.

   There should be sharing of the standards and supporting materials with program and fiscal staff that have monitoring responsibilities. Staff should review the standards and help plan for implementation and compliance.

   There should be opportunities to sit down with staff to review current monitoring systems, procedures, and tools to see where the Standards are already being met and where changes are needed.

   There should be meetings with providers/sub-grantees to introduce the standards and clarify compliance issues. The frequency for training sub-grantees regarding eligibility or any other compliance issue is at the discretion of the grantee.

3. Key actors and their roles (examples):

   Fiscal desk audits are performed by the staff position that approves sub-contractors’ invoices. The quality staff usually assesses the services provided, including the impact on consumer satisfaction. The program staff appraises compliance with the scope of work.

4. Development of tools for corrective measures when providers fail to meet standards:
A corrective action plan should be developed that identifies the areas of non-compliance and allows sub-contractors to provide a time-sensitive corrective action plan that outlines the corrective actions to be taken. These may include:

- Improved oversight.
- Redistribution of funds.
- A “corrective action” letter.
- Sponsored technical assistance.

Further, the grantee must follow through to ensure completion of the goals of the corrective action plan. (Standard 3; Section E, Universal Monitoring Standards)

See: Universal Monitoring Standards: Part A & B (PDF - 117 KB)

Site Visits

Grantee

Site visits are key component of HRSA/HAB oversight to verify: 1) compliance with Ryan White legislative requirements, 2) compliance with Ryan White Part B Program requirements, 3) the provision of high quality HIV clinic care and compliance with HHS guidelines, and 4) administrative and fiscal integrity resulting in a technical assistance plan that addresses program deficiencies and brings a program into compliance.

HRSA has implemented a risk based strategy for selecting grantees for site visits. The strategy includes but is not limited to:

- Comprehensive Site visits on a periodic basis—3 to 5 years.
- An initial site visit for newly awarded grantees.
- Low score on recent competitive application or poor non-competing applications.
- Lack of communication with the Project Officer.
- Habitual and problematic grantee staff turnover.
- Problematic spend-down patterns (PMS requests) and/or multiple years with unobligated balances.
- Consistently failing to meet work plan objectives.

Sub-grantee

The awarding agency, HHS, prescribes the frequency of the monitoring activities. The monitoring standards for Ryan White Part B grantees describe the frequency of site visits to sub-grantees as annually. The standards require an annual comprehensive monitoring site visit as delineated in Section I.E. of the Part A and B Universal Standards. The visit must test compliance with Fiscal, Programmatic, and Universal Standards. The Monitoring Standards require as a minimum an annual visit to all providers. The usefulness of desk audits and any timelines for their use are determined by the grantee. Desk audits may not be used as a substitute for comprehensive annual site visits.
There is a site visit waiver process via EHB Prior Approval Portal. For the waiver request, using the EHB portal, the grantee must submit a letter that describes:

- Barriers and challenges binding the program from conducting annual visits.
- Frequency and/or schedule of site visits the program can conduct.
- Site visit protocol (if available, send as attachment).
- A monitoring plan for the years the visits will not be conducted.
- Process for corrective action plans.
- Number of staff participating on the site visit team.
- The number of providers/sub-grantees that the Ryan White Part B grantee funds.

When structuring a monitoring program, grantees that are also service providers must be careful to avoid conflicts of interest. Contracted providers have an inherent conflict of interest when they are involved in monitoring their own contracts or services. For example, a health department that is the administrator of the Ryan White Part B funds and the provider of Ryan White Part B core and support services. A grantee may decide to share some of its monitoring responsibilities with a local lead agency such as a fiduciary or regional consortium. This decision should depend on the ability of a lead agency to fulfill the monitoring requirements.

When establishing a site visit monitoring process, grantees should ensure from the beginning that sub-grantee/contractors understand the monitoring process. Thus, the grantee may want to outline the process as follows:

- Site Visit Review Team plans a calendar of visits.
- Conference calls with sub-grantees/contractors to verify visit dates, draft an agenda, and explain the process once on site.
- Site visit tools and documentation are explained.
- Visit should start with an entrance conference (opportunity to explain visit and sub-grantee/contractor has an opportunity to present its program).
- Visit should end with an Exit Meeting where the monitoring teams get an opportunity to discuss the areas of non-compliance and the proposed recommendations with agency staff.

The site visit grantees or lead agencies/consortia may want to develop a fiscal and program tool to use to ensure that each sub-grantee or lead agency contractual obligation is reviewed in sufficient detail. A site visit might include staff interviews, observation of services, client records or chart reviews, a facility tour, and a review of documentation and testing relating to the following compliance aspects of sub-contractor operations.

There is no expectation that all client records must be reviewed. A random sampling methodology should be established as part of the monitoring protocols. The sample size is not specified in the standards, because it depends on the size of the client population being sampled and on the number and complexity of the variables you are reviewing. For a client population of 50 or less, the norm is to review 100% of folders; 50% or less is acceptable for a population of
51 to 100. The percent to be sampled gets smaller as the population gets larger – from 10% for a client population of 500 or more to 3 to 5% for a client population of 1000 or more.

VI. Ch 5. References, Links, and Resources

1. National Monitoring Standards:
   ● Fiscal Monitoring Standards: Part A (PDF - 492 KB) & Ryan White Part B (PDF - 301 KB)
   ● Program Monitoring Standards: Part A (PDF - 428 KB) & Ryan White Part B (PDF - 492 KB)
   ● Universal Monitoring Standards: Part A & B (PDF - 117 KB)
   ● Frequently Asked Questions (FAQs) (PDF - 161 KB)


For More Information

Please refer to the HAB Target Center at https://careacttarget.org.
Section VII: Clinical Quality Management

VII. Ch 1. Overview

The Department of Health and Human Services (HHS) released the National Quality Strategy in March 2011 and put forth 3 broad aims to “guide and assess local, State and national efforts to improve the quality of health care.” The aims are (1) Better Care, (2) Healthy People / Healthy Communities, and (3) Affordable Care. The National Quality Strategy provides a roadmap requiring continuous advancement of measurement and initiatives with a collaborative stakeholder process.

As part of HHS, HRSA/HAB defines quality as “the degree to which a health or social service meets or exceeds established professional standards and user expectations.” In order to continuously improve systems of care, evaluations of the quality of care should consider the service delivery process, quality of personnel and resources available, and the outcomes. The overall purpose of a quality management program is to ensure that:

- Services adhere to HIV/AIDS treatment guidelines and established clinical practice.
- Develop strategies for improvement of services provided, including clinical services and supportive services.
- Demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic and quality of care.
- Appropriate leaders and stakeholders are included throughout the quality improvement process.
- Continuous processes to improve quality of care are in motion.

Quality management is a systematic, structured, and continuous approach to meet or exceed established professional standards and user expectations. Quality management is implemented by using tools and techniques to measure performance and improve processes through three main components: quality infrastructure, performance measurement and quality improvement.

Quality infrastructure is the structure and supports that allow the organization to measure performance and improve processes. Quality infrastructure components include leadership, quality improvement teams, quality related training/capacity building, and a written quality management plan. It is often difficult to sustain a success quality management program if the infrastructure components are missing or weak.

When most people think about quality management, performance measurement and quality improvement come to mind. Performance measurement is the routine collection and analysis of data. The analysis is completed by defining the data elements used to calculate the numerator and denominator. Performance measures must be based on established professional standards and/or evidenced based research, when possible. An example of a performance measure is viral load suppression. HAB has developed, released, and refined performance measures for use by Ryan White Program grantees. HAB performance measures were developed using professional standards such as the Department of Health and Human Services HIV Clinical Guidelines.
including *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection*, among other Federal and national guidelines for the care and treatment of PLWH. These performance measures can be found on the HAB website. ([http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html](http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html))

Quality improvement is a method that uses the tools of quality in an effective, logical and systematic process to solve problems, improve efficiency and eliminate non-value adding steps in the workflow. The most common quality improvement method is the Plan-Do-Study-Act or PSDA.

It is important to conduct performance measurement and quality improvement activities in balance. That is to say that you do not want to do one without the other and you want to implement equally amounts of each. You would not want to develop and implement a quality improvement project without regularly measuring performance to see if the project is having an impact.

**VII. Ch 2. Legislative Background**

**Clinical Quality Management**

Section 2618(b)(3)(E) of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that “Each State that receives a grant under section 2611 shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.”

Additional language under Section 2618 administrative expenses sets limits on the amounts to be expended as follows:

“(ii) USE OF FUNDS-
(I) IN GENERAL- From amounts received under a grant awarded under section 2611 for a fiscal year, a State may use for activities associated with the clinical quality management program required in clause (i) not to exceed the lesser of--
(a) 5 percent of amounts received under the grant; or
(bb) $3,000,000.
(II) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES- The costs of a clinical quality management program under clause (i) may not be considered administrative expenses for purposes of the limitation established in subparagraph (A).”
VII. Ch 3. HAB Program Expectations

The Ryan White Program places major emphasis on enhancing the quality of care for PLWH. The complexity of HIV care and the Ryan White Program’s commitment to equal access to quality care for all HIV-positive individuals require systematic efforts to ensure that the Ryan White Program services are delivered effectively.

It is important to remember that the Ryan White legislative requirements for clinical quality management apply to both the clinical and support services funded and sub-grantees.

In 2011, HAB released the *Ryan White HIV/AIDS Program Part A and B Monitoring Standards*. In the *Part A Program Monitoring Standards*, Section D is entitled *Quality Management* the Ryan White legislative requirement for clinical quality management (as mentioned above). The legislative requirements are referred to as the “standard” in the Monitoring Standards. The “performance measure” identifies what one would look for in order to understand if the grantee was meeting the “standard.” The “responsibility” states what the grantee and provider/sub-grantee need to complete in order to meet the “standard.”

At a minimum, Ryan White Program Part B grantee quality management must have:

- Established and implemented a statewide quality management plan with annual updates.
- Established processes for ensuring that services are provided in accordance with the Department of Health and Human Services (HHS) treatment guidelines and standards of care.
- Incorporated quality-related expectations into Requests for Proposals (RFPs) and State/Territory contracts, including contractors/subcontractors at the consortia and sub-recipient level.

A successful quality management program should:

- Have identified leadership, accountability, and dedicated resources available to the program.
- Use data and measurable outcomes to determine progress toward evidenced-based benchmarks.
- Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement.
- Be adaptive to change and fit within the framework of other programmatic quality assurance and quality improvement activities (*i.e.*, Joint Commission on the Accreditation of Healthcare Organizations [JCAHO], Medicaid, and other HRSA programs).
- Ensure that data collected are fed back into the quality improvement process so that goals are accomplished and improved outcomes are realized.
Quality Management Plan

HAB outlines its expectations related to QM in program guidance documents and legislative requirements under Section 2664. At a minimum, Ryan White Part B grantee quality management must have:

- Established and implemented a statewide quality management plan with annual updates.
- Established processes for ensuring that services are provided in accordance with HHS treatment guidelines and standards of care.
- Incorporated quality-related expectations into Requests for Proposals (RFPs) and State/Territory contracts, including contractors/subcontractors at the consortia and sub-recipient level.

HAB/DSHAP Monitoring

DSHAP will monitor grantee compliance with clinical quality management requirements through questions in funding opportunity announcements, progress reports, and site visits. States must sign assurances in their annual applications attesting that appropriate quality management programs are in place.

VII. Ch 4. Quality Management Concepts

A number of tested concepts can be used in Ryan White Part B quality management program efforts. They include quality assurance, quality improvement, continuous quality improvement (CQI), and outcomes evaluation. Continuous quality improvement and quality assurance are particularly relevant because of their focus on managing program quality.

Model for Improvement

The Model for Improvement was developed by Associates in Process Improvement and is a simple yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes. The model has two parts:

- Three fundamental questions, which can be addressed in any order.
- The Plan-Do-Study-Act (PDSA) cycle** to test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

1. Plan – Identify problems (including their components—not just the big picture) and then plan strategies/tests that might result in improvements.
2. Do – Use strategies that are designed to address problems.
3. Study – Collect and analyze data to see if strategies have resulted in improvements.
4. Act – If the strategies are effective, make them an ongoing activity. If they are not effective, return to the Plan stage. Use collected data to identify new ways to address problems.

Measuring Clinical Quality
HAB has created performance measures that Ryan White HIV/AIDS Program grantees can use to monitor the quality of care and services they provide. The performance measures can be used at the provider or system level—in their current format or further modified to meet grantee needs. HAB also created Frequently Asked Questions (FAQ) to assist in the use of these performance measures. The FAQs are also available on the HAB website.

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Table 3: Frequently Asked Questions (FAQ) Regarding Performance Measures


National Quality Forum HIV Measures

HAB regularly reviews its portfolio of performance measures for gaps and relevance. As part of recent reviews, HAB sought national endorsement for a selection of HIV performance measures in 2012. The National Quality Forum conducts the process by which performance measures are endorsed. National endorsement is important as many payers of health care, including insurance companies and the Centers for Medicare and Medicaid Services, choose or favor nationally endorsed performance measures when selecting measures to include in their programs. The performance measures that received national endorsement are also part of other programs within the Department of Health and Human Services. See the table below describes that HAB performance measures that received national endorsement and their role in other Department of Health and Human Services programs.
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<td>24 Month medical visit frequency</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Jan. 2013 (NQF 2079)</td>
</tr>
<tr>
<td>Prescription of antiretroviral therapy</td>
<td>X</td>
<td></td>
<td></td>
<td>Jan. 2013 (NQF 2083)</td>
</tr>
<tr>
<td>Viral load suppression</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Jan. 2013 (NQF 2082)</td>
</tr>
</tbody>
</table>

Table 4: HAB performance measures


**Other Important Quality Topics**

Standards or targets can be used to determine whether a program’s implementation and/or outcomes are successful. Listed below are examples of criteria that can be used to evaluate service delivery processes and/or outcomes:

- **Benchmarks/Best Practices.** Benchmarks provide performance data that are used for comparisons. A program may compare its performance with that of a recognized high-quality provider that offers similar services or with leading performance standards for the health (or social services) profession. Some organizations use their own data as a baseline benchmark against which to compare future performance.

- **Clinical Practice Guidelines.** Such guidelines provide statements by recognized authorities on the most appropriate treatments for specific diagnoses or conditions. Clinical practice guidelines are developed to promote effective patterns of practice and to reduce inappropriate and unnecessary care.

- **Critical Pathways.** These pathways are statements of the specific steps and procedures that should be followed when diagnosing, treating, and managing specific medical problems. The intent is to ensure that only the indicated steps are taken and that these steps are taken in the correct sequence. Because resources vary from one health facility to another, critical pathways may be developed locally.

- **Standards of Care.** Standards of care are principles and practices for the delivery of health...
and social services that are accepted by recognized authorities and used widely. Standards of care are based on specific research (when available) and the collective opinion of experts.

VII. Ch 5. References, Links, and Resources


National Quality Center (NQC). The purpose: of NQC is to provide no-cost, state-of-the-art technical assistance to all Ryan White funded grantees to improve the HIV/AIDS care and the services they provide. NQC aims to build capacity for quality improvement across all Parts as the nation’s premiere improvement resource in HIV care nationwide. http://nationalqualitycenter.org/

NQC Quality Academy – An internet-based modular learning program on quality improvement, accessible 24/7 and free of charge. The currently available tutorials stress quality improvement theories and methodologies, real world examples from other HIV providers, and methods for applying this information in HIV programs. http://nationalqualitycenter.org/index.cfm/17263

HRSA Quality. HRSA’s primary goal is to “Improve Access to Quality Health Care and Services” and has a longstanding commitment to improve the quality of healthcare for people who are uninsured, isolated or medically vulnerable the in the United States. HRSA is active in improving quality at the Federal, state and local levels and at the point of care. The HRSA Quality website (http://www.hrsa.gov/quality) provides a centralized source of information and technical assistance for HRSA grantees and the safety net population.

Agency for Health Research and Quality. AHRQ is the lead Department of Health and Human Services (HHS) agency supporting research to improve quality of care, reduce costs, and increase access to essential services. Website: http://www.ahrq.gov

Center for HIV Quality Care. This center conducts research on issues including appropriate standards of HIV care, including ancillary services at all stages of illness, and the cost of HIV care that corresponds to these standards of care. The effort is to create a national picture of Medicaid managed care benefit packages and capitation rates. For further information, contact the Infectious Diseases Society of America, Arlington, VA 22209, 703-299-0204, http://www.idsociety.org, info@idsociety.org.

The National Quality Measures Clearinghouse (NQMC). Under development by ECRI through a contract from AHRQ, the National Quality Measures Clearinghouse is designed to provide an Internet-based resource of evidence-based quality measures. Using a standardized language and common platform, the NQMC links two well-established AHRQ resources:

- The National Guideline Clearinghouse (NGC), a public resource for evidence-based clinical practice guidelines sponsored by AHRQ in partnership with the American Medical Association and the American Association of Health Plans. An Internet-based repository of
clinical practice guidelines, it allows for detailed comparisons across different guidelines. Summaries of guidelines are provided for clinical, methodological, and bibliographic areas. Website: [http://guideline.gov/](http://guideline.gov/).


The NQMC will allow users to search these databases in combination and receive a report that lists evidence-based quality measures and guidelines.

**National Quality Forum.** This private, nonprofit organization has responsibility for the creation of comprehensive quality measures that are consistent with national aims for quality improvement. Website: [http://www.qualityforum.org](http://www.qualityforum.org).

**Business and Higher Education Developed CQI and Total Quality Management (TQM) Information.** Business-focused CQI information can often be applied to the health care setting and used to advance the quality of HIV/AIDS services. Many business-oriented websites require a fee or membership to access CQI and TQM information. See the following:

- **American Society for Quality (ASQ).** The ASQ website includes an introduction to quality, an online catalog including a listing of education courses and conferences, an on-line directory for products and services for quality and continuous improvement, and a quality search option. Website: [http://www.asq.org](http://www.asq.org).

- **National Committee for Quality Assurance.** The NCQA website includes resources, information, and training opportunities on evaluating health care. This site includes information on the Health Plan Employer Data and Information Set (HEDIS), a performance measurement tool that contains a set of standardized measures specifying how health plans collect, audit, and report on their performance in important areas of health and customer satisfaction. Website: [http://www.ncqa.org](http://www.ncqa.org).

**For More Information**

Please refer to the HAB Target Center at [https://careacttarget.org](https://careacttarget.org).
Section VIII. Grants Administration

VIII. Ch 1. Overview

The Federal rules governing grants management for Ryan White HIV/AIDS Program service providers are provided in Office of Management and Budget (OMB) circulars and the Code of Federal Regulations (CFR). Ryan White Part B grantees are expected to be familiar with these documents and assure that all service providers follow the procedures outlined in these documents.

In addition, The Ryan White HIV/AIDS Program, as authorized and funded under Title XXVI of the Public Health Services Act, and amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009, includes specific provisions and directives for the provision of fundable services.

The Division of Grants Management Operations, Office of Federal Assistance Management, HRSA/HAB oversees grant awards to Ryan White Part B States and territories. As the counterpart to the business office of the grantee, DGMO handles business management aspects of the review, negotiation, award, and administration of grants, as follows:

- Receiving all grant applications.
- Monitoring the objective review process.
- Performing cost analysis prior to grant award and negotiating changes in budgets as necessary.
- Providing business management consultation and technical assistance.
- Signing and issuing grant awards, amendments to awards, and notices of suspension and termination.
- Receiving and responding to all correspondence related to business activities.
- Receiving all documentation submitted for compliance with the terms and conditions of the grant award (progress reports, financial reports, revised budgets, and other conditions of award).
- Maintaining the official grant file.
- Conducting continuous surveillance of the financial and management aspects of grants, and resolving audit findings.

VIII. Ch 2. Payer of Last Resort

By statute, the RWHAP funds may not be used for any item or service “for which payment has been made or can reasonably be expected to be made” by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service (PHS) Act.). At the individual client level, this means that grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Consistent with past communications from HRSA/HAB, grantees and their contractors are expected to vigorously pursue Medicaid enrollment for individuals who are likely eligible for coverage. Grantees should ensure that eligibility for other funding sources (e.g., Medicaid, CHIP,
Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.) is consistently assessed and enrollment is pursued, to extend finite RWHAP grant resources to new clients and/or needed services.

It is important to remember that the RWHAP is the payer of last resort and is also able to wrap around health care and supportive services not covered by public or private health insurance plans.

In cases where the operations of the Ryan White Part B Program and/or its eligibility determinations are made through a sub-contractual relationship, the assurance that Ryan White program funds remain the payer of last resort should be maintained. Contractors with the authority to conduct eligibility should also perform insurance verification, and make every effort to identify primary payer verifications. Such actions will reinforce the integrity of the Ryan White Part B funds being spent on clients identified as eligible.

VIII. Ch 3. Maintenance of Effort

Introduction

The Ryan White HIV/AIDS Program requires Ryan White Part B Program grantees to maintain State expenditures for HIV-related activities at a level equal to the 1-year period preceding the fiscal year (FY) for which the grantee is applying to receive a Ryan White Part B grant as mandated under Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87). States must comply with maintenance of effort (MOE) requirements, which include: a signed assurance that maintenance of effort has been maintained, a description of a consistent data set of local government expenditures for two previous years, and methodologies for calculating maintenance of effort expenditures.

Ryan White Part B funds are not intended to be the sole source of support for HIV care and treatment services for States. The maintenance of effort requirement is important in ensuring that Ryan White HIV/AIDS Program funds are used to supplement existing State expenditures for HIV-related care and treatment services and to prevent Ryan White Part B funds from being used to offset specific HIV-related budget reductions at the State level.

Legislative Background

Section 2617(b)(7)(E) of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) states the Ryan White Part B maintenance of effort requirement as follows: “the State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the 1-year period preceding the fiscal year for which the State is applying to receive a grant....”
Definitions

<table>
<thead>
<tr>
<th><strong>Consistent</strong></th>
<th>A consistent data set has the same elements listed from year to year, although there may be instances where changing needs result in new data elements replacing older ones.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV-related Activities</strong></td>
<td>A spectrum of categorical or specifically identified HIV activities as defined by HRSA/HAB, with concurrence from the Office of the General Counsel. Examples include outpatient ambulatory care and treatment, inpatient care, case management, prevention, surveillance, and research activities.</td>
</tr>
<tr>
<td><strong>In-kind contributions</strong></td>
<td>Non-cash contributions that a State or Territory may provide to support HIV-related activities. These non-cash contributions must be fairly valued and may include plant equipment, or services.</td>
</tr>
</tbody>
</table>

Table 5: Definitions

**Determining the Elements That Constitute Maintenance of Effort**

To demonstrate compliance with this provision, States and Territories must maintain adequate systems for consistently tracking and reporting on HIV-related expenditure data from year-to-year. Grantees are accountable to ensure that Federal funds do not supplant State spending but instead expand and enrich HIV-related activities. These requirements resulted from an audit conducted by the OIG, HHS, which recommended that HRSA require a more detailed written accounting of how Ryan White HIV/AIDS Program grantees meet the maintenance of effort requirement. In addition, States and Territories are required to: 1) define consistency; and 2) define the methodology used and maintain reported data consistently year to year.

The elements, or items, that grantees use to document maintenance of effort compliance are defined in the legislation as HIV-related activities. Grantees may choose which elements to include but are directed to include, at a minimum, HIV-related activities for which a line item can be identified in the budgets and subsequent expenditure reports of State agencies. Examples of such identifiable line items would include State appropriations to AIDS Drug Assistance Programs (ADAP), State-funded HIV care and/or prevention programs, and State-funded surveillance efforts.

**Ryan White Part B Grantee Documentation Requirements**

To demonstrate compliance with the maintenance of effort requirement the grantee must develop and maintain a written, auditable system adequate to document compliance. In every Ryan White Part B grant application, the State/Territory must attach a report detailing the year-to-year HIV-related expenditures by the State/Territory for the previous two complete fiscal years.

1. Documentation (or worksheet) proving that the overall level of HIV-related expenditures has been maintained year-to-year for the previous two complete fiscal years.
2. A brief narrative explaining any changes in the data set where HIV-related expenditures have been reduced or where the purpose of an HIV-related expenditure has changed.
3. Sign an assurance that they are complying with the maintenance of effort requirement.
Securing Maintenance of Effort Data from State Government Agencies

The following is guidance for working with state government agencies to compile information for the maintenance of effort requirement:

- The fiscal year for reporting data should be that of the grantee.
- For documentation purposes, all communication between the grantee and state government agencies regarding maintenance of effort must be in writing or electronically documented. It is not acceptable to compile information by telephone without a documentary record.
- Grantees should provide written guidance to their state agencies of the purpose and reporting requirements for HIV related services.
- There is no expectation or requirement by HAB/DSHAP that grantees will undertake complex efforts to determine expenditure amounts where HIV line items do not exist (e.g., complicated mathematical exercises to quantify the portion of a public hospital’s non-specific inpatient expenses).
- Grantees should review and attempt to clarify any questionable data or omission of data submitted by State government agencies before that information is reported to HAB/DSHAP.
- Consistency (i.e., use of a consistent data set) does not mean that all grantee government agencies must use the same methodology but rather that an overall calculation for a State must be arrived at in a consistent manner over time.
- Any change to the prior MOE reporting must be documented and explained in writing. For example the elimination of State funding for a category of service (e.g., hospice care) and the initiation of State funding or significant enhancement of such funding for another category (e.g., laboratory tests or pharmaceuticals).

Monitoring and Compliance

Grantees are required to assure that maintenance of effort has been fulfilled. During a comprehensive site visit or at any time during the grant year HAB can request for review the following documents:

- Budget elements that document the contributions of the State or Territory.
- Description of the tracking/ accounting system that documents the State or Territory’s contribution to core medical services and supportive services.
- Grantee budget for State or Territory contributions.
- The actual tracking/accounting documentation of contributions.

Instructions and Examples for Documenting Maintenance of Effort

As outlined above, States have considerable latitude in deciding what to include in the maintenance of effort base beyond HIV-specific line items in agency or department budgets. In
deciding whether to include in the base expenditures elements that may not have an HIV-specific line item, grantees should consider several factors. While it is simpler to report only expenditures with an HIV-specific line item, these line items may be subject to reduction if State revenues decline or other pressures come to bear on the appropriations process. The somewhat more detailed process of devising a reasonable method for consistently estimating the percent of State Medicaid expenditures linked to HIV (minus the Federal share of Medicaid expenses), prison inmate HIV health expenditures, etc., may provide a somewhat larger and more stable base for year-to-year State HIV spending.

VIII. Ch 4. State Matching or Cost Sharing Funds Requirements

Introduction

The Ryan White legislation requires States that have reported to the Centers for Disease Control and Prevention (CDC) more than one percent of U.S. AIDS cases in the prior two years to provide a match for their Ryan White Part B grant. The required matching rate is based on the number of years the State meets the one percent threshold. The match ceiling is different for Ryan White Part B formula award ($1 for each $2 of Federal funds) and the ADAP Supplemental grants ($1 for each $4 of Federal funds) and the match requirement for ADAP Supplemental funds can be waived. The ADAP Supplemental matching amount is based on the amount of the award, not the amount of grant funds actually expended.

Legislation, HRSA Program Requirements, and Expectations

The Ryan White legislation states the following regarding State matching requirements:

Section 2617(d)(1) In general. In the case of any State to which the criterion described in paragraph (3) applies, the Secretary may not make a grant under this part unless the State agrees that, with respect to the costs to be incurred by the State in carrying out the program for which the grant was awarded, the State will, subject to subsection (b)(2), make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to—

(A) for the first fiscal year of payments under the grant, not less than 16 2/3 percent of such costs ($1 for each $5 of Federal funds provided in the grant);

(B) for any second fiscal year of such payments, not less than 20 percent of such costs ($1 for each $4 of Federal funds provided in the grant);

(C) for any third fiscal year of such payments, not less than 25 percent of such costs ($1 for each $3 of Federal funds provided in the grant);

(D) for any fourth fiscal year of such payments, not less than 33 1/3 percent of such costs ($1 for each $2 of Federal funds provided in the grant); and

(E) for any subsequent fiscal year of such payments, not less than 33 1/3 percent of such costs ($1 for each $2 of Federal funds provided in the grant).

(2) Determination of amount of non-Federal contribution.—

(A) In general.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the
Federal Government, and any portion of any service subsidized by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(B) Inclusion of certain amounts.—
(i) In making a determination of the amount of non-Federal contributions made by a State for purposes of paragraph (1), the Secretary shall, subject to clause (ii), include any non-Federal contributions provided by the State for HIV-related services, without regard to whether the contributions are made for programs established pursuant to this title;
(ii) In making a determination for purposes of clause (i), the Secretary may not include any non-Federal contributions provided by the State as a condition of receiving Federal funds under any program under this title (except for the program established in this part) or under other provisions of law.

(3) Applicability of requirement.—

(A) Number of cases.—A State referred to in paragraph (1) is any State for which the number of cases of HIV/AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the period described in subparagraph (B) constitutes in excess of 1 percent of the aggregate number of such cases reported to and confirmed by the Director for such period for the United States.

(B) Period of time.—The period referred to in subparagraph (A) is the 2-year period preceding the fiscal year for which the State involved is applying to receive a grant under subsection (a).

(C) Puerto Rico.—For purposes of paragraph (1), the number of cases of HIV/AIDS reported and confirmed for the Commonwealth of Puerto Rico for any fiscal year shall be deemed to be less than 1 percent.

(4) Diminished State contribution.—With respect to a State that does not make available the entire amount of the non-Federal contribution referred to in paragraph (1), the State shall continue to be eligible to receive Federal funds under a grant [under this part], except that the Secretary in providing Federal funds under the grant shall provide such funds (in accordance with the ratios prescribed in paragraph (1)) only with respect to the amount of funds contributed by such State.

Section 2618(a)(2)(F)(ii) outlines supplemental drug treatment grants as follows:
(III) State requirements.—The Secretary may not make a grant to a State under this clause unless the State agrees that the State will make available (directly or through donations of public or private entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to $1 for each $4 of Federal funds provided in the grant, except that the Secretary may waive this sub-clause if the State has otherwise fully complied with section 2617(d) with respect to the grant year involved. The provisions of this sub-clause shall apply to States that are not required to comply with such section 2617(d).

State Match Principles and Definitions
Ryan White funds are intended to supplement resources provided by metropolitan areas and States in providing services to individuals with HIV/AIDS and their families. For States, Ryan White Part B funding was never intended to be the sole source of support for community-based HIV care services, and the matching requirement, along with other legislative requirements such as maintenance of effort, assure a concomitant level of State support.

The following definitions may be helpful in reading and understanding this section:

- **In-Kind Contributions.** Non-cash contributions that a State may provide to support HIV-related services. These non-cash contributions must be fairly valued and may include plant equipment or services.

- **Required Rate of State Matching.** The minimum level of cash and/or in-kind contributions a State must provide according to a schedule established in 2617(d) of Ryan White.

- **State.** A State is defined to include each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico and the Territories of the Virgin Islands, Guam, American Samoa, and Commonwealth of the Northern Mariana Islands, Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands. However, Puerto Rico is specifically exempted from the State match requirement.

- **State Matching.** The non-Federal cash or in-kind contributions provided by the State to supplement the Federal funds received. State contributions claimed as match for other Federal programs (such as Medicaid) may not be used to meet the match requirement for the Ryan White Part B grant. Amounts provided by the Federal Government, and any portion of any service subsidized by the Federal Government, may not be included in calculating the amount of the State matching contribution.

The HRSA/HAB National Monitoring Standards, Fiscal Monitoring Standards, address State matching requirements as follows:

*Grantees are expected to ensure that non-Federal contributions (direct or through donations of private and public entities) are:*

- Verifiable in grantee records.
- Not used as matching for another Federal program.
- Necessary for program objectives and outcomes.
- Allowable.
- Not part of another Federal award contribution (unless authorized).
- Part of the approved budget.
- Part of unrecovered indirect cost (if applicable).
- Apportioned in accordance with appropriate Federal cost principles.
• An integral and necessary part of the time allocated value similar to amounts paid for similar work in the grantee organization, if including volunteer services.

Value services of contractors at the employees’ regular rate of pay plus reasonable, allowable and allocable fringe benefits.

Assign value to donated supplies that are reasonable and do not exceed the fair market value.

Value donated equipment, buildings, and land differently according to the purpose of the award.

Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value). (From HAB fiscal monitoring standards.)

Expectations

The Ryan White legislation stipulates that the HHS Secretary may not make grants to States with more than one percent of the reported AIDS cases for the two most recent Fiscal Years unless those States agree to make available non-Federal contributions to match the Ryan White Part B funding they receive. The matching amount includes non-Federal contributions such as cash or in-kind contributions provided directly by the State or through donation from public or private entities. In making a determination of the amount of non-Federal contributions made by a State, the Secretary shall include any non-Federal contributions provided by the State for HIV-related services without regard to whether the contributions are made specifically for Ryan White programs. If a State provides matching funds/assets, but the rate of matching is not at the level prescribed in the legislation, the Ryan White Part B grant will be reduced to achieve the required matching ratio.

Grantees must ensure that Federal funds do not supplant State spending but instead expand HIV-related activities. Funds that States may use to demonstrate compliance with match requirements are those that have, at a minimum, an identifiable line item in State budgets and expenditure reports from State agencies. These funds may include:

• State contributions to other Ryan White services and/or ADAP.
• Prescription drug rebates.
• State Pharmacy Assistance Programs.
• State-funded salaries of Ryan White Part B staff.
• State funds spent on health insurance.
• State-funded ADAP delivery fees.
• State Department of Correction expenditures on care and treatment for HIV+ inmates.
• The State share of Medicaid expenditures for PLWHA.
• State contributions to HIV prevention and surveillance activities.
• State contributions to HIV research.

Determining the Rate of State Match
Program experience shows that a small number of States have been above, and have then fallen below the one percent threshold over different fiscal years. A State that meets the one percent threshold in a particular Fiscal Year and then falls below that threshold in a subsequent fiscal year is not required to meet the matching fund requirement for the year in which it is below the threshold. If, however, the State subsequently meets the threshold again, only the years in which that State meets the one percent threshold are counted in determining the required rate of match.

**Ryan White Part B Match Documentation Requirements**

Since the Secretary may not make a grant under Ryan White Part B unless the State agrees to make available the required match, the State must provide documentation with its Ryan White Part B application that such match requirements will be met. This documentation includes signed assurances, which include the agreement to meet the required State match and specific information submitted as per instructions found in the Ryan White Part B Application Guidance for States. While the Ryan White Part B grantee is not required to submit the specific calculations or sources for meeting the match requirements, the grantee must maintain that documentation for audit and site visit purposes.

Ryan White Part B grantees are also required, 90 days after the end of each budget period, to submit a final Financial Status Report (FSR). Items 10b (Recipient Share of Outlays) and 10e (Recipient Share of Un-liquidated Obligations) of this report document that the required State match for the grant has been met (i.e., the requirement is met when the sum of 10b and 10e equals the required State match amount). In addition, starting with the Fiscal Year final progress report due 30 days after the end of the budget period, States must describe the activities, personnel, and other object class categories actually supported through use of matching funds.

Future awards will be unaffected for those States submitting an FFR and final progress report indicating the required State match has been met and how, as outlined in the previous section. If a State submits an FFR indicating a level of recipient outlays and un-liquidated obligations below the required State match, subsequent grant awards will be offset by the appropriate proportional amount. The amount by which the grant is offset will be reallocated to other Ryan White Part B grantees.

**VIII. Ch 5. Grants Management**

**Introduction**

The Federal rules governing grants management for Ryan White HIV/AIDS Programs service providers are provided in Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, OMB circulars, the Code of Federal Regulations (CFR), and the HRSA policy notices and letters. Ryan White Part B grantees are expected to be familiar with these documents to assure that all service providers (lead agencies, sub-contractors, providers and/or consortia) follow the procedures outlined in these documents. The Ryan White Part B grantee is responsible for the proper stewardship of all grant funds, even if some of the fiscal management of those funds is shared with first line entities.

The HRSA Division of State HIV/AIDS Programs (DSHAP) and the HRSA Office of Federal

Assistance Management, Division of Grants Management Operations, oversee Ryan White Part B grants management to States and territories. The financial management aspects of the grant, involves the following:

- Performing cost analysis prior to grant award and negotiating changes in budgets as necessary.
- Providing business management consultation and technical assistance to program.
- Signing and issuing grant awards, amendments to awards, and notices of suspension and termination.
- Receiving and responding to all correspondence related to financial activities.
- Assuring that all documentation for compliance with the terms and conditions of the grant award (progress reports, financial reports, revised budgets, and other conditions of award) has been submitted through the EHB on a timely basis.
- Maintaining the official grant file.
- Conducting continuous surveillance of the financial and management aspects of grants.
- Resolving audit findings.

Administration of Grants: Program Requirements

Ryan White Part B grantees can find relevant information regarding the administration of grants in the following OMB Circulars (which can be obtained from OMB’s Office of Federal Financial Management, at (202) 395-3993, [http://www.whitehouse.gov/omb/circulars_default](http://www.whitehouse.gov/omb/circulars_default) or [http://www.ecfr.gpoaccess.gov](http://www.ecfr.gpoaccess.gov).


The circulars cover:

- Standards for financial management systems, including payments, program income, revision of budget and program plans, and non-Federal audits.
- Purpose of property standards, including the purpose of insurance coverage, equipment, supplies, and other expendable property.
- Purpose of procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records.
- Purpose of reports and records, including monitoring and reporting program performance reports, financial reports, and retention and access requirements.
- Purpose of termination and enforcement.
- Purpose of closeout procedures.

Costs Applicable to Grants and Contracts
The following resources establish principles and standards for determining costs applicable to grants, contracts, and other agreements entered into by the types of organizations specified:

- OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (codified in 2 CRF 225)

**Audit Policies and Standards**

Government-wide policies and standards for non-Federal organization-wide audits of recipients of Federal awards are explained in:

OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

**Additional Guidance**

For additional guidance, Ryan White Part B grantees may also utilize the January 1, 2007, HHS Grants Policy Statement. This policy statement compiles policies and reviews policy issues that have been raised in the past regarding the administration of grant awards (http://dhhs.gov/asfr/ogapa/grantinformation/hhsgps107.pdf).

In addition, HRSA develops policies that implement the Ryan White legislation providing guidance to grantees in understanding and implementing legislative requirements. Program letters provide additional guidelines to grantees (http://www.hab.hrsa.gov/manageyourgrant/policiesletters.html).

**Summary of Annual Fiscal Year Notice of Grant Award**

The Notice of Grant of Award (NoA) contains all the legislative and programmatic requirements of the grant. The grantees are responsible for meeting all grant specific term program, standards terms and fulfilling all reporting requirements indicated in the NoA. Failure to comply with any of the special conditions and/or reporting requirements of award by the specified due date may result in the suspension of the grantee’s ability to drawdown funds, the disallowance of funds, or both.

In addition, the NoA includes a Special Remarks section which contains information such as matching requirements, expenditure limitations, and the dollar amount included in the award for a specific activity (e.g., Minority HIV/AIDS Initiative funding, AIDS Drug Assistance Program funding). There is also a contact section with names, addresses, and telephone numbers of persons to contact regarding grants management issues and/or programmatic issues.

**Tracking and Reporting Unobligated Balances**
The UOB Policy 12-02 for Ryan White Part B Formula, Supplemental and MAI funds provides guidance on Ryan White Part B Unobligated Balances and Carryover Provisions. Ryan White Part B formula funds include the Ryan White Part B Base and ADAP earmark formula awards; and supplemental funds include the ADAP Supplemental, Emerging Communities and Ryan White Part B Supplemental awards. Grantees must separately track formula/base, ADAP Base, ADAP Supplemental, Emerging Communities, and MAI grant funds and the unobligated and carryover funds for each of these grant fund categories as applicable. Information about the data system(s) utilized to track funds is important.

The unobligated balance provision does not apply to funds from drug rebates under Ryan White Part B. By law, drug rebate amounts are not considered part of the grant award and are not subject to the unobligated balances provisions. **Rebate funds should never be recorded as UOB on any FFR.**

### Unobligated Balances and Carryover of Funds

Legislative language in Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) interrelates the reporting of Unobligated Balances (UOB) with the uses of UOBs. Grantees are required to submit an Estimated Carryover Request together with the estimated UOB 60 days before the end of the grant year or by January 31. Failure to submit a timely carryover request and estimated UOB in the EHB portal can result in a grantee being ineligible to receive Ryan White HIV/AIDS program Ryan White Part B formula carryover funds.

If a grantee does not request a waiver, and later identifies and reports unobligated Ryan White Part B formula funds in the Final Federal Financial Report (FFR), the grantee will not be able to carryover any part of its UOB. Once the grantee carryover waiver request is approved by HRSA, the grantee will be able to expend the approved UOB in accordance with the purpose stated in the application. If funds are not expended in the carryover year, the funds will be cancelled and cannot be used in subsequent years.

The Ryan White HIV/AIDS legislation requires a waiver to request carryover of unobligated formula funds before the end of each fiscal year as necessary regardless of the amount of remaining funds. The carryover request must be submitted electronically using the Electronic Handbook application. The request must contain the following information:

- Estimate of the unobligated balance at the end of the grant year.
- Estimated amount of funds projected to be available for carryover including the methodology used for estimating the carryover amount.
- Source of the unexpended carry over funds (administrative, direct service, program support, certain provider categories).
- Proposed use (existing or new service, new priority, one-time use, maintenance of enhanced levels of service, and cost annualization in future years).
- Justification for use of funds (quantification of number of clients, units of service, link/responsiveness of proposed use to identified need).
- Time period proposed for use of funds and ability to use.
- Capacity of the grantee to make funds available for use and of the entities to utilize such funds in the designated time period.

**Monitoring Compliance of Carryover Requests**

In reviewing requests for approval of carryover funds, HAB will continue to assess the following:

- History of expenditures and carryover requests.
- Specific situations regarding the current year’s awards.
- Submission of the final FFR on or before July 30 reconciled with the grantee Payment Management System account.
- Intended purpose and budget justification for the request.
- Performance issues, including compliance with conditions of grant award.

**Maintenance of Effort and Matching Funds**

For information about these requirements, see relevant chapters in this manual.

**Grantee and Provider Contract Requirements**

According to OMB Circular A-102 (or 45 CFR Part 92), local government grantees may use their own procurement procedures that reflect applicable State and local laws and regulations, provided that the procurement procedures conform to applicable Federal law and the standards identified in the Circular (Part 92.36). Identified standards concern the following areas:

- Written code of standards of conduct for employees involved in the award and administration of contracts.
- Procedures to avoid the purchase of unnecessary and duplicative items.
- Making awards to responsible contractors.
- Maintaining records to detail the history of a procurement.
- Settlement of all contractual and administrative issues.
- Protest procedures to handle and resolve disputes.
- Providing for full and open competition.
- Written selection procedures for procurement transactions.

A contract must contain the clauses necessary to ensure that all requirements under the grant will be satisfied, since neither 45 CFR Parts 74 and 92 nor other documents are directly binding on a contractor. The contract should specify:

- Nature and number of services to the provider.
- Eligibility requirements for consumer enrollment in services.
- Line item budget and/or a payment rate per unit per service.
- Nature and frequency of required reports.
- Data collections criteria and expected reporting.
- Processes for reimbursement payments including invoicing and time frames.
- Program and fiscal monitoring processes and time frame.
- Quality management expectations.
VIII. Ch 6. Costs for Administration, Planning, Evaluation, and Clinical Quality Management

Introduction

The Ryan White legislation defines administrative activities in Ryan White Part B programs to include routine quality management monitoring, and limits the percentage of the award that the grantee can spend on administrative activities. Ryan White includes several requirements regarding the use of Ryan White Part B funds to carry out administrative activities. Some of these requirements apply to grantees, while others apply to lead agencies, consortia, and subcontractors. While the legislation does not require any single provider to meet administrative cost caps on their own, the State grantee must limit the aggregate administrative costs of its first-line entities to 10 percent of the total funds awarded to those entities.

Legislation, HRSA Program Requirements, and Expectations

Planning, Evaluation, Administration, and Clinical Quality Management Costs

The Ryan White legislation defines administrative activities for Ryan White Part B grantees as follows: Section 2618 (b)(3)(A) of the limits Ryan White Part B grantees to spending not more than 10 percent of their grant on planning and evaluation activities, not more than 10 percent of their grant on administration, and, when combined, not more than 15 percent of their grant on planning, evaluation, and administration.

In the case of entities and subcontractors to which a State allocates amounts received by the State under a grant under section 2611, the State shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).”

“From amounts received under a grant awarded under section 2611 for a fiscal year, a State may use for activities associated with the clinical quality management program required in clause (i) not to exceed the lesser of 5 percent of amounts received under the grant or $3,000,000.”

HRSA/HAB Monitoring Standards on administrative costs state:

“Ryan White Part B Fiscal Monitoring Standards: Section A. Limitation on Uses of Ryan White Part B Funding. 5. Appropriate sub-grantee assignment of Ryan White Part B administrative expenses, with administrative costs to include:
   a. Usual and recognized overhead activities, including rent, utilities and facilities costs; and
   b. Costs of management oversight of specific programs funded under [Ryan White Part B], including program coordination, clerical, financial,
management staff not directly related to patient care, program evaluation, liability insurance, audits, computer hardware/software not directly related to patient care.”

**Defining Clinical Quality Management Costs**

In deciding what quality management activities to undertake, Part B grantees should coordinate clinical quality management efforts with program evaluation activities supported by Ryan White Program funding. Clinical Quality Management funds are used for Ryan White expenditures that are not service-oriented or administrative in nature. Clinical Quality Management activities may include but are not limited to:

- Capacity building
- Management of Clinical Quality Management Program (convene a quality committee, work with first line entities, implementing quality improvement projects, etc.)
- Data management (performance measure data collection, aggregation, analysis, and reporting)
- Clinical Quality Management site visit (patient chart audits, meeting with patients, etc.)
- Estimated patient experience (surveys, focus groups, patient interviews, etc.)
- Training (clinical care and quality-related)

**Administrative Costs Caps**

**Ryan White Part B Grantees**

Administrative costs associated with the 10 percent administrative cap for Ryan White Part B grantees include the following:

- Development of funding applications and receipt and disbursal of program funds.
- The receipt and disbursal of pharmaceutical funds.
- The development and establishment of reimbursement systems (340B rebate, Medicaid back billing), and accounting systems.
- The preparation of routine programmatic and financial reports, including the minimum requirements of completing Ryan White data reports.
- Compliance with grant conditions and audit requirements.
- All activities associated with the grantee’s contract award procedures, including the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, development and implementation of grievance procedures, monitoring of contracts through telephone consultation, written documentation or on-site visits, reporting on contracts, and funding reallocation activities.

**First Line Entities/Lead Agencies with Management and Oversight Functions**

While first line entities are subject to the aggregate cost cap associated with the administrative activities listed above, they may also be subject to the grantee administrative cap associated with the following activities:
Development of funding applications and proposals.
Receipt and disbursal of program funds.
Development and establishment of reimbursement and accounting systems.
Preparation of routine programmatic and financial reports, including the minimum requirements of completing Ryan White data reports.
Compliance with contract conditions and audit requirements.
Subcontract monitoring and reporting, through telephone consultation, written documentation or on-site visits, developing funding applications and proposals, and the receipt and disbursal of program funds.

Planning and Evaluation (Grantees)

Planning and evaluation includes grantee activities related to planning for the use of ADAP funds and evaluating the effectiveness of those funds in delivering needed services. Specific activities that planning and evaluation funds may support for ADAPs include the following:

- Capacity-building to increase the availability of services.
- Technical assistance to contractors.
- Program evaluation.
- Assessment of service delivery patterns.
- Assessment of need.
- Obtaining community input.
- Drug utilization reviews.

Program Support and Quality Control by First-Line Entities

Program support and quality control activities for first-line entities include the following:

- Client satisfaction surveys.
- Technical assistance to subcontractors.
- Staff training.

Administrative Cost Caps

Ryan White Part B Grantees

In accordance with Section 2617(b)3(A) of the Ryan White legislation, grantees are allowed to use up to 10 percent of Ryan White Part B funding for the payment of administrative costs in any given grant year, with a total of 15 percent of the Ryan White Part B grant used for the combination of grantee administration, planning and evaluation.

Ryan White Part B grantee administrative, planning and evaluation costs charged to the Ryan White Part B grant must fall within the limits as calculated above. Ryan White Part B grants include a Federal earmark for the ADAP. The calculations for planning and evaluation, administrative costs, and clinical quality management costs may be done separately on each portion of the grant. The selected percentages taken from each part of the grant do not have to be
the same, but they each must fall within the caps as calculated above. Any funds taken out of the ADAP earmark must be spent on the grantee’s administration, planning, evaluation, and clinical quality management costs related to the ADAP.

There is no requirement that funds taken out of ADAP non-earmarked amount for administration costs be used in any set proportion between ADAP and other program components.

**First-Line Entities**
The 10 percent administrative cost cap applies only to first line entities, which can include State-run ADAPs and Health Insurance Continuation programs, among others. A program’s administrative costs may be separated from the grantee’s administrative costs if the program is run by the grantee itself or by a closely related unit of State government. The basis for calculating the aggregate administrative cost cap for first line entities under Ryan White Part B is the total amount remaining after the grantee takes its administrative, planning, and evaluation costs out of the award. The 10 percent factor is applied to this total amount. For example, if a grantee receives a grant award of $3,000,000 and uses the maximum amount of 15 percent ($450,000) for its own administrative, planning, and evaluation activities, $2,550,000 remains for distribution. For first line entities that receive $2,550,000, a maximum of 10 percent ($255,000) can be charged to the Ryan White Part B grant for administrative costs. That is, regardless of how much an individual first line entity spends on administrative costs, when added across all such entities, administrative costs that are paid for with Ryan White Part B funds cannot exceed $255,000.

**Second or Third-Line Entities**
Second and third line entities (sub-contractual providers) administrative costs are included as part of the aggregate administrative costs. Therefore their 10% cap would apply against the first line entity cap. The Grantee responsibility is to monitor all administrative costs to ensure they do not exceed the allowable rate.

**Program Income and Client Charges**
HRSA/HAB Monitoring Standards on program income state:

**HRSA/HAB Fiscal Monitoring Standards.** Section C: Income From Fees for Services Performed. 5. Ensure service provider retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: Funds added to resources committed to the project or program, and used to further eligible project or program objectives; Funds used to cover program costs. **Note:** Program income funds are not subject to the Federal limitations on administration (10%), clinical quality management (5%), or core medical services (75% minimum). For example, all program income can be spent on administration of the Ryan White Part B program, except in ADAP.

**HRSA/HAB Fiscal Monitoring Standards. Section D.** Imposition & Assessment of Client Charges. 1. Unless waived, Ensure grantee and sub-grantee policies and procedures that specifies charges to clients for services, which may include a documented decision to
impose only a nominal charge. Note: This expectation applies to grantees that also serve as direct service providers and/or ADAP pharmacies.

**Standard.** No charges imposed on clients with incomes below 100 percent of the Federal Poverty Level (FPL).

**HRSA/HAB Fiscal Monitoring Standards. Section D:** Imposition & Assessment of Client Charges 3. Charges to clients with incomes greater than 100 percent of poverty that are based on a discounted fee schedule and a sliding fee scale. Cap on total annual charges for Ryan White services (including ADAP) based on percent of patient’s annual income, as follows: 5 percent for patients with incomes between 100 percent and 200 percent of FPL; 7 percent for patients with incomes between 200 percent and 300 percent of FPL; 10 percent for patients with incomes greater than 300 percent of FPL.

In accordance with Section 2617(c)1 of the Ryan White legislation, an ADAP must have a sliding fee scale if clients are billed for services.

**Documentation and Compliance**

**Grantees**
Ryan White Part B grantees are required to submit categorical budgets and narrative justifications to the HRSA for approval. These budgets must be submitted for administration, planning, evaluation, and services. Project officers and grants management staff review the grantee budgets and determine whether the grantee’s administrative costs fall within the statutory limits.

**First Line Entities**
Governors (or their designees) are required to sign program assurances with their application to HRSA for funding (SF 424B, Program Assurances). Included among them is an assurance that the 10 percent aggregate administrative cost cap requirement will be met. Like all other program assurances and legal requirements, compliance is subject to audit by such entities as the Office of the Inspector General at the U.S. Department of Health and Human Services and the Government Accountability Office. HRSA/HAB strongly recommends that grantees encourage lead agencies to use a budget format that clearly identifies the costs for administration (as defined in this chapter under “Definitions, Defining Administrative Costs, and Lead Agencies”).

In their budget justifications, grantees will be required to identify the following information for “first-line” entities:

- The aggregate amount of funds available for the entities to spend on administrative costs.
- An estimate of the total amount of administrative costs those entities will incur over the budget year.

At the end of the budget year, as part of the final progress report submitted to HRSA, this information must be updated to reflect actual expenditures. Both the initial and final documentation of these figures will have to be signed by the financial officer in charge of the Ryan White grant.
VIII. Ch 7. References, Links, and Resources

2. HHS Grants Policy Statement, January, 2007:  

For More Information

Section IX. Insurance Programs

IX. Ch 1. Overview

Most Americans receive health insurance coverage through their employers under group policies, while a smaller proportion buys individual policies. Group and individual health insurance policies are offered through private health insurance companies or self-administered plans that employers fund. Complementing private coverage are public programs that offer health coverage similar to private plans. It is within this health insurance marketplace that Ryan White Part B Programs have the option of purchasing health coverage for their clients instead of paying solely for HIV/AIDS medications. Many States have health insurance purchasing programs—under Ryan White Part B and/or through their Ryan White Part B ADAP. The programs are expected to increase under the Affordable Care Act as options for purchasing insurance expand under State Health Insurance Exchanges. Options include:

- **Coverage on the Individual Health Insurance Market.** State Health Insurance Exchanges will be fully operational in 2014, providing expanded options to purchase individual and small group health insurance coverage.

- **State High-risk Pools.** Risk pools are mechanisms to provide insurance for people in a variety of situations: when individuals have lost their coverage, are ineligible for Medicaid or Medicare, cannot purchase insurance due to eligibility criteria that exclude pre-existing conditions, and/or cannot otherwise afford insurance. Risk pools are likely to wane with full implementation of the Affordable Care Act, which—for example—prohibits pre-existing condition exclusions.

- **Pre-existing Condition Health Insurance Plans (PCIP).** This Affordable Care Act provision (scheduled to end December 31, 2013) is a Federal version of State high risk pools. Federal funds enabled States to establish state-administered PCIPs or default to the federally administered PCIP. Persons eligible for PCIPs must have a pre-existing condition, be a U.S. citizen, and be uninsured without creditable coverage for the prior six months. Nearly half of ADAPs were able to enroll ADAP clients in PCIPs, although some barriers were reported (e.g., establishing the infrastructure to coordinate with PCIPs, individual State PCIP prohibitions on third party payers). Ryan White funds may be used to pay the premiums, co-pays and deductibles for clients that are enrolled in a PCIP, just as they may for Medicare Part D or other health insurance. Ryan White funds may not be used to pay for administrative costs associated with PCIP.

IX. Ch 2. Legislative Background

The Ryan White legislation defines core medical services, including: 2612 (b)(3)(F): Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.
In addition, Section 2615 provides for the use of amounts under Ryan White Part B for programs that extend private health insurance or create risk pools as follows:

“SEC. 2615. [300ff–25] CONTINUUM OF HEALTH INSURANCE COVERAGE.  
(a) IN GENERAL.—A State may use amounts received under a grant awarded under section 2611 to establish a program of financial assistance under section 2612(b)(3)(F) to assist eligible low-income individuals with HIV/AIDS in—
   (1) maintaining a continuity of health insurance; or
   (2) receiving medical benefits under a health insurance program, including risk-pools.
(b) LIMITATIONS.—Assistance shall not be utilized under subsection (a)—
   (1) to pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools); and
   (2) to pay any amount expended by a State under title XIX of the Social Security Act.”

Section 2616, provision of treatments, provides further defines the use of health insurance and plans as follows:

“Section 2616. 300ff–26 Provision of Treatments. 
(f) USE OF HEALTH INSURANCE AND PLANS.—
   (1) IN GENERAL.—In carrying out subsection (a), a State may expend a grant under section 2611 to provide the therapeutics described in such subsection by paying on behalf of individuals with HIV/AIDS the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.
   (2) LIMITATION.—The authority established in paragraph (1) applies only to the extent that, for the fiscal year involved, the costs of the health insurance or plans to be purchased or maintained under such paragraph do not exceed the costs of otherwise providing therapeutics described in subsection (a).”

In addition, HAB Policy 07-05 and 10-02, and policy letters provide further guidance to grantees on health insurance purchase option under Ryan White Part B Program grants.

HAB Policy Notice 07-05, The Use of Ryan White HIV/AIDS Program Ryan White Part B ADAP Funds to Purchase Health Insurance states, in part:

“HAB Policy Notice 07-05. Ryan White Part B funds, including ADAP funds, may be used to purchase health insurance that includes the full range of HIV treatments and access to comprehensive primary care services, subject to the conditions noted in the ADAP earmark funds (and other ADAP designated funds) can be used to purchase health insurance for ADAP clients. These health insurance policies must include access to comprehensive primary care services and, at a minimum, include coverage for medications that are equivalent to the State’s ADAP formulary. ADAP dollars may be
used to cover any costs associated with the health insurance policy, including co-
payments, deductibles, or premiums to purchase or maintain insurance policies.”

HAB Policy Notice 10-02 defines eligible individuals and service categories representing
allowable uses of Ryan White HIV/AIDS Program funds. Includes health insurance continuation
eligibility formerly included under Policy Notices 97-01 and 97-02.

HAB’s Dear Colleague letter on insurance plans states, in part:

“HAB’s Pre-existing Condition Insurance Plan and the Use of Ryan White Funds “Dear
Colleague” letter dated March 15, 2011: Ryan White funds may be used to pay the
premiums, co-pays and deductibles for clients that are enrolled in a PCIP, just as they
may for Medicare Part D or other health insurance. Ryan White funds may not be used to
pay for administrative costs associated with PCIP. See HAB’s policies and program

IX. Ch 3. Private Insurance Coverage for HIV/AIDS Care

Historically, PLWHA have had a difficult time obtaining private health insurance and have been
particularly vulnerable to insurance industry abuses. Private insurance still represents a
significant source of coverage for individuals with HIV/AIDS.

Group health insurance is private insurance often comes with employment. Many of these
programs cover comprehensive medical care, including hospital visits, outpatient care (clinic
settings) prescription coverage and specialist visits. Persons with HIV/AIDS who are insured in
the group insurance market tend to have the most comprehensive coverage and experience less
problems obtaining and keeping that coverage. By law, an employer cannot refuse insurance
coverage to any employee who is covered by the group plan and meets the eligibility
requirements. In other words, an employee cannot be denied insurance coverage by a group plan
based on a pre-existing health condition such as HIV. An employer also cannot require an
employee to pay an increased rate for insurance based on a pre-existing condition. All employees
are expected to pay the same amount of money for the same type of coverage.

Under Federal COBRA (Consolidated Omnibus Reconciliation Act) legislation, employers are
required to offer individuals leaving their workforce continued health insurance coverage, at the
individual’s expense, under the employer’s group plan. Coverage can be continued for 18
months and a person may become eligible for an extension of the maximum time period in two
circumstances. The first is when a qualified beneficiary (either the individual or a family
member) is disabled; the second is when a second qualifying event occurs. Persons are expected,
however, to pay the full amount of the monthly premium.

Persons with HIV/AIDS may be able to buy an individual health insurance policy, but they tend
to be more expensive and require a pre-screening application that may exclude coverage for pre-
existing conditions, like HIV disease.
The insurance market is largely regulated at the state level; however, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), also known as HIPAA, established basic national standards for insurance regulation in the small group insurance market (firms with 2 to 50 workers) and, to a lesser extent, in the individual insurance market. Protections covered in HIPAA included the following:

- **Portability.** Exclusions of preexisting medical conditions are limited to a maximum of 12 months.
- **Nondiscrimination.** Insurers in the group market are prohibited from conditioning persons’ eligibility for group coverage on their health status. This does not apply to individual policies.
- **Guaranteed issue.** Insurers must offer all of their small-group policies to any small employers that want to purchase coverage for their workers.
- **Guaranteed renewal.** Insurers must allow all policies—group and individual—to be renewed.

While private insurance represents a significant source of coverage for individuals with HIV/AIDS, it is reduced in its importance as a source for coverage as a person’s HIV disease progresses, which is when Federal entitlement programs begin to increasingly take over as the primary source of source of insurance coverage.

**IX. Ch 4. Public Health Care Programs**

**Introduction**

Currently, fewer than one in five (17%) PLWH has private insurance and nearly 30% do not have any coverage. Medicaid, the Federal-State program that provides health care benefits to low-income people and those living with disabilities, is a major source of coverage for PLWHA, as is Medicare, the Federal program for seniors and people with disabilities. The Ryan White HIV/AIDS Program, funded through the Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) is another key source of funding for health and social services for this population. There are a number of Federal and State sponsored programs and initiatives that are available to the public to pay for healthcare needs.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (Affordable Care Act) and set into place an effort that will help ensure Americans have secure, stable, and affordable health insurance. Historically, PLWHA have had a difficult time obtaining private health insurance and have been particularly vulnerable to insurance industry abuses. People with HIV/AIDS also face barriers to obtaining care from qualified providers. Consistent with the goals of the President’s National HIV/AIDS Strategy, the Affordable Care Act makes considerable strides in addressing these concerns and advancing equality for PLWHA.

Medicaid: Coverage for Persons With HIV/AIDS

Medicaid, Title XIX of the Social Security Act, is the largest source of public financing for HIV/AIDS care in the United States. Created in 1965, Medicaid is a jointly funded, jointly administered Federal-State health insurance program for low-income people who meet one or more of several categorical eligibility requirements, including disability. The program is administered through the Centers for Medicare and Medicaid Services (CMS). Through Medicaid, the Federal Government provides matching funds to States that meet certain minimum Federal standards in operating their Medicaid programs. States have broad flexibility in designing their Medicaid programs, and consequently there is significant variation in eligibility, benefits, provider payments, and other aspects of the program at the state level.

State Medicaid policies vary considerably even among similar-sized and or adjacent States. Thus, a person who is eligible for Medicaid in one State might not be eligible in another State; and the services provided by one State may differ from those of another State. Because many people with HIV/AIDS are low income—or become low income—and disabled, Medicaid is an important source of coverage.

To be eligible for Medicaid, a person must meet the categorical and financial eligibility criteria in his or her State’s Medicaid program. Most adults with HIV/AIDS who qualify for Medicaid do so because they meet the disability and income and assets criteria of the Federal Supplemental Security Income (SSI) program for persons who are aged, blind, or disabled. For purposes of SSI eligibility, a person is disabled if he or she is unable to engage in any gainful activity due to a medically determined physical or mental impairment expected to result in death or last for a continuous period of at least 12 months. Some States, known as 209(b) States, may apply more restrictive eligibility rules under SSI. People with HIV may also qualify for Medicaid through a State’s medically needy program that enables those who meet categorical eligibility requirements, such as disability, to spend-down their incomes to meet their State’s income eligibility threshold, which varies among States. Individuals must also meet a State’s resource test.

Federal rules require States participating in Medicaid to cover a set of mandatory services to eligible people in order to receive Federal matching payments (Box 3-1). States may also choose to provide optional services and receive matching payments. FDA-approved prescription drugs are an optional benefit that all States have chosen to provide. Medicaid coverage of prescription drugs includes all FDA-approved highly active antiretroviral therapy (HAART) drugs, but coverage of these drugs is at State option and subject to amount, duration, and scope limits (e.g., limit on the number of prescriptions), nominal co-payments for adults, and prior authorization controls. Other optional services that can be important for people with HIV/AIDS include case management, prevention services, tuberculosis-related services, and hospice services. States may also seek waivers to cover certain services that would not otherwise qualify for Federal matching funds, and a number have done so.

Medicare: Coverage for Disabled and Elderly Persons with HIV/AIDS
Medicare (Title XVIII of the Social Security Act) is the nation’s Federal health insurance program for the elderly and disabled. It was established in 1965 and is also administered by CMS. Medicare is an important source of coverage for people with HIV/AIDS who are disabled, have sufficient work history to qualify for disability insurance, and live long enough to qualify for Medicare. As people with HIV/AIDS live longer, the number of people with HIV/AIDS on Medicare is expected to grow, and Medicare spending is also expected to increase. Some individuals with Medicare coverage also qualify for Medicaid because they have low income levels; they are considered to be dual-eligible. For these individuals, Medicaid provides varying levels of coverage, including payment of premiums, some cost sharing, coverage of services during the waiting period (for those under 65 years), and coverage of prescription drugs.

Most Americans ages 65 and older are entitled to Medicare as soon as they are eligible for Social Security payments. People under age 65 who receive Social Security Disability Insurance (SSDI) benefits and individuals with end-stage renal disease may also qualify for Medicare. People with HIV/AIDS who meet SSDI eligibility criteria are eligible for Medicare benefits. The Social Security Administration defines disabled to mean that an individual 18 years or older is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment(s) that can be expected to result in death or that has lasted or can be expected to last for a period of not less than 12 months (SSA, 2004).

Social Security taxes through their workplace for a minimum number of fiscal quarters. Federal law, however, requires a 5-month waiting period after disability determination to receive SSDI benefits and then a 24-month waiting period before an SSDI beneficiary can join Medicare, resulting in a total of 29 months before receipt of health benefits (SSA, 2004).

- Part A covers inpatient hospital services, skilled nursing facilities, home health services, and hospice care.
- Ryan White Part B helps pay for the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.
- Part C allows beneficiaries to choose to enroll in a health maintenance organization or other managed care plan, a preferred provider organization or to choose a medical savings account.

The Ryan White HIV/AIDS Program: Health Insurance Continuity Program

Introduction

One of the five program components specified under Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) for which Ryan White Part B funds may be spent is a continuum of health insurance coverage for PLWH. Loss of health insurance or lack of coverage is always a fearful prospect and even more so for people dealing with costly disease such as HIV.
The number of such programs, and the amount of Ryan White Part B resources devoted to them, has increased since initial passage of the Ryan White HIV/AIDS Program legislation. Health insurance continuum of coverage programs are important for Part B programs for the following key reasons:

- **Cost Effectiveness.** Paying health insurance premiums for individuals disabled by HIV disease can be less expensive, in some cases, than covering medical expenses directly under financially stretched programs like ADAP. According to the National Alliance of State and Territorial AIDS Directors (NASTAD), States report cost savings in spending in covering health insurance premiums for persons diagnosed with AIDS.

- **Expanded Access to Care.** Health insurance can improve access to care, including antiretroviral therapies and prevention and treatment of opportunistic infections.

- **Reforms in State and Federal Health Insurance Laws.** A large number of States have enacted reforms that have the potential to broaden access to individual and small group health insurance; similar provisions have been enacted at the Federal level under the Health Insurance Portability and Accountability Act (HIPAA) and other reform efforts. Among the reforms are provisions that are intended to make it easier to access health insurance, including:
  - Getting or keeping health insurance for those with pre-existing conditions (like HIV disease).
  - Maintaining coverage when changing insurance or jobs.
  - Obtaining insurance through “guaranteed issue” laws.
  - Renewing insurance through “guaranteed renewal” laws.
  - Securing insurance at a more reasonable cost due to “rating” laws that proscribe how much can be charged for health insurance.

**Insurance Funding Options**

Health insurance continuity programs generally operate as premium payment plans. HIV-specific programs were initially created to continue payment of employment-related, group health insurance premiums, through COBRA, for individuals who became disabled and could no longer work. COBRA coverage lasts 18 months plus a 20-month extension for individuals leaving employment due to a disability. When COBRA coverage expires, individuals can obtain a conversion policy, which may provide the same benefits as their previous group plan but often at higher rates.

While COBRA coverage and conversion coverage are standard in most continuums of coverage programs, some have broadened their scope and purchase new health insurance coverage for hard-to-insure individuals through mechanisms like insurance purchasing projects or State-run risk pools.

Continuity programs often work closely with public programs to transition clients as they become eligible for public benefits.

Since health insurance is primarily governed by State laws, the implementation of health insurance continuity programs varies from State-to-State with respect to certain specifics (e.g.,
use of State funds to support the program; and administration by the HIV/AIDS program office, the State’s Medicaid program, or community agencies). However, many programs share the following characteristics:

- Continuity programs typically require health insurance policies to cover HIV-related care and prescription drugs in order to be eligible for continuation. Policies without such coverage are not typically worth continuation given the care needs of a person living with HIV disease.
- All programs cover COBRA premiums, and many continue paying premiums for individual policies when COBRA group coverage expires.
- Most continuity programs exclude Medicaid-eligible individuals because programs under Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) are the payer of last resort and, in some States, Medicaid may operate such a program.
- Programs are defined as a transitional step prior to eventual coverage by Medicaid or Medicare.
- Most continuity programs involve intensive staff work in tracking policies and monitoring benefit changes. They begin covering an individual’s premium payments immediately upon enrollment in the program in order to avoid termination of the policy due to nonpayment of premiums.
- Eligibility criteria usually include an AIDS diagnosis, disabling HIV status, maximum income (as a percentage of the Federal poverty level), a cap on assets, and residency within the State.

**Benefits of Health Insurance Continuity Programs**

The experiences of programs shows that States should study the applicability of continuity programs relative to their own unique fiscal and political circumstances. For some States, the most important consideration may be the cost savings realized by operating a health insurance continuity program. For others, it may be the ability to enhance the continuity and comprehensiveness of care for its residents with HIV/AIDS. Benefits of continuity programs include:

- Maintaining a continuum of coverage in health care services for participants.
- Sharing the cost of providing care to persons with HIV/AIDS across private and public health insurance programs, thereby reducing the fiscal impact on publicly funded programs.
- Allowing clients to continue working part-time without risking a loss of insurance coverage (in contrast with public health insurance, where rising income results in a loss of eligibility and services).
- Providing assistance until persons disabled by HIV disease can qualify for Medicaid or Medicare.
IX. Ch 5. References, Links, and Resources

5. ADAP Manual 2012: https://careacttarget.org/content/adap-manual

For More Information

Please refer to the HAB Target Center at https://careacttarget.org.
Section X. Planning and Planning Bodies

X. Ch 1. Overview

Ryan White Part B funds are awarded to the State agency, usually the State health department, designated by the Governor to administer the Ryan White Part B Program. States are responsible for managing grant funds and overseeing services. They must ensure appropriate needs assessment and planning for the use of Ryan White Part B funds to provide essential health and support services, through regional or statewide planning bodies or other means.

Ryan White Part B planning bodies, Statewide or regional, are established or chosen for these roles by the State (as the Ryan White Part B grantee). Ryan White Part B regional or statewide planning bodies are often called consortia. Consortia are groups of providers, consumers, and others who perform a planning and advisory function to regions, or the entire State, in determining needs and planning for the delivery of essential health and support services for PLWHA. States may provide these Ryan White Part B services directly or through consortia. Regardless of the mechanism used, planning is an essential part of determining how to use limited Ryan White Part B funds in providing a system of HIV/AIDS care and to ensure that the Ryan White Program is the payer of last resort.

Both the State and consortia have designated responsibilities in the areas of planning and delivery of Ryan White services. Regardless of the set-up, planning requires broad membership involvement in order to bring diverse experience and input into such tasks as needs assessment, developing a comprehensive plan, setting priorities, and allocating funds to service categories. Ensuring smooth operation of planning bodies also requires planning bodies to have in place operating policies and processes as well as conflict of interest and grievance procedures to guide their decision making.

Beyond their planning duties, consortia have other responsibilities that are prescribed in the legislation. Other responsibilities are delegated by the State, and still others are assumed by each consortium in response to needs in its service area. In some cases, consortia actually deliver services, while other consortia do so through funding agreements. The Ryan White legislation describes the State’s responsibilities related to planning efforts, processes and bodies. The chapters that follow will provide detailed legislative background related to relevant issues addressed.

X. Ch 2. Legislative Background

State Requirements

Section 2617(b)(3) requires the State to submit a Ryan White Part B application that contains [in part] a determination of the needs of the population with HIV/AIDS in the State, “with particular attention to—
“(A) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; and
(B) disparities in access and services among affected subpopulations and historically underserved communities;”

and (5) a comprehensive plan that—
“(A) establishes priorities for the allocation of funds within the State based on” [in part]—
(iii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities;”
“(B) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds; and”
“(F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title.”

Minority AIDS Initiative

Section 2693 (a) authorizes funds for activities “to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.”

Needs Assessment

Section 2617(b)(2)) and (b)(3) of the Ryan White legislation requires States to determine:

“the size and demographics of the population of individuals with HIV/AIDS in the State;” as well as “the needs of such population, with particular attention to—
(A) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; and (B) disparities in access and services among affected subpopulations and historically underserved communities;

Section 2617(b)(8) requires States to assess the needs of persons with HIV/AIDS unaware of their status through a comprehensive plan:

(A) containing an identification of individuals with HIV/AIDS as described in clauses (i) through (iii) of section 2603(b)(2)(A) and the strategy required under section 2602(b)(4)(D)(iv);
(B) describing the estimated number of individuals within the State with HIV/AIDS who do not know their status;
(C) describing activities undertaken by the State to find the individuals described in subparagraph (A) and to make such individuals aware of their status;
(D) describing the manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS; and
(E) describing efforts to remove legal barriers, including State laws and regulations, to routine testing.

Section 2618(a)(2)(F) describes the needs assessment process for awarding supplemental treatment drug grants under Ryan White Part B as including the demonstration of severe need, including factors such as eligibility standards, formulary composition, inability of State to provide therapeutics to eligible persons, and anticipated increase of eligible PLWHA.

Under Section 2620, States that have demonstrated need under Section 2617 for supplemental grants and did not have funds canceled, offset or waived under Sections 2618 or 2622, utilizing the following factors:

“(b) Demonstrated Need- The factors considered by the Secretary in determining whether an eligible area has a demonstrated need for purposes of subsection (a)(1) may include any or all of the following:
(1) The unmet need for such services, as determined under section 2617(b).
(2) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.
(3) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.
(4) The current prevalence of HIV/AIDS.
(5) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.
(6) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.
(7) The prevalence of homelessness.
(8) The prevalence of individuals described under section 2602(b)(2)(M).
(9) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.
(10) The impact of a decline in the amount received pursuant to section 2618 on services available to all individuals with HIV/AIDS identified and eligible under this title.”

Emerging Communities under Section 2621 are required to “submit a detailed description of the manner in which the State will use amounts received under the grant and of the severity of need.” The description must include a demonstration of the manner in which the proposed services are consistent with local needs assessments and the statewide coordinated statement of need.

Needs assessment data are critical to conducting other planning tasks. Needs assessment results must be reflected in both the State/Territory priority setting and resource allocations and in the comprehensive plan. Planning councils are required to:

- Address coordination with programs for HIV prevention and the prevention and treatment of substance abuse.
- Include links with outreach and early intervention services.
Address capacity development needs.

Be closely linked with comprehensive planning and annual implementation plan development, as interconnected parts of an ongoing planning process.

Section 2620(b) noted above also specifies the factors that the Secretary may consider in making awards for demonstrated need.

Ryan White Part B grantees are responsible for setting service priorities, determining how best to meet those priorities, and allocating resources. Since 2006, the legislation has stipulated that not less than 75 percent of service dollars are to be used for core medical services. This requirement, along with waiver provisions established by HRSA, needs to be factored into the priority setting process.

Priority Setting

Under Section 2617(b)(5) States are required to develop a comprehensive plan “that shall include a description of the purposes for which the State intends to use such assistance, and that—

(A) establishes priorities for the allocation of funds within the State based on—

(i) size and demographics of the population of individuals with HIV/AIDS (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));

(ii) availability of other governmental and nongovernmental resources, including the State Medicaid plan under title XIX of the Social Security Act and the State Children’s Health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with HIV/AIDS;

(iii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and

(iv) the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;”

Resource Allocation

Section 2617(b)(5) requires States comprehensive plan to provide a description of the manner in which “services funded with assistance provided under section 2611 will be coordinated with other available related services for individuals with HIV/AIDS, a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need, and key outcomes to be measured by all entities in the State receiving Ryan White assistance.

Section 2613, “Grants to Establish HIV Consortia” establishes grants by States to entities for the provision of comprehensive health and support services in specific localities within the State.
Other service categories specifically mentioned in the Ryan White legislation as eligible to receive funding amounts from State grants include home and community-based care, provision of treatments, health insurance coverage are covered under core services provision in Section 2612.

**Legislative Requirements for Use of Funds**

Ryan White legislation contains a number of provisions relating to use of funds that must be factored into the priority setting and resource allocation process. These are found in Section 2612 of the Ryan White legislation.

**Develop a Comprehensive Plan**

Section 2617(b)(5) requires States to: “develop a comprehensive plan for the organization and delivery of health and support services” to be funded under Section 2611 that shall include a description…that—

“(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);

(E) provides a description of the manner in which services funded with assistance provided under Section 2611 will be coordinated with other available related services for individuals with HIV/AIDS;

(F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title;”

**Participation in Public Planning Processes**

Planning body requirements for States are outlined in Section 2617(b)(6) and (7). States are required to engage in “a public advisory planning process” to secure broad input in the development and implementation of the comprehensive plan from grantees under each Part, PLWHAs, federally recognized Indian tribes as represented in the State, providers, and public agency representatives, and other agencies, similar to those outlined for Part A planning councils in Section 2602(b)(2):

“(b) DESCRIPTION OF INTENDED USES AND AGREEMENTS.—The application submitted under subsection (a) shall contain—

(6) an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a federally
recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need;

(7) an assurance by the State that—

(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (6), and the types of entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (5) and commenting on the implementation of such plan;”

**Consortia**

Ryan White Part B planning body requirements are also outlined for consortia. Section 2613 requires the consortium membership to be inclusive in terms of (1) agencies with experience in HIV/AIDS service delivery and (2) populations and subpopulations of PLWH, who are reflective of the local incidence of HIV. Such consortia are also to be located in areas where such populations reside.

Section 2613(c)(2) also provides for additional involvement by diverse perspectives by requiring consortia, in establishing their service plans, to demonstrate that they have consulted with PLWH, the public health agency or other entity(ies) providing HIV-related health care in the area, at least one community-based AIDS service provider, Ryan White Part B grantee, Part D grantees or organizations with a history of serving children, youth, women, and families with HIV, and entities such as those required to be represented on Part A planning councils (e.g., PLWHA, health and social service providers, other payers).

**Ryan White Part B Responsibility for Convening SCSN**

The Statewide Coordinated Statement of Need (SCSN) has been a requirement of the Ryan White HIV/AIDS Program since the 1996 reauthorization. The State Ryan White Part B program is responsible for convening the SCSN for all Ryan White grantees under the following provisions:

Section 2617(b)(5)(F) requires the State’s Ryan White Part B application to “provide a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding” under this title;”

Section 2617(b)(6) requires “an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need;”

X. Ch 3. Planning Body Policies and Procedures

A. Introduction

In order to operate effectively, planning bodies require policies and procedures to guide their planning and decision making. For consortia and other Ryan White Part B planning bodies, these often include bylaws, policies, and procedures similar to those of a Part A Planning Council or an unincorporated coalition. They should be developed and approved by the entire membership, and reviewed by the grantee, with copies provided in the form of a manual to all members. Changes will occur over time, proposed by members or committees and approved by the full body.

Provisions should cover such areas as the mission of the body; membership; meeting and decision-making procedures (e.g., conflict of interest); roles for officers, board members, and committees; lead agency procedures; and enforcement.

B. Policies and Procedures Manual

A policies and procedures manual should include the following:

- Mission and objectives (including legislative requirements).
- Bylaws or related policies and procedures specifying structure; membership size, composition, terms, and selection; member roles and responsibilities; meetings, quorum, and decision making; committees; and reference to key policies.
- Meeting procedures including attendance requirements and voting procedures.
- Annual work plan.
- Detailed membership procedures (including recruitment strategies, application process, selection, and methods for removing members).
- Committee policies and procedures.
- Job descriptions for all officers, general members, and committee members.
- Lead agency duties (if applicable) and the relationship of the planning body and lead agency, or similar information about the relationship with another administrative agency or the grantee.
- Staffing, including procedures for hiring, supervising, and managing staff where applicable, as well as position descriptions.
- Definitions and a glossary of frequently used words and acronyms.
- Confidentiality policy, including sanctions for breaches.
- Code of conduct, for members and for non-members attending meetings.
- Conflict of interest policies and procedures.
- Conflict resolution policies.
- Documentation of needs assessment, priority setting, and evaluation procedures.
- Description of resource allocation process (if this is a responsibility).
- Processes for adopting and changing policies and procedures.
• Where applicable, budget information explaining resources and how funds are budgeted.
• Other policies and procedures related to the planning body’s role in the community.

C. Key Questions to Consider

In developing policies and procedures, consider the following questions, and develop policies and procedures to answer them. For planning bodies that have been in existence for some time, review questions to be sure that current policies and procedures answer them.

D. General Procedures

• What is the mission?
• Are there formal bylaws?
• What are the body’s responsibilities?
• Which roles involve final decision making, and which are advisory?
• How is performance evaluated?
• What is the conflict of interest policy and process?
• What is the confidentiality policy?
• What policies and processes govern conflict resolution?
• If the body has staff, how are staff selected and evaluated?
• What is the relationship between the body and the State? Lead agency or other administrative agency?

E. Membership Procedures

• What categories of members are required? Desired but not required?
• What outreach procedures exist to recruit new members?
• What outreach procedures exist to identify and recruit PLWHA?
• How are members selected?
• Are there policies to help ensure that the membership includes historically underserved groups and reflects the demographics of the local epidemic?
• Do all members vote, and if not, how are voting rights established?
• What roles are specified for members? What are their job descriptions?
• What is the length of a term of membership? What are the criteria for continuing membership? Are there term limits?
• Are terms staggered so they don’t all end the same year?
• Are members required to sign a commitment statement? A code of conduct agreement?
• What is the process for removing members?
• What is the member complaint or dispute resolution process?

F. Meeting Procedures

• What are the attendance requirements?
• Does each member have one vote or is there one vote per organization?
What is the decision-making process (e.g., consensus, voting)?
What are the rules and ground rules for discussion and deliberations at meetings? Do meetings follow Robert’s Rules of Order?
Is attendance through telephone conference call permitted?
Who chairs meetings?
Who takes meeting minutes?
What is quorum requirement?
How will meetings be announced? What public announcements are required by law? By Ryan White policies?
When are meetings held?
How are reasonable accommodations made for participants with special needs?
Are alternate members designated to attend meetings for members who are unable to attend? If so, are the alternates allowed to vote?

G. Officers and/or Board Members Procedures

What are the officer and/or board member positions?
How are officers and board members selected?
What are the roles and responsibilities of each officer and board member?
What authority does each officer or board member have to make decisions?
What is the process to remove officers and board members?
How will officers’ and board members’ performance be evaluated?

H. Committee Procedures

What are the standing committees?
What, if any, ad hoc committees are needed and how are they established?
What written instructions, such as a charge to the committee, are provided, and who is responsible for preparing them?
What are the roles and responsibilities of each committee?
Do committee members include only planning body members or are they open to other people?
How are committee members selected? Do committees require a mix of providers, PLWHA, or other categories of members?
What rules and procedure are used to guide discussion and decision making at committee meetings? Do committees use Robert’s Rules of Order?
What is the quorum requirement?
What, if any, authority do committee members have to act independently of the committee or the full consortium?
How can committee members be removed?
How is committee performance evaluated?

I. Lead Agency Procedures
What are the roles and responsibilities of the lead agency?
What is the relationship between the planning body and the lead agency, as stated in a letter of agreement or memorandum of understanding?
What decisions of the planning body are binding on the lead agency and which are advisory?
What is the relationship of the planning body to the grantee?
How is the planning budget for the planning body determined, and how is it managed? Is it managed through the lead agency?
What if any decisions of the planning body is the grantee required to follow, and which are advisory?
What authority does the lead agency have to act independently of the planning body?

J. Procurement and Provider Monitoring

What is the lead agency or consortium’s responsibility for procurement?
What process is used for procurement? Is the process specified by the grantee or the lead agency? Is the process competitive?
How is the availability of the funds announced to potential service providers?
What are the guidelines or criteria for selecting service providers?
Who selects service providers?
How is conflict of interest avoided?
What is the funding appeals or grievance process for service providers who apply?
What is done to ensure that the content of provider contracts meets HRSA/HAB requirements, including National Monitoring Standards provisions?
What processes are used to ensure that the National Monitoring Standards are used by the lead agency in program and fiscal monitoring of funded providers?
How, and by whom, are funded providers evaluated, and how does the lead agency coordinate with the grantee?

K. Planning Bodies Responsible for Multiple Funding Sources

What are the relationships between the different funding sources and planning bodies, including Ryan White programs, Centers for Disease Control and Prevention (CDC) Prevention Planning Groups, HOPWA, and State general funds?
What if any responsibility does the Ryan White Part B planning body have for planning, priority setting, and/or resource development for funding sources other than Ryan White Part B?
What specific policies and procedures are used to guide planning or other tasks carried out on behalf of funding sources other than Ryan White Part B?
What policies and procedures govern the overall process?

L. Enforcement of Policies and Procedures

The body as a whole must agree to enforce its own policies and procedures. While one or two people may be assigned to monitor compliance, responsibility for effective functioning of the
group rests with every single planning body member. Hence, the body will set its own culture or “tone” of compliance with and enforcement of its own policies and procedures.

Members should be encouraged to speak up if they feel that policies and procedures are not being followed by the membership. Options include reconsidering the policy or procedure because it is not being used or no longer applies, or enforcing it. This requires agreement and implementation of specific actions when members disregard policies or procedures.

M. Changing Roles, Policies, and Procedures

Over time, Ryan White Part B planning bodies are likely to find that their roles will change as legislation is amended and various external factors influence Federal and State priorities. The planning body needs to stay flexible in order to meet changing requirements from the State, HRSA/HAB, and other outside authorities. Changes in the Ryan White legislation, other changes in the health care system such as those associated with the Affordable Care Act, and implementation of the National HIV/AIDS Strategy are among the external factors that may lead to changes in planning body responsibilities and operations.

N. Technical Assistance

The Ryan White Part B grantee (i.e., State) can provide technical assistance to ensure that policies and procedures are developed, implemented, and maintained. The State can also request technical assistance for the planning body through its HAB/DSHAP Project Officer. Direct interventions may sometimes be required by a Ryan White Part B grantee to ensure that legislative mandates are carried out. Ultimately, the Ryan White Part B grantee is responsible for ensuring that planning bodies within their State comply with Federal and State requirements and guidance, as well as for keeping the planning body informed about changes in requirements.

X. Ch 4. Member Involvement and Retention

A. Introduction

Ryan White puts planning in the hands of groups broadly representative of the local community. In general, membership should be as inclusive and as diversely representative as possible. This includes representatives from all populations directly impacted by HIV/AIDS and from the broader health care community. The typical planning body is composed primarily of people directly involved with HIV/AIDS, either as consumers or providers of health care services. The more perspectives that are represented in the planning process, the better the chances that decisions will reflect community needs and be supported by participants and the broader community.

Multiple areas of expertise should be represented in the membership of a planning body. Examples include expertise in what it is like to live with HIV; expertise in how to deliver care and treatment programs to PLWHA; technical expertise in the health care planning activities required of the planning body, including needs assessment, priority setting, comprehensive planning, resource allocation, and evaluation; and expertise in group process.
A possible formula for membership recruitment and maintenance is: **The better organized and operated the planning body; the easier it is to recruit new members and to retain current members.** Members will feel that they are making a worthy contribution to an effective enterprise if the following holds true:

- The mission is clearly defined.
- Policies and procedures are documented and agreed on by all members.
- New members received a thorough orientation and ongoing mentoring, and all members receive training when the planning body assumes new tasks.
- Tasks necessary to the mission are specified and pursued by the members themselves.
- The committee structure allows all participants to understand their roles and responsibilities.
- Meetings are conducted in a participatory, efficient, and timely manner.
- The group acknowledges that everyone has an equally important contribution to make and that not everyone must be an expert in every aspect of the process.

**B. Different Types of Participation**

Most Ryan White Part B planning bodies have specified membership, such as service providers and PLWHA, and they are voting members. Many planning bodies also have non-voting members or other individuals that regularly attend meetings in an advisory role. The latter are usually staff or board members of a lead agency. Sometimes contracted service providers are not given a vote because of concern that assigning voting privileges to these members could lead to problems associated with conflict of interest. Other groups allow only a designated number of voting members from each of the perspectives represented—consumer, provider, and individuals with other types of affiliations and expertise. Additional representatives can participate as non-voting members. Often, a single organization can have only one voting member on a planning body. Finally, there are bodies that offer non-voting membership to people who cannot attend regularly.

While the body guides planning locally, membership should not be a requirement to participate in planning. Nonmembers can contribute needed expertise through participation on selected committees, caucuses, and task forces, respond to surveys, and participate in focus groups or key informant sessions to identify needs and service gaps. Some nonmembers with special expertise can be recruited to join in an advisory capacity, with limited duties. This approach has been used to involve experts, such as local physicians, who may have limited time. They might be asked to review needs assessment results and the draft comprehensive plan and give feedback.

**C. Obstacles to Participation**

Obstacles that can harm member participation in consortia and other planning bodies include the following:

- **Lack of clearly defined roles, responsibilities, and expectations for members.** New members who are unclear about their role may become observers rather than participants.
Further, potential new members may not continue because they do not know how to contribute or where they fit into the process.

- **Lack of formal orientation and training.** New members need to be oriented and all members need ongoing training in the skills required to perform their duties. Without orientation, new members may feel discouraged because they do not understand what is happening. Without training, members who feel they cannot participate fully in all activities may simply attend meetings and observe – and then eventually stop attending. This dynamic sets up a situation where the process is dominated by a few members.

- **Lack of knowledge of the formality and complexity of planning body processes.** The primary tasks – needs assessment, comprehensive planning, priority setting, resource allocation, and evaluation – are complex. To understand and participate in them requires a fairly high level of knowledge and training. Additionally, procedures used to enact business, such as parliamentary procedures and the relationships of committees to the full consortium, can be confusing to participants.

- **Inaccessible meeting times or locations.** Members who participate as part of their job requirements because they are employed in agencies related to the activities of the body tend to prefer meetings during their work days. Members who are employed outside of the HIV/AIDS field often find it difficult to attend meetings during the day and prefer evening meetings. Location of the meeting can also affect who attends, and frequent changes of meeting times and locations can hurt attendance.

- **A meeting process that is filled with conflict and does not seem productive.** When meetings are badly run, overly long, or filled with anger and conflict, members tend to stop participating and then stop attending.

- **Lack of administrative support.** Some planning bodies do not receive enough funding to pay for administrative support, and the lead agencies often have to contribute these services. Members are often expected to volunteer large amounts of time to the process.

- **Lack of consumer knowledge about policies and procedures to support their involvement.** Sometimes appropriate policies and procedures do not exist. Sometimes, supports for consumers exist but are unknown to new members. New members may be unfamiliar with expense reimbursement policies and uncomfortable asking about them. They may be unaware that child care or transportation assistance can be arranged. They may be unclear about access to office equipment such as a fax machine or copier, or secretarial support available to assist them in carrying out tasks. Further, new members may not understand how to ask for what they need. They may not know how to sustain their involvement should they become ill or unable to participate for a period of time.

- **Lack of flexibility regarding participation.** Membership policies and procedures are sometimes rigid and inflexible and do not allow for remote participation (such as telephone hook-ups) or other flexibility necessary to encourage participation by consumers.

- **Burnout and over commitment.** Sometimes members, including PLWHA, are expected to serve on too many committees and take too much responsibility for tasks like reporting back to the community and recruiting new members. Some groups have unrealistic expectations of members and provide few opportunities for renewal and recognition.

**D. Ways to Encourage Participation**
The following actions can help encourage participation:

- Formal membership plan.
- Orientation of new members.
- Ongoing training for all members.
- Clear roles and responsibilities.
- A culturally sensitive environment.
- Flexibility about meeting times, locations, and participation requirements.
- PLWHA participation as a priority.
- Creativity in finding solutions to administrative support needs.
- Action to prevent burnout and sustain member commitment.
- A membership removal process for those who do not participate.

E. Develop a Formal Membership Plan

Member recruitment and retention can be tracked and analyzed when there is a formal membership plan that addresses (1) representation, (2) diversity (key occupational, geographic, demographic, and social characteristics representative of the area and population served by the body) and (3) recruitment and selection of members.

**Representation** means the extent to which the planning body includes diverse membership, including legislated categories for consortia that provide multiple perspectives to the planning process. For example:

- Consumers, including PLWHA and their families and significant others.
- Other Ryan White Parts and programs.
- Community leaders, including neighborhood leaders.
- Community-based organizations, including those serving various ethnic communities, other health issues, and community action agencies.
- Gay/lesbian/bi-sexual, and transgender organizations and individuals.
- AIDS service organizations.
- Medical providers, including hospitals, health departments, health maintenance organizations (HMOs), private medical and dental groups, medical societies, primary care clinics, community and migrant health centers, home health agencies, hospices, and nursing associations.
- Health planners and evaluators.
- Public health professionals, such as epidemiologists and prevention staff.
- Mental health providers, including mental health clinics, crisis centers, and substance abuse treatment programs, and private counselors and therapists.
- Social and support service providers, including social service departments, adoption agencies, food banks and emergency relief agencies.
- Housing providers, including housing authorities, programs funded under Housing Opportunities for Persons with AIDS (HOPWA), long-term care facilities, housing for PLWHA, and homeless shelters.
- Programs that address needs of formerly incarcerated populations.
- Programs that enhance access to care and treatment, including Medicaid, clinical trials, sexually transmitted disease clinics, and tuberculosis prevention/treatment services.
- Business people, including small business owners and corporate officials.
- Educational institutions, including schools, colleges, technical schools, and professional schools.
- Religious leaders, including rabbis, priests, ministers, and others.
- Law enforcement and correctional officers, attorneys, and judges.
- Media, including advertising, print, radio, television, and cable.
- Youth services, including runaway and homeless youth shelters, teen clinics, youth organizations, and community centers.
- Women’s services, including family planning, women’s health, rape, and domestic violence programs.
- Family centered caregivers.
- Other (e.g., vocational rehabilitation services, client assistance programs (CAPs), and disability community organizations).

**Diversity and reflectiveness** of the HIV epidemic in the service area, based on population characteristics such as the following:

- Geography, including neighborhoods in urban areas and counties or communities in rural areas.
- Sexual and gender orientation, including heterosexual, homosexual, bisexual, and transgender.
- Age, from parents of children with HIV/AIDS to young adults and senior citizens.
- Racial/ethnic background, including the various ethnic and cultural communities within the consortium area.

**A process for recruitment and selection of members** may include answers to the following:

- What nominations process will be used?
- How will members be recruited?
- How do nonmembers become members, and what are the membership criteria?
- What are the requirements to maintain membership?
- How will current members be prepared to help recruit new members?

Each of these questions is addressed in greater detail in Appendix A at the end of this chapter.

**F. Orient New Members**

Orientation of new members helps them understand the Ryan White program as well as planning body roles, responsibilities, and operating procedures, and prepares them to participate actively. Well-planned orientation and training activities demonstrate the value the group places on new member participation. Orientation activities might include the following:

- An initial orientation prior to each new member’s first meeting, which should cover how
the Ryan White Part B program is organized, how the planning body is structured, their roles and responsibilities as members, the annual work plan, and timeline for activities and topics to be addressed at the next meeting. A new member Orientation Manual or Packet might include:

- History and overview of the Ryan White Program.
- Planning body history and mission.
- Planning body roles and responsibilities and member job description.
- Bylaws, policies, and procedures.
- List of fundable core medical and support services.
- Resource inventory or list of services provided in this service area.
- Chart of the committee structure and responsibilities.
- List of members including addresses and phone numbers (prepared according to the wishes of the membership).
- Reimbursement policies and procedures.
- Current comprehensive plan.

The orientation manual should not be used as a substitute for an interactive orientation.

Written materials should be compiled and adapted as necessary to accommodate the language preferences and literacy levels of new members. Materials should also be available on the planning body’s website.

- A formal procedure to introduce and welcome new members at meetings. Attending a full-membership meeting for the first time can be overwhelming and confusing, especially if there is no mechanism to acknowledge and integrate new members.
- Debriefing with new members after their first meeting.
- A mentor or “buddy” system. Assigning a current member to be a “buddy” to a new member, for at least three months, helps new members feel welcome, learn about individual member perspectives, and become comfortable with the processes and interactions of the group.
- Training to address individual needs. For example, training should address the problem of burnout, helping new members make realistic time commitments and avoid becoming overcommitted.
- Sensitizing of all members to the importance of consumer input.

G. Provide Ongoing Training for All Members

Continuing education and training opportunities promote constructive working relationships among members, reward members for their time and effort, develop members’ knowledge and skills related to HIV/AIDS and organizational functioning, and advance the work of the group. The following educational opportunities can be useful for members:

- Strategic planning retreats.
- Trust-building and team-building workshops.
- Conflict-management workshops.
• Training on comprehensive planning, priority-setting methodology, using data and statistics to plan, and evaluation methodology.
• HIV/AIDS informational topic sessions (e.g., anti-retroviral therapies).
• Workshops on roles and responsibilities of consortium members.
• Development of skills for facilitation and chairing a successful meeting.

Even if the planning body has limited resources, often such training and briefings can be arranged at little or no cost, with help from the local health department, service providers, local universities, local chapters of public health-related associations, and other nonprofits.

H. Clearly Outline Roles and Responsibilities

Clear information will enhance functioning, and should include clearly defined roles and responsibilities; policies and procedures that are written in plain language and available to all members; and written definitions of all operating concepts, abbreviations, and acronyms. Use agreed-upon ground rules for all meetings. Conflict of interest and grievance policies and procedures should be defined and distributed in writing to all members, and members should receive training to ensure that they understand and comply with conflict of interest policies.

Ryan White-specific activities often require specific information. To illustrate, all fundable service categories should be clearly defined before the needs assessment process begins, using the most recent HRSA/HAB definitions and explanations and differentiating core medical and support services. Establishing such definitions up-front is critical to all aspects of the planning process.

I. Create a Culturally Sensitive Environment

Never assume that there is only one way to conduct business of the group. The effort is a collaboration of many different people, all of whom bring their own expectations and backgrounds to the table. A formal process governed by parliamentary process and Robert’s Rules of Order does not necessarily work in all environments. As needed, modify and create procedures for doing work that meet the needs of most members, promote full participation and high levels of productivity, and create a comfortable atmosphere that is inviting to new members.

J. Be Flexible about Meeting Times, Locations, and Participation Requirements

Meeting times, locations, and requirements for participation should be revisited on a regular basis. The group changes as new members join, older members leave, and the requirements of the epidemic change. Many groups reported changes in their PLWHA participation following the widespread use of anti-retroviral therapy, as greater numbers of consumer members returned to work or became employed. They have been forced to change their meeting times accordingly. Some are only meeting as a full body on a quarterly basis and rely more and more on committees to complete operational tasks. Some use consumer and service provider caucuses to review the work of the full group and provide input, but do not require caucus members to participate in general membership meetings. Much more information is disseminated via email, websites, and social media. The key is flexibility and taking the time to develop a process that works best for
your planning body.

K. Show that PLWHA Participation is a Priority

The following approaches will help assure PLWHA participation:

- Develop a formal PLWHA membership plan.
- Provide supports for PLWHA members with limited physical capacity or special needs.
- Demonstrate respect for PLWHA member input and recognition of contributions by paying attention to what PLWHA say, insisting on an atmosphere of mutual respect, encouraging everyone to participate, and maintaining an orderly process.
- Seek PLWHA representation on all committees at the same level as on the full planning body.
- Develop a formal leadership development training program for PLWHA.
- Have policies and procedures that recognize that PLWHA may need to participate in different ways based on their health status.
- Directly address grief and loss within the membership and the HIV/AIDS community.

For more information, see the chapter on PLWHA/Consumer participation in this section.

L. Be Creative in Meeting Administrative Support Needs

Take the time to assess administrative support requirements and resources available to meet them. Do not assume some members will volunteer to do all the work or that the lead agency will automatically agree to donate those services.

First, discuss administrative requirements and develop an administrative budget with the State grantee and/or its administrative agency (if it has one). States with higher prevalence rates and statewide consortia often have sufficient administrative funds to meet staffing and planning needs. If the administrative cap is inadequate to meet planning body needs, alternative resources need to be found. There are many creative solutions to the barrier of administrative support. Some groups recruit specific people or entities to make targeted contributions, such as small business owners willing to photocopy documents as a contribution to the process. Others rely on local universities, colleges, or trade schools to provide interns to assist with administrative tasks, such as taking meeting minutes. In other areas, groups from adjoining regions have combined their administrative allocations and hired or contracted with a person to provide administration to multiple groups.

M. Take Action to Prevent Burnout and Help Sustain Member Commitment

Sustaining commitment and enthusiasm is challenging. All membership organizations experience an ebb and flow of involvement. Thus, it is important to bring in new members on an ongoing basis. They bring new energy and fresh perspectives. It is also important to rejuvenate existing members. Methods to sustain member commitment include the following:

- Acknowledge people for their contributions and give them positive feedback on an
ongoing basis by thanking members at meetings, honoring them at special events, developing an awards program, or featuring members in newspaper or newsletter articles or on the planning body website. Celebrate accomplishments at an annual social event.

- Provide opportunities for continuing education, training, leadership development, and growth-promoting activities.
- Make meetings well organized and use members’ time effectively. Start by sending out an agenda and a packet of background information needed for decision making at least one week before the meeting. Specify when the meeting will begin and end. Start and adjourn on time. The meeting facilitator or leader should ensure that discussion does not stray from the agenda and that the discussion leads to an agreed-upon course of action on all items that require decisions.
- Consider scheduling time for optional socializing and networking immediately before or after the meeting. For some people, these opportunities represent a critical reason to remain involved.

N. Have a Membership Removal Process

Once criteria for membership have been established, adopt a process for removing members who have very low attendance, no longer meet the criteria, or violate the rules. To discourage attempts at removal based solely on personality conflict, the removal process must be fair, impartial, and clearly spelled out. When the problem is lack of attendance, the process can be based on clear attendance requirements and procedures, including recording of non-attendance, a warning letter, and automatic removal after a specified number of missed meetings or activities. When the issue is a change in the member’s status so s/he no longer fits membership criteria – for example, a member chosen to represent a particular type of service provider changes employment and career focus – policies should be in place to require a member to step down. For removals based on misconduct, use the following four steps, which are drawn from standard organizational personnel policies:

Step 1. Written notification to the member about the violation. This notice should specify actions necessary to correct the violation and the time frame within which the corrective action must occur. It is typically written by the leader or designee (e.g., the chair of the membership committee).

Step 2. A meeting to mediate a solution between the member or members and the leader or leadership group such as the Executive Committee.

Step 3. Mediation and conflict resolution facilitated by an outside expert. This action should be taken if the member or members refuse to pursue a solution with the leadership.

Step 4. A motion to remove the member if all attempts at mediation fail. The motion should be introduced to the membership committee or the full membership, with complete written documentation of all prior steps taken. Removal usually requires a two-thirds vote of the members.
Appendix A

Model Recruitment and Selection Process

Address the following topics in the process that is established:

- Nominations process.
- Recruitment methods.
- Process for becoming a member.
- Criteria for membership.
- Requirements for maintaining membership.
- Engagement of current members.

Nominations Process

An open nominations process might include the following minimum standards:

- Nominations process is described and announced before recruitment begins.
- Criteria are specified so that the planning body membership:
  1. Includes the legislatively required positions (membership categories)
  2. Reflects the HIV/AIDS epidemic in the State or region
  3. Reflects the geography of the State or region
  4. Reflects any other locally determined membership needs
  5. Incorporates conflict of interest requirements
- The need for members is publicized, including advertisements in local HIV publications, announcements on appropriate websites, notices to service providers, press releases, and other community announcements.
- Potential applicants are informed of:
  1. The time commitments involved in serving on the planning body
  2. Conflict of interest standards
  3. Any HIV disclosure requirements for PLWHA
- A membership application is used to:
  1. Collect information about the nominee’s characteristics, experience, and background, with specific attention to legislatively mandated membership categories and the characteristics of the local epidemic
  2. Include an open-ended response category for nominees to describe their experience and why they believe they would be an effective planning body member
  3. Provide information to potential members about time commitments and other demands of planning body membership, meeting schedules, HIV disclosure requirements, and the conflict of interest standard
  4. Describe the application and selection process
- A representative nominations or membership committee reviews all nominations and conducts interviews of potential members.

Recruitment Methods

Methods for recruiting planning body members include:
• Disseminate an announcement of membership opportunities and the application form via email, website postings, and social media.
• Contact other organizations’ mailing lists and ask current members to send announcements to their personal email lists. If materials are mailed, take steps such as using unmarked envelopes to maintain confidentiality.
• Have consortium members telephone potential members who belong to targeted groups and talk to them about becoming members. Provide opportunities for potential members to attend a planning body or committee meeting. Consider use of a mentoring or buddy program where members agree to pick up potential members and drive them to meetings and help them understand the process.
• Engage in collaborative community networking. Planning body members should attend other organizations’ meetings and promote membership on the planning body in their public venues or during public comments periods at other meetings. Some consortia are developing speakers’ bureaus not only to provide education about HIV/AIDS and Ryan White-funded services, but also to advertise and promote planning body membership.
• Use newspapers and newsletters. Consortium meetings should be regularly advertised in local newspapers and member organizations’ newsletters, both online and hard copy.
• Assess the success of various recruitment methods and refine them based on what you learn. Distributing flyers at various locations certainly promotes the planning body but has generally seen little direct success as a technique for recruiting members.
• Consider translating announcements and the application form into the major language of populations targeted as planning body members.
• Use multiple methods to recruit consumers and other PLWHA. Do outreach to service providers and individual staff who serve clients with HIV/AIDS to identify unaffiliated PLWHA nominees. (Unaffiliated refers to consumers who do not have a potential conflict of interest, meaning they have no financial or governing interest in funded agencies.) Contact PLWHA coalitions as well.

**Sensitivity to Special Needs**

With recruitment in mind, members should show sensitivity to the special needs of many targeted populations by providing appropriate supports to enable them to participate fully. When recruiting, make it clear that the planning body will provide the following, for consumers:

• Transportation
• Child care

For any member with a need:

• Sign language interpreters for people who are hearing impaired
• Special presentations for those with visual problems
• Oral communication of printed materials for those with low literacy levels
**Process for Becoming a Member**

Following are pathways and steps for an individual in becoming a planning body member. More than one of these processes might be used as part of the selection process; most planning bodies require a written application once a potential member shows interest in being considered for membership, and many interview applicants using a consistent set of questions. Listed below are the pathways and steps:

- Invitation to apply.
- Submission of an application for membership.
- Appointment or interview with membership committee representatives.
- Election by the full body.
- Formal voting membership following attendance at several planning body meetings or committee meeting.
- Formal voting membership after volunteering.
- Signing of a member commitment statement (see sample membership commitment statement at the end of this chapter).

**Membership Criteria**

Criteria for membership might include the following:

- Support for the mission of the planning body.
- Characteristics that provide for consortium diversity in such areas as race/ethnicity, place of residence, gender, or age.
- PLWHA or consumer status.
- Affiliation with a targeted type of service provider or agency.
- Experience with HIV/AIDS prevention or care.
- Some specific skills or experience identified as necessary for the consortium (e.g., health planning, substance abuse treatment).

**Requirements for Maintaining Membership**

Members may be required to do the following to maintain their membership:

- Participate on a committee.
- Participate in full planning body meetings.
- Meet attendance requirements.
- Participate in special projects or activities.
- Comply with planning body policies and procedures.

**Current Member Engagement in Recruitment**

All members have an investment in new member recruitment and should be encouraged to participate in recruiting new members. The most successful recruitment technique identified by planning bodies across the country is the personal connection of asking someone directly to join.
The best way to recruit a potential member through communicating the importance of the group’s work is for someone with a prior personal connection to meet with the potential member.

When meeting with a prospective member, current members should do the following:

- Explain the mission and goals of the planning body.
- Connect on a personal level by explaining why they joined.
- Describe why the potential member is needed and the specific contribution they can make
- Candidly estimate the time commitment.
- Be clear about what is expected; go over the membership commitment statement (See example at the end of this attachment) or member job description).
- Explain the member selection process.
- Explain the member orientation process.
- Give the potential member time to consider membership.
- Follow up with a telephone call to assess the candidate’s interest and answer any questions.

X. Ch 5. PLWHA/Consumer Participation

A. Introduction

Ryan White Part B Ryan White planning creates a participatory planning process to ensure that local health care and social service programs are responsive to the needs of PLWHA. Unique PLWHA perspectives are a major benefit of consumer involvement in such terms as design of appropriate services and identification of needs. Barriers to eliciting and maintaining effective PLWHA involvement include time constraints, lack of understanding about complex planning duties, and health concerns.

Recruitment measures are needed to secure representation on the planning body, such as a variety of outreach methods to identify potential members. Retention measures are needed to help consumer members stay engaged and participate fully, such as orientation and training, mentoring, and financial support for the costs of participating.

B. Benefits of Consumer Participation

- **Consumer Perspective.** PLWHA provide a critical consumer perspective on Ryan White service planning, delivery, and evaluation. Consumers should reflect the diversity of the local epidemic, which provides for a range of perspectives that contributes to informed decision making.
- **Reality Check.** PLWHA help keep the members of the consortium focused and on track by providing a first-hand perspective on issues facing PLWHA and their families. PLWHA can discuss their actual experiences in seeking and obtaining services.
- **Help in Needs Assessment.** PLWHA can help ensure that needs assessments consider the needs of PLWHA from differing populations and geographic locations, including
those in and out of care. They can help recruit other PLWHA for town halls, focus groups, and other input sessions.

- **Identifying Service Barriers.** PLWHA can identify service barriers that may not be evident to others and can help consortia plan to overcome those barriers.

- **Outreach.** PLWHA can help identify ways to reach the PLWHA communities served, including minority and other special populations with unmet need for services.

- **Quality Management.** PLWHA who are clients of Ryan White services can provide direct feedback on the quality of services. Their voices can help determine what services are needed, including how to improve service delivery models.

- **Community Liaison.** PLWHA provide an ongoing link with the community. They can bring community issues to the group, as well as help to bring research and care information to the community.

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**PLWHA Roles**

When considering ways to increase involvement of PLWHA in Ryan White activities, assess what PLWHA involvement is wanted. Roles for PLWHA include regular membership, participation in a PLWHA caucus, committee membership, and participation in specific activities.

Success might be realized with recruiting PLWHA, but retention as active participants can be harder. Often, this is because PLWHA roles have not been clearly defined. Members may not have received orientation or training or other necessary support. Maintaining active involvement of PLWHA also requires effective utilization of the skills and resources that PLWHA bring to the planning process.

It should never be assumed that the only way a consumer can participate is to be an active member. Some consumers may feel they do not have the skills to participate or prefer not to assume the responsibilities of active membership. However, their voices and participation are valuable to the overall planning process, as are those of the PLWHA who are active members, sit on committees, and participate in mandated activities. Some planning bodies have active consumer caucuses that meet separately and send a representative to serve as a member. Others access local support groups for feedback at targeted points in the planning process. For example, the consumer caucus or support groups may participate in the needs assessment, provide input to the development of priorities being recommended, and review a draft of the comprehensive plan. Further, PLWHA input is often a specific component of quality management and evaluation (client satisfaction).

**C. Recruitment of PLWHA**

Recruitment of PLWHA members is a responsibility of the entire group. Groups often use personal contacts and other individual interactions as the chief means of PLWHA recruitment. Recruitment generally requires personal contacts with potential members, but outreach beyond individual networks is important in widening the search. Membership and outreach committees
are ways of overcoming problems encountered in recruitment. Many such committees have identified the following useful practices in recruiting PLWHA:

- **Establish and Explain Guidelines Regarding Representation and Affiliation.** This includes clearly stated conflict of interest guidelines that explain that a PLWHA is considered “unaligned” or unaffiliated when s/he has no financial or governance affiliation with a funded Ryan White Part B provider.

- **Formalize Recruitment and Outreach Procedures.** These may be summarized in policies and procedures, providing the membership/outreach committee and the full planning body with a clear and publicly known process to follow, year after year.

- **Implement a Formal Outreach and Recruitment Process.** The responsibility for PLWHA recruitment should not be placed primarily on the current PLWHA members but rather shared by the entire planning body. Outreach should be extensive, ongoing, and culturally competent. Recruitment requires contacts throughout the community, not focused on a single organization or limited to individuals or groups personally known to consortium members. Methods of outreach include:
  - Contacts with a wide range of non-HIV-specific health groups, social service agencies, and PLWHA groups.
  - Advertisements in local online and print publications, especially publications targeting HIV-positive people, racial and sexual minorities, and underserved populations.
  - Posting of opportunities on the planning body or lead agency website
  - Use of social media such as Facebook.
  - Contacts with local community colleges and universities.
  - Public meetings arranged in consultation with Ryan White service providers.
  - Outreach materials and programs that emphasize commitment to a diverse HIV-positive membership and are specific about populations that need to be represented.

- **Communicate Expectations Clearly.** PLWHA, like other members, need to know what is expected of them in terms of time requirements, travel, roles and responsibilities, and public visibility. A job description is especially helpful. Clearly state disclosure requirements and indicate limitations and expectations regarding affiliation with AIDS service organizations (ASOs) or other providers or membership preference for unaffiliated or “unaligned” PLWHA. Recruitment materials should clearly state available supports, such as expense reimbursement, transportation assistance, and child or partner care reimbursement.

- **Make the Process Efficient and Timely.** If the nominations and selection process is lengthy, planning bodies may have PLWHA vacancies for many months, and nominated individuals may lose interest. The selection process should be efficient in filling all membership slots, but especially PLWHA slots. One way to minimize vacancies is to allow PLWHA to serve as members of consortium committees, including PLWHA committees or caucuses, both to become familiar with the work of the planning body before nomination and to remain engaged while awaiting appointment.

- **Ensure That Members Reflect Changes in the Demographics of the Area’s HIV**
Epidemic. As the demographics of HIV change, it becomes important for the membership to reflect these changes. Attaining diversity among PLWHA representation requires carefully planned outreach into many different communities with the help of a variety of individuals and community groups. Policies might state that the PLWHA membership will reflect the demographics of the HIV/AIDS epidemic in its service area.

- **Do Ongoing Recruitment.** Ongoing recruitment is required because of the changing health status of PLWHA members, as well as to replace members who move, become employees (or consultants or Board members) of a provider and therefore are no longer considered unaligned, change their employment or family status, are burned out, or change their community priorities.

### D. Barriers to PLWHA Recruitment

Recruitment of PLWHA requires first understanding and then overcoming a number of barriers that prevent or discourage PLWHA membership. Barriers may exist within the planning body, the community, and the person living with HIV/AIDS. Following are frequently identified barriers, from the perspectives of PLWHA and planning bodies:

- Lack of PLWHA awareness of Ryan White programs and planning bodies.
- Lack of knowledge about how to become involved.
- Lack of written criteria for membership.
- Unclear member roles, responsibilities, and expectations.
- Lengthy nomination and selection process.
- Lack of consumer representation among planning body leadership.
- Belief that PLWHA members are not taken seriously.
- Fear of disclosure of HIV status, sexual orientation, drug-using behavior, etc.
- Uncertainty about financial costs of participation.
- Limited physical capacity.
- Distrust of public programs and providers.
- Lack of understanding and/or discomfort with formality and complexity of planning body procedures.

### E. Maintenance of PLWHA Involvement

Recruitment of a diverse PLWHA membership is only the first step in effective PLWHA involvement. Sustaining and maintaining effective PLWHA involvement requires continuing attention. Many factors—related to the community, the consortium, and the individual—can cause a PLWHA member to become inactive or resign.

Many of the factors that help with PLWHA recruitment also contribute to their effective and sustained involvement. Outlined below, they include orientation, training, and mentoring to enable PLWHA to actively participate in deliberations and also make all members, including PLWHA, feel valued.

**Orientation.** Orientation should occur prior to the first meeting. All new members – including
consumers – should receive a practical orientation to their roles and responsibilities as members, the work plan and timeline of the group, policies and operating procedures for meetings (e.g., bylaws, Robert’s Rules of Order), and a typical planning body agenda. They also need an understanding of the structure of committees, their mandates, when they meet, and their leaders’ names and contact information. They should receive a full planning council roster including committee assignments. This kind of orientation offers new members access to the people who are part of the system. The orientation should be supplemented with a member manual and other handouts, but written materials are no substitute for an interactive orientation process.

**Training.** Further training can provide the technical knowledge and skills needed for full participation in the consortium’s activities. Training should provide an understanding of the Ryan White legislation and implementation process, the service delivery system and provider profiles, and planning and other tasks (i.e., needs assessment, priority setting, resource allocation, comprehensive planning, evaluation). Understanding and accepting some of the constraints within service systems is an important area; orientation and training can help members understand processes and procedures for change and recognize some of the complexities within the system. Training should prepare members to use and understand epidemiologic, client utilization, and needs assessment data and to participate actively in needs assessment, priority setting, and other key processes. Most of this training is needed by all new planning body members, but may be particularly important for members who have not previously been involved in community planning activities.

**Mentoring.** Mentoring helps PLWHA, including new members, feel welcome, learn about individual member perspectives, and become comfortable with processes and interaction. Some groups assign each new member to a veteran member who takes special responsibility for making sure the new member understands the background and context of discussions and actions, and gets an explanation of the many terms and acronyms used in meetings. Mentoring typically lasts for three to six months.

**Relationship Building.** Developing positive relationships between PLWHA and other members can greatly enhance the planning process through mutual understanding and communication. Periodic retreats or other facilitated sessions build a sense of teamwork and trust among all the members. Requiring PLWHA representation on committees is another way to increase PLWHA involvement and participation.

**PLWHA Representation on Committees.** Requiring PLWHA representation on all committees is another way to increase PLWHA involvement and participation. Such a requirement demonstrates that PLWHA input is needed and valued at all levels of planning body activity.

**Access to Information.** It is important that PLWHA members receive information important to them and the consumer community. Address this need by ensuring that materials from the State grantee, lead agency, and the consortium and its various committees are shared with all members and PLWHA caucuses.

**Financial Support.** One of the greatest obstacles to PLWHA involvement is the financial cost of participation. Costs of attending meetings may involve transportation, child or other dependent
care, and meals. Additional expenses might include sending and receiving faxes, making telephone calls, preparing materials, and accessing the Internet. These expenses can present a problem for PLWHA on disability or with very limited incomes, and for PLWHA without access to office equipment and supplies.

Financial reimbursement to PLWHA for the direct costs of involvement needs to be addressed with respect to several different issues:

- What kinds of Ryan White funds are available for use in providing financial support for activities related to PLWHA involvement?
- What are the State contracting restrictions and policies on reimbursement?
- What kinds of expenses can be covered for PLWHA?
- What constitutes “reasonable costs?”

Ryan White Part B grants allow for consortia administrative support. Federal guidelines allow Ryan White administrative funds to be used to cover expenses for unaligned PLWHA, such as child and dependent care, transportation, office supplies, or other costs directly related to participation. In addition, contracted services can be used, such as transportation or child care services, provided they are paid for through the administrative budget, not from service funds. Planning bodies should establish, explain, and consistently implement specific policies related to expense reimbursements for consumer members. These policies should specify what types of expenses are reimbursable, under what conditions, required documentation, and expenditure limits.

Consortia are permitted to provide budget support for PLWHA participation in local conferences. However, State (grantee) contract guidelines may not permit use of the funds to cover expenses in this manner. Stipends or honoraria are not permitted as cash payments using Ryan White funds. The payments must represent reimbursements for actual allowable expenses, backed up by documentation such as taxi receipts. If alternate funds are available for stipends, consortia may give PLWHA the option of receiving or declining a stipend for services, since such income could affect eligibility for Medicaid coverage, Supplemental Security Income (SSI), or other entitlements that may have income caps. For further details, refer to the “Guidelines on Reimbursement of Individuals Serving on a Ryan White Part A Planning Council and/or Ryan White Part B Consortium” (DSHAP Program Policy Guidance Number 9), which are included in this manual and available on the HAB website.
### Resources for Training Consumers

To facilitate the full participation of consumers in planning bodies, HAB provides training opportunities and provides technical assistance.

HAB maintains cooperative agreements with various national organizations that prepare training resources and conduct leadership and skills-building training for consumers who are members of Ryan White planning bodies. The HAB Website ([http://hab.hrsa.gov](http://hab.hrsa.gov)) provides details about training resources for planning body members and the TARGET Center ([http://www.careacttarget.org](http://www.careacttarget.org)) provides a variety of resource documents, including training materials used by Ryan White programs.

### F. Barriers to Sustained PLWHA Participation on Planning Bodies

Planning bodies and PLWHA have identified many of the following obstacles to sustained PLWHA participation.

#### Barriers Within Structures and Processes

- Lack of clearly defined roles and responsibilities
- Lack of – or insufficient or poorly designed – orientation and training or mentoring of PLWHA members
- Poor relationships or conflict within the planning body
- Lack of demonstrated respect for PLWHA input – such as lack of PLWHA in committee or overall leadership positions
- Lack of communication within the consortium and limited access to information
- Bureaucratic processes and long delays before results are seen
- Unrealistic time/commitment expectations given PLWHA capacities at various stages of illness
- Lack of ongoing supports such as accessible meeting locations, expense reimbursements, rest breaks during meetings
- Financial costs that are not reimbursed, such as meal costs
- Lack of support for members with special needs (e.g., visually or hearing impaired, limited English proficient)
- Lack of or inadequate commitment to meeting needs of PLWHA
- Lack of flexibility regarding participation (not allowing telephone hook-ups or leaves of absence during times of illness)

#### Community Barriers

- Discrimination against people with HIV/AIDS
- Discrimination against sexual minorities
- Discrimination against people of color
- Large geographic areas requiring time-consuming, long distance travel
Personal Barriers

- Poor health
- Burnout
- Competing family, professional and/or personal demands on time and energy
- Lack of financial resources – for example, insufficient funds to cover costs even if they will be reimbursed
- Discomfort with processes and requirements of the planning body
- Change in affiliation

G. Nonmember Involvement

All groups need input from PLWHA who are not members. Only a small number of HIV-positive individuals are members, and they cannot fully represent the entire consumer community. PLWHA should not feel that they are expected to know everything about people infected or affected by HIV/AIDS. To avoid this additional—if unintentional—pressure on PLWHA, groups should encourage broader community input. Either unilaterally, or in partnership with PLWHA caucuses, consortia can do the following:

- Welcome community PLWHA to meetings and subcommittees meetings.
- Provide a public comment period at each planning body meeting.
- Open committees like Needs Assessment to non-planning body members.
- Include in bylaws a consumer or PLWHA standing committee with membership including both planning body members and non-members.
- Provide PLWHA opportunities for input into Ryan White needs assessment and priority-setting processes through methods like town hall meetings, sessions with PLWHA caucuses, and focus groups.
- Develop small work groups so that people can have an active voice in the process without making long-term commitments.
- Provide regular feedback to appropriate segments of the community.

The following approaches have been helpful in various communities:

- Enable anyone to become a voting member of some consortium committees after attending three consecutive meetings, even if he or she is not a member of the planning body.
- Develop methods for involving those who do not attend meetings, such as a telephone call-in number to connect them to the meeting, enabling them to listen, provide information, or ask questions.
- Use publications, including mainstream media and newsletters of PLWHA caucuses and other community organizations, to request input and publicize hearings and community meetings.
- Set up a formal communication structure with special PLWHA caucuses and support groups where consortium information and draft plans can be presented and input and feedback solicited.
X. Ch 6. Managing Diversity

A. Introduction

One of the greatest challenges in planning and maintaining an HIV/AIDS service delivery system under the Ryan White Program is ensuring and managing the diversity in planning body membership and community input required by the legislation in order to adequately consider the needs of populations with HIV/AIDS that “reside in traditionally underserved communities” and have “disparities in access and care.”

Managing a multicultural process can be approached on two levels: organizational and individual membership. On the former, this entails attention to planning processes like meeting rules and policies. Individually, approaches used for recruiting new members and orienting them once they join can enhance a smoothly functioning planning group. The ideal outcome, of course, is creation of programs that better meet the diverse needs of PLWHA in the service area.

B. The Challenge

Membership in a planning body should reflect the demographics of the HIV/AIDS epidemic at the State or regional level. This requires active recruitment of people who represent diverse perspectives and have diverse characteristics in terms of race/ethnicity, age, gender identity, sexual orientation, age, and geography, among other factors. Also essential is securing a membership representative of different sectors and organizations in the community.

Recruiting the range of people that comprise an appropriately diverse planning body is challenging. Further, learning to communicate and creating a high-performing team within a diverse environment means understanding that there will be differences among people in many areas that affect how they interact in planning bodies. For example, there may be differences in language, attitudes and values, roles for individuals based on gender and age, the concept of time, nonverbal expression, social interaction, and views about the role of government and nonprofit organizations.

Understanding those differences and how they are reflected in the behaviors of diverse planning body members is another step in managing diversity. Integrating diverse values, norms, vocabulary, and rules into the activities of the group further moves everyone along the spectrum toward multicultural competency.

C. Multicultural Competence Continuum

Developing multicultural competence helps you to communicate and to interact effectively and positively with diverse individuals and groups in a diverse society. The multicultural competence continuum below shows a series of steps that define levels of awareness, sensitivity, and competence in dealing with people of various cultures.
Cultural Destructiveness. Making people fit the same cultural pattern, and excluding those who do not fit; forced assimilation. Emphasis on using differences as barriers.

Cultural Blindness. Not seeing or believing there are cultural differences among people; “everyone is the same.”

Cultural Awareness. Being aware that we live and function within a culture of our own and that our identity is shaped by it.

Cultural Sensitivity. Knowing that there are cultural differences and understanding and accepting different cultural values, attitudes, and behaviors.

Multicultural Competence. Having the capacity to communicate and interact effectively with culturally diverse people, integrating elements of their culture, vocabulary, values, attitudes, rules, and norms. Translation of knowledge into action.

Definitions become critical as groups attempt to understand their diversity. We all have values, act on stereotypes, hold prejudices, and—often unwittingly—practice discriminatory behavior. The key is acknowledging the existence of values, stereotypes, prejudices, and discrimination, and then being willing to change.

The following definitions are offered as a place to begin:

Values are established and accepted ideals, customs, and standards for deciding right and wrong, or deciding whether behavior is proper or improper.

Stereotypes are standardized and usually (but not necessarily) negative mental pictures of a group of people, representing an oversimplified opinion, attitude, or judgment. They result from limited contact with those we perceive as different and are an expression of our even more limited knowledge and understanding of what they are like. Stereotypes involve generalizations.

Prejudice involves negative views or beliefs about a group of people that reflect the formation of an opinion without taking the time to judge fairly. Prejudices are often the result of stereotypes.

Discrimination is behavior in which people are treated negatively because of specific cultural or diversity characteristics.

The following are basic steps in successfully managing diversity:

- Accept that there are differences.
- Learn what those differences are and how they manifest themselves.
- Move beyond being aware and sensitive to the differences and start respecting and valuing them.
- Integrate the differences into models, structures, policies, and procedures that are comfortable and appropriate for all participants at all levels of the Ryan White Part B
D. Culturally Competent Organization

A planning body should examine all aspects of its organization in terms of embracing and promoting diversity. Commitment to a diverse membership means that all aspects of the way the planning body conducts its business should be examined for how well they foster the comfort of all participants. If one culture or group’s values dominate, the membership tends to reflect only that one group or culture. Other cultures and groups do not feel comfortable, do not participate, do not feel valued, and are often treated as tokens.

All aspects of a planning body should reflect the values and norms of its diverse membership, from the way meetings are run to the language used to write policies and procedures. Diversity will not happen simply because diverse participants are invited to attend a meeting. The culture of the group must reflect commitment to competently managing diversity. All parts of the planning body must be examined and changed when necessary to create an environment that promotes a diverse team. The make-up of the group will ultimately reflect the quality of the resulting planning and programs.

The following elements need to be examined for cultural competency:

- Membership recruitment.
- Orientation of new members.
- Meeting locations and times.
- Meeting process and rules of interaction.
- Leadership.
- Committees.
- Policies and procedures documents.

Below is a list of questions for each of these areas that can be used as a checklist to evaluate how well diversity is being managed.

E. Membership Recruitment

Assess the cultural competency of membership recruitment by asking the following:

- Is there a formal policy for recruiting members which reflect the diversity in the community?
- Is the committee that is responsible for membership recruitment diverse enough?
- Have key contacts and leaders from all the targeted communities been identified and contacted?
- Have the different community leaders been asked specifically about the best way to solicit input and new members from their communities?
- Is there a membership recruitment plan that has been used by the consortium?
- Does the membership recruitment plan offer different strategies for reaching each
targeted community?
  • Are the outreach materials culturally and linguistically appropriate?

**F. Orientation of New Members**

Examine the cultural competency of new member orientation by asking the following questions:

  • Is there a formal interactive orientation as well as written materials?
  • Is there a mentoring program?
  • Are the written materials culturally and linguistically appropriate?
  • Are specific roles, responsibilities, and member job descriptions identified and articulated?
  • Is the orientation conducted by members who are culturally competent?

**G. Meeting Locations and Times**

A failure to consider the needs of all members when setting meeting locations and times can limit the full participation of some. To determine how well diversity is being managed in terms of meeting arrangements, ask the following:

  • Are the meetings held in locations that are comfortable to all participants?
  • Are the meeting times appropriate to the most diverse membership possible?

**H. Meeting Process and Rules of Interaction**

Formal and informal ways of interacting at meetings and around decision making should be examined to make sure all members are comfortable with procedures and expectations. Ask the following:

  • Are the meeting rules clearly understood by all members?
  • Is the meeting process simple, written down, and understood by all members?
  • Do members have the opportunity to be involved in discussions about any changes in the meeting process?
  • Is the meeting process periodically evaluated by the members?
  • Are the methods of changing the meeting process clearly communicated in writing?
  • Is the meeting environment friendly and open?
  • Is the style of running the meetings comfortable to most participants?
  • Are all members comfortable with the way decisions are made?
  • Do all members have opportunities to suggest ways to make the process more comfortable and appropriate?

**I. Leadership**

A culturally competent approach to leadership aims to open leadership positions to a diverse set of members. Ask the following questions:
• Is there a formal leadership development or mentoring program that specifically encourages diversity?
• Are leaders offered training?
• Has shared leadership been considered to encourage diversity (e.g., co-chairs or chair-elect)?

J. Committees

Committees must be open and accessible to diverse membership in order to foster the cultural competence of the whole group. Ask the following questions:

• Is committee leadership by members from diverse communities encouraged?
• Do committees meet in locations and at times that are comfortable for all members?
• Do committees welcome members who are not members of the consortium?
• Is the mission of the committee clearly understood by all members?
• Are all committee members given specific tasks to perform?
• Is there a committee work plan to meet its goals and objectives?
• Are meetings run in a way that is comfortable for diverse members?

K. Policies and Procedures Documents

Written policies and procedures reflect how well the group incorporates diversity. The following questions can be asked:

• Are the policies and procedures written in a straightforward, “plain language” style?
• Do the policies reflect an understanding of member diversity – for example, do documents refer to both spouses and domestic partners?
• Do all members have the opportunity to participate in the development and approval of any changes in the policies and procedures?
• Do all members have a complete set of all the policies and procedures?
• Is the method for making changes in policies and procedures clearly understood by all members?
• Are the policies and procedures periodically evaluated?
• Are the policies and procedures followed?

L. Approaches for Individuals in Groups With Diverse Membership

The following are some ways individual members can learn to work together as part of a diverse team:

• Pay attention to what others are saying to you.
• If someone is bothered by the actions of another group member, look for a way to address his or her concerns and resolve the problem.
• Treat everyone with the same level of respect, showing your recognition that everyone
has equal rights.

- Learn about and welcome diversity; if your initial reaction to differences is negative, ask yourself if that reaction is due to fear of the unfamiliar.
- Do not engage in or condone intolerant behavior within the group; do not make jokes or stereotype individuals, and do not permit others to do so.
- Verbally and publicly support other members of the planning body in situations where outsiders fail to show respect.
- Discuss problems and try to explain your perspective; do not ignore concerns or problems.
- Talk about problems and concerns directly with the other person(s) involved, not behind their backs.
- If you cannot resolve a problem directly, seek a mediator.
- Do not make excuses if you are having trouble getting along with someone different from you.
- Ask for help.

X. Ch 7. Managing Conflict

A. Introduction

Many people have been socialized to feel that conflict is bad and to be avoided at all costs. In fact, respectful conflict can benefit planning in the course of bringing together different perspectives. Too much agreement may signify a group’s failure to find creative solutions or recognize emerging challenges. It may mean that people are not voicing their concerns. When agreements come too easily, it may mean that final decisions do not really have the commitment of the entire group.

Conflict is necessary in participatory planning. Group members must hear one another’s differences before they can perform as a team. However, conflict that is not managed can result in negative consequences such as high member turnover and inadequate service planning that reduces the quality of care provided. Conflict that is well managed can encourage both cooperation and constructive conflict within an environment that respects open dialogue—and the conflicts that will inevitably arise. Helpful conflict management tools include policies and procedures, effective leadership, diversity of membership, and mutually agreed-upon ground rules for interaction.

If conflict management activities do not work, outside mediation can be used or, if that fails, binding arbitration. However, mediation and arbitration can be very costly. Every member must take responsibility for helping manage conflict and, as such, should not let high levels of conflict harm the group’s ability to develop and implement plans for HIV/AIDS care.

B. Areas of Conflict in Planning Bodies

Conflict in planning bodies often arises over the following matters:
Where, when, and how meetings are conducted.
Actual or perceived differences in values, interests, and personal styles (e.g., discrepancies in work output, commitment to service delivery, definitions of services, styles of expressing anger, frustration, discomfort and disagreement; differences in cultural backgrounds, sexual orientation, race, and class give rise to conflict and misunderstanding).
Selection of service priorities.
Interpretation of needs assessment results.
Allocation of funds and choices of subcontractors.
Staffing decisions.
Roles, responsibilities, and relationships with lead agency and the State.
Client grievances.
Monitoring and evaluation of provider organizations.

C. Actions That Promote Unproductive Conflict

The following attitudes, actions, and skill deficits may lead to unproductive conflict:

- Wanting to be right at all costs.
- Believing there is only one way (your way).
- Poor listening skills.
- Placing blame versus focusing on solving the problem.
- Attacking people or agencies viewed as potential competitors as opposed to attacking problems.
- Dredging up historical issues and failing to focus on the current moment and future plans.
- Stereotyping people.
- Presuming to know what others think before they have a chance to speak.
- Not being open and honest.
- Letting a few people dominate a meeting.
- Not sharing the same information with everyone.
- Letting ego, power, or status get in the way.
- Not acknowledging that every member needs something from the process.
- Refusing to take personal responsibility for one’s own conflict-handling style.
- Lacking understanding and/or appreciation of different communication styles.
- Engaging in power plays.
- Indulging in rivalries.

D. Determining Your Conflict Style

People deal with conflict in a variety of ways. Understanding how individuals deal with conflict will help the group manage conflict because—ultimately—the only behavior you can change is your own. Described below are three ways that conflict is typically handled: avoidance, confrontation, and collaboration. Note that these styles are not mutually exclusive. Most people possess the capacity for exhibiting more than one style.
Style 1: Avoidance

Some people will do anything to avoid conflict. They will agree simply for the sake of harmony and even hold back their own good ideas. Sometimes avoidance is caused by a fear of emotional confrontation that stems from beliefs about human behavior such as “It’s not nice to fight” and “If you don’t have something good to say, don’t say anything at all.” Acting on these beliefs, people who avoid conflict are less productive than they can be.

Successful groups create an atmosphere where all feel comfortable expressing their ideas and opinions without fear of ridicule or criticism. One way to draw out members who avoid conflict is to take the time to make sure everyone speaks before an important decision is made. The results will be better solutions to problems, higher quality decisions, and everyone’s commitment to support the decision.

Style 2: Combative

This style is the exact opposite of the first. Combative people give their opinions, ideas, suggestions, and comments very quickly, often without thinking about the consequences. They are passionate and direct with their words so you always know where they stand, but they are so abrasive that people get offended by what they say and, especially, how they say it. Being combative may come across as being mean and uncaring when, in fact, the person may have very good intentions. The consequence of this style is that other members become fearful of saying anything that might be ridiculed or criticized. As other members say less, a combative person begins to dominate. After a while, members begin to resist the combative person’s ideas, even the good ones.

Successful groups help combative people become more aware of their style and its consequences. Making sure the group hears everyone before making a decision is helpful. So is setting time limits so each speaker has only a certain amount of speaking time and one person doesn’t dominate. Combative people need help in seeing that their style causes win-lose games, which is the opposite of what they want (win-win), and that actually they can achieve more by choosing their words more carefully, weighing consequences before they speak, and listening more than they talk.

Style 3: Collaborative

A story frequently told in negotiation seminars is of two girls fighting over the same orange. Their mother intervenes and cuts the orange in half. The first girl throws away the orange peel and eats the fruit. The second girl throws away the fruit and uses the peel to bake a cake. If the two girls had collaborated, they would have seen that underneath their conflict were needs that were not in conflict. Collaborative people don’t assume that there has to be both a winner and a loser. Instead, they communicate with the people they are in conflict with and, eventually, come to a mutually agreed-upon solution with which both parties can live and even thrive.

A collaborative member does not avoid conflict, but also does not create it unnecessarily.
Members must learn to be collaborative and work through conflict to arrive at win-win solutions because win-lose solutions leave hurt feelings that hinder the members’ ability to work together and prevent the arrival at outcomes that are best for all parties.

E. Strategies to Manage Conflict

Creating an atmosphere conducive to open and honest discussion and respect for diverse viewpoints is the best way to prevent conflicts from degenerating into destructive rivalries and power plays. Helpful activities include the following:

- Establish ground rules.
- Ask each member to talk about his or her needs.
- Do not avoid conflict.
- Facilitate open communication.
- Create written policies and procedures for conflict management.
- Use mediation.
- Use arbitration.
- Check with your grantee.

Each of these strategies is discussed below.

F. Establish Ground Rules

Ground rules, agreed upon by all participants and reviewed at the beginning of every meeting, promote effective communication during meetings. Useful ground rules may include the following:

- One person speaks at a time; others listen and do not interrupt.
- Each person speaks for himself or herself, using “I”; individuals don’t claim to speak for others.
- Be polite. It is acceptable to disagree, but do so respectfully. Insults and accusations are unacceptable.
- Observe confidentiality within established policies.
- Share group time fairly. Allow everyone a chance to speak and listen.
- Be open to listening to and learning from others’ viewpoints.
- When the group is locked in conflict, agree to stop the agenda and brainstorm creative options.
- Refer to written policy and procedures for handling conflict that cannot be resolved in a regular meeting.
- Allow adequate agenda time for particularly sensitive issues. Make sure that each person has time to discuss all aspects of the issue without unrealistic time constraints being imposed.
- Clarify who will monitor group interactions for compliance with the ground rules and agree to what happens to repeat offenders.
G. Ask Each Member to Talk About His or Her Needs

Every member is there for a reason. Whether they are consumers who want to ensure quality services for themselves and their friends, or service providers who want to secure funding, all members need something from their participation in the process. This is not wrong or bad. One of the great myths of the planning process is that everyone must be there for altruistic reasons that have nothing to do with personal needs, desires, and wants. Encouraging everyone to be up-front with their needs will not only help dispel this myth (e.g., a service provider should never need to apologize for wanting to secure funds to provide services) but will help minimize the number of hidden agendas that lead to unproductive conflict. This could be done annually as part of the formal disclosure process to comply with conflict of interest policies and procedures (see the chapter on Conflict of Interest in this manual). Simply ask members: “What do you need from this group?” or “What do you want to get out of your membership?”

H. Do Not Avoid Conflict

Acknowledge that differing points of view exist and that conflict is a natural part of the discussion process. Do not attempt to avoid conflict or sweep it under the carpet when it surfaces, but be careful to define the conflict. The more specifically the problem is defined, the more suitable the solution is likely to be. The group should also distinguish between the issues and the individuals involved in the conflict. When conflict flares up, attempt to address and resolve it. If you must move ahead to other matters, make sure to return to the issue at a later date.

While acknowledging and dealing with conflict is important, it is also imperative to be careful that the conflict is appropriate. Some issues belong in other forums but are brought to the planning body because that process is often seen as more open. The mission should be clearly understood by all participants and, when issues outside the mission are brought forward, members need to refer the issue to a more appropriate forum. For example, if the consortium does not have responsibility for HIV/AIDS education and prevention planning under the Centers for Disease Control and Prevention’s (CDC) Prevention Community Planning Group initiative, then heated discussion about controversial changes in the use of the State’s CDC prevention dollars is not a good use of planning body time, even if it is a serious concern of some members.

I. Facilitate Open Communication

Facilitate the expression of opposing views by providing ample opportunity for their advocates to speak and to listen to each other. A process that is always hurried and driven by a need to move quickly almost always promotes unproductive conflict. Slow the process down when the decisions on the table are critical (e.g., during the annual priority setting process). As a first step toward proposing alternative solutions and attempting to reach a negotiated agreement, encourage each party to restate the other’s arguments to clarify any misinterpretations or misunderstanding. Understand that differences in experience, culture, class, gender, and personality influence how conflict is expressed. An effective chair or facilitator can facilitate the process of negotiation and help reach a solution that allows all parties to feel they have gained
from the process, rather than that some people won and some people lost.

**J. Create Written Policies and Procedures for Conflict Management**

A written policy describing the mechanism for addressing and resolving internal disagreements may help in situations that cannot be resolved in ordinary group meetings. These policies should define what constitutes a conflict, how it should be resolved, what qualifies it as irresolvable, and what the next steps will be.

A sample policy could read: “A conflict could be defined as occurring when there is a designated percentage split in opinion between the voting members. If the conflict is unresolved after two meetings, an outside mediator will be requested. If mediation does not resolve the conflict to the satisfaction of both factions, and parties, then binding arbitration will be used.”

**K. Use Mediation**

A mediator is an unbiased third party experienced in conflict resolution techniques. A mediator should be used to manage conflict situations that have reached an impasse and threaten to disrupt or delay decision making or disbursement of funds. The mediator does not decide who is right and wrong and does not tell the parties what to do. Instead, the mediator requires both parties to adhere to a step-by-step process that often facilitates a consensus agreeable to both parties. (For more on mediation, see the Grievance Procedures chapter in this manual.)

**L. Use Arbitration**

In arbitration, the conflicting parties agree to a formal hearing before a neutral arbitrator or panel. All parties make a binding agreement to honor the decision of the arbitrator. Arbitration involves an initial agreement to arbitrate, preparation of the case, a pre-hearing conference to clarify procedures, a hearing, review of evidence, and the decision. (For more on arbitration, see the Grievance Procedures chapter in this manual.)

**M. Check With Your Grantee**

Disputes that advance to requiring mediation and/or arbitration, especially if they involve funds, could be taken out of the planning body’s hands. A consortium may not have the authority to make final decisions about when and how to take steps beyond the consortium’s dispute resolution process. This level of conflict management should be addressed with the grantee and could depend upon State law or contract provisions with the consortium or lead agency. Many grantees have language regarding conflict resolution in their guidance.

**X. Ch 8. Conflict of Interest**

**A. Introduction**

The Ryan White legislation allows States to use consortia to guide the development of Ryan
White Part B HIV/AIDS services and requires them to utilize a public planning process to develop their comprehensive plans. Inclusion of broad membership is required, including providers and consumers of HIV/AIDS services. In mandating membership from individual or organizational representatives with direct personal or professional expertise related to HIV/AIDS services, Congress has built a conflict of interest challenge into consortium and planning operations. These challenges are even greater in situations where consortia or their lead agencies are responsible for procurement.

Conflict of interest is an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. Conflict of interest occurs when an appointed or voting member of a consortium or other planning body has a direct or indirect fiduciary or other personal or professional interest in a decision or in the outcome of a vote. Conflict of interest also occurs when members use their positions for purposes that are—or appear to be—motivated by pursuit of private gain for themselves or their families, friends, or business associates.

The greatest challenges in conflict of interest occur when consortia or their lead agencies are responsible for not only the prioritization of service needs but also the actual selection and oversight of service providers. As earlier chapters have indicated, many consortia are planning bodies with no responsibility for procurement. HAB/DSHAP expects Ryan White Part B grantees to review the effectiveness of their consortium models in the context of legislative changes and policy and program requirements. Where consortia or their lead agencies do play this role, management of conflict of interest goes beyond the requirements for a planning body to include ensuring a fair and open procurement process. For example, if objective review committees are established to review funding applications, consortium members should not be permitted to serve on such committees. The criteria for review, the process of selection, and the appeal process should be published beforehand.

Conflict of interest challenges can occur in any Ryan White Part B planning body where funded service providers are members who actively participate in all aspects of the planning process. Activities that may breed conflict of interest include:

For all planning bodies:
- Prioritization of services.
- Allocation of resources to service categories.
- Needs assessment.
- Comprehensive planning.

For consortia that also manage procurement:
- Selection of service providers.
- Funding decisions, which are usually made through a competitive process but in some cases may involve sole source contracting.
- Contract monitoring.

To minimize the negative impact of conflict of interest, processes must be open and based on clear policies, which include:
- A definition of conflict of interest.
- A method of disclosure of actual or potential conflict of interest, including a disclosure form that is updated regularly (usually annually or when the member’s affiliations change) as well as oral disclosure in specified situations.
- Procedures for managing conflict of interest and resolving situations when a conflict of interest occurs or may occur.

**B. Defining and Managing Conflict of Interest**

For Ryan White planning bodies, conflict of interest is most often defined as an actual or perceived interest by a planning body member or close relative in an action that results in, or has the appearance of resulting in, personal, organizational, or professional gain. Any action that could be seen as an attempt to influence the process for personal, organizational, or professional gain should be included in a definition of conflict of interest. This bias, or appearance of bias, in the decision-making process would reflect the dual role played by many members, who in addition to serving on the planning body are often affiliated with other organizations, either as an employee, a member, a board member, a volunteer, or in some other capacity.

Most conflict of interest definitions cover not only the individual, but also certain relatives, most often as a spouse or committed partner, parent, child, or sibling. The definition should indicate which family members are covered. Safeguards are needed to prevent members from using or seeming to use their positions for private gain. The best way to establish safeguards and manage conflict of interest is to develop a definition of conflict of interest and policies and procedures to manage it. The procedures should include specific actions to be taken when a potential conflict arises and when someone violates conflict of interest policies.

Most States and local governments have conflict of interest standards in place, which can be reviewed to determine if they govern the activities of the planning body or can be adopted for this purpose. Any entity serving as a Ryan White Part B administrative agent should have conflict of interest policies in place that cover its employees and board members.

**C. Areas Where Conflict of Interest Can Happen**

The potential for conflict of interest is present in all planning processes: needs assessment, comprehensive plan development, priority setting, allocation of funds, and evaluation. In particular, priority setting and allocation of resources should be kept separate from those actions that procure services and select service providers. Some consortia have implemented policies that allow a lead agency to coordinate processes but not apply for Ryan White Part B funding. However, many have limited resources and members, making this recommendation difficult to apply.

Following are conflict of interest considerations for specific areas:

**Membership.** A person living with HIV/AIDS whose sole relationship to a Ryan White Part B-funded provider is as a client receiving services or serving as an uncompensated volunteer is not considered to have a conflict of interest; such individuals are described in the legislation as
“unaligned consumers.” However, like other planning body members, PLWHA should not be involved in decisions that can affect entities in which they have a financial interest or a governance responsibility. This includes being an officer, employee, or paid consultant to a Ryan White Part B provider agency or to the administrative agency that administers that Ryan White Part B grant. HAB/DSHAP encourages consortia to seek out as unaligned consumers as members.

Expectations should be clearly defined for members who represent a community, though serving in such a role is not in itself a conflict of interest. A good planning process gathers diverse perspectives. There are times when a member should advocate for the interests of a geographic or demographic community, and other times when all members should be planners, focusing on what is best for all PLWHA within the State or region. Members may need training and guidance on when it is appropriate to be an advocate and when they need to serve as a planner. The roles should be communicated clearly, and members who serve as community representatives should receive a job description clarifying both roles. This includes making it clear that it is always a conflict of interest to advocate for a personal agenda or a particular service provider.

Members who have more than one role need to clearly identify the perspectives they are representing. A good example of this is the member who is an employee of a funded provider, a PLWHA, and a member of a community of color. Which perspectives does this member represent? This person brings valuable experience, but needs to be able to differentiate roles – and the planning body needs to have a membership that is large and diverse enough to provide broad perspectives, rather than depending on a small number of individuals to represent all the perspectives necessary to make truly informed decisions.

**Leadership.** Some Ryan White Part B planning bodies have a policy that an employee of the State, the lead agency, or a funded provider may not be the sole Chair of the planning group. (This is a legislative requirement for Part A planning councils.) Some planning bodies use a Co-Chair structure, with one Co-Chair required to be an unaligned consumer. This helps ensure that, on all matters, at least one Co-Chair will not have a conflict of interest. Some planning bodies do not allow employees of the lead agency or grantee to be voting members.

**Needs Assessment.** An actual or perceived conflict of interest can occur in conducting the needs assessment and using its results in preparing the comprehensive plan and conducting priority setting and resource allocation. Conflict of interest can emerge at the following decision points of the needs assessment process:

- How to conduct a needs assessment.
- Which groups to survey or target.
- What role funded providers will play in providing access to their clients for surveys, focus groups, or interviews.
- What questions to ask.
- How to phrase the questions.
- How to interpret the results.
- How to review external data, such as epidemiologic data.
- Which data to use.
A good needs assessment contains input from consumers and providers, as well as non-funded providers and other experts in HIV/AIDS care and research. Examples of conflict of interest regarding input into a needs assessment process might include the following:

- Providers advocate successfully for survey or interview questions likely to provide data that make their services seem especially important
- A provider convinces the consortium to overemphasize the input of its own clients
- A provider representative determines which clients within its agency are targeted for the needs assessment
- The needs assessment solicits the opinions only of members and individuals they select.

**Priority Setting and Resource Allocation.** Examples of conflict of interest in priority setting include the following:

- Setting priorities based on who was the most vocal at the priority-setting meeting.
- Failure to use the consortium’s criteria to set priorities and instead advocating for narrow provider or personal interests.
- Choosing to allocate funds to service categories that do not match the needs identified in the needs assessment.
- Convincing consumers that their service will be in jeopardy unless they support increased allocations to particular service categories.

The setting of priorities should flow from the results of the needs assessment and other data such as client utilization, not from the individual interests of members. Focus should be on ensuring a continuum of care that includes the services that are likely to be needed by Ryan White-eligible PLWHA in the service area. Priorities should seem reasonable to an objective viewer.

Funding allocation decisions should reflect changes in the local epidemic and the need to meet the service gaps and unmet needs of PLWHA in the service area, including those persons not in care. They should also reflect the need to identify and bring into care PLWHA who are unaware of their status. In justifying allocations, planning bodies must consider the availability of other funding sources to lessen the need for Ryan White Part B funding of a particular service and reduce duplication of effort. This includes looking at service utilization in the prior year and whether all available funds for that service category were spent.

**Comprehensive Plan.** In the comprehensive plan, conflict of interest can lead to problems such as the following:

- Inadequate planning for underserved populations and subpopulation groups.
- Biased analysis of needs assessment and client utilization data in determining service barriers and gaps and needed changes in the continuum of care.
- An ineffective planning process that results in a service delivery system not fully responsive to a changing epidemic.
Effective comprehensive planning requires a clearly defined planning process with clear tasks, responsibilities, and timelines. Broad planning body and PLWHA involvement also help prevent persons or organizations with conflicts of interest from directing the process in a biased or unfair way and helps ensure that the plan is followed.

**Evaluation.** Consortia are responsible for evaluating both their own planning process and their cost effectiveness in meeting the needs identified by their needs assessment. Grantees are responsible for assessing the effectiveness of their administrative mechanism in rapidly allocating funds to areas of greatest need within the State, and consortium self-assessments can contribute to this assessment. Consortia work with grantees to measure performance using agreed-upon HRSA/HAB Performance Measures, and they and providers have clinical quality management responsibilities. The results of such evaluation should be used to improve the consortium’s ability to plan and deliver high quality, cost-effective services to meet the needs of PLWHA in their communities. However, conflict of interest can influence:

- The extent to which evaluation is conducted.
- How it is conducted.
- Who helps to conduct it and provides data.
- How the data are interpreted.
- How the results are used.

Conflict of interest can lead to a stagnant process where the *status quo* is maintained, with no real evaluation of efficiency and effectiveness.

**D. Techniques for Managing Conflict of Interest**

Groups should 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. In a broader sense, where the planning body’s deliberations are open and accessible to consumers and the broader public, members are less likely to engage in behavior that reflects narrow concerns or conflict of interest. Examples of useful strategies are described below.

**Disclosure Forms.** Planning body members should complete forms that identify any affiliations that may create real or perceived conflicts of interest. The form might include the following:

- A listing of all relationships the member has to organizations that could benefit from an action by the planning body (such as a current or potential Ryan White Part B provider or contractor).
- The relationship that causes the potential conflict of interest (e.g., member serves on the Board, partner is an employee).
- The duration of the conflict of interest (current, past, temporary).
- A description of what actions will be used to prevent or resolve a conflict of interest.
Disclosure forms should be updated annually or whenever an affiliation changes, to maintain accurate information. Often the policy requires a member to submit a new disclosure form within a specified period of time (e.g., ten business or working days) after a change in affiliation that may create a conflict of interest.

**Public Disclosure.** Members are required to declare their potential conflicts of interest verbally once a year, semiannually, or even at every meeting. Sometimes verbal disclosure is specifically required during priority setting and resource allocation. Planning body members should be required to provide a verbal disclosure any time discussion or decision making involves an entity or situation in which the member has a real or perceived conflict of interest.

**Conflict of Interest Standards.** Successful resolution of conflict of interest situations requires adoption of conflict of interest standards and their routine application in planning body decisions. Such standards should be outlined in the planning body’s bylaws. The planning body needs to decide what it considers to be a fair and practical method to manage and resolve conflict of interest issues, recognizing that no solution is perfect. Conflict of interest cannot be fully prevented or resolved; it can be managed consistently and fairly. Specific standards include the following:

- Define conflict of interest to cover not only the individual member but also his/her close relatives, partners and spouses.
- Prohibit members with a potential conflict of interest from voting on issues relating to a particular organization or category of service. In priority setting and resource allocations, permit them to vote only on a slate of priorities or a combined set of allocations.
- Assign a co-chair or committee to review all conflict of interest concerns. Authorize any member to make a request for review of a perceived conflict of interest; define the process of review in writing, establishing timelines so that any review is undertaken in an expeditious manner; and establish policies for dealing with members who engaged in a conflict of interest and/or refused to cooperate in a conflict of interest review.

**Reminders of Potential Conflict of Interest.** The following actions may be useful in increasing planning council member awareness of conflict of interest:

- Provide a written or projected matrix of members and their conflicts of interest at every meeting.
- At the beginning of each meeting, when doing introductions, ask members to identify any service categories for which they have a conflict of interest.
- Provide members with the planning body’s mission statement to remind them of the purpose of their work.
- Require members to sign a declaration of commitment to the purposes of the planning body.

**Well Publicized Open Meetings.** Planning body meetings and most committee meetings are open to the public. Where members of the public, including consumers, are present, planning body members are reminded of their responsibility to represent and serve the community.
**Input During Meetings.** Orderly processes that can reduce conflict of interest include allowing for regular input from community members at meetings. Requests for time to comment on concerns should be submitted in advance of or at the beginning of the meeting. The time allocated for public comment should be limited, while allowing for diverse expression and full debate.

**Other Forums for Input.** Input beyond the planning body membership can include consumer caucuses, provider caucuses, support groups, and *ad hoc* committees to get input at each step of the process.

**Clear Processes With Open Participation.** Processes that are well defined and open to the public protect the interests of all members. Included in those processes should be avenues for broad and balanced input from a variety of sources. The needs assessment process, for example, must include input from providers and consumers as well as other interested parties and should not be dominated by a particular group. Similarly, comprehensive planning activities should be based on a clear structure and process that identifies action steps, timelines, and specific roles and responsibilities. Perhaps most important, the setting of priorities must be data-based, flowing from the results of the needs assessment and comprehensive planning process.

**Member Term Limits and Staggered Terms.** This can allow for new voices to be heard.

**Memorandum of Understanding Between Planning Body and Grantee.** This document can outline duties of each entity and the roles of particular staff so that expectations are clear.
Some Special Situations

In small and very remote places where there are few providers, there may be few service providers with the capacity and willingness to provide HIV/AIDS services. This means that the planning body knows that when it allocates funds to a particular service category, it is in effect deciding how much money a particular provider will receive. The planning body should proceed in its decision making. The administrative agency in such situations has a special responsibility to seek out other potential providers and to ensure that it does not encourage the planning body to maintain the status quo in a way that protects its members’ own interests rather than addressing the needs of PLWHA. In the situation where the group feels there is only one possible provider for a service, the service evaluation process becomes critically important.

In States where contracting requirements mandate a competitive bidding process, consortia should consult with their grantees about such requirements and not assume they can award a sole source contract. Many States will allow exceptions when certain criteria are met, but consortia must meet their State requirements for contracting. Awareness of a potential conflict of interest keeps everyone alert as to the factors that influence decision making.

Some groups share expertise across regions in order to bring fresh ideas to their planning and manage conflict of interest. For example, consortia can assist each other not only in planning but in the RFP and selection process. People with expertise in a particular service category might sit on the review committee in another region. This ensures expertise while eliminating conflict of interest.

Grievance Procedures. In cases where a conflict of interest evolves into a dispute regarding whether the planning body’s policies and procedures have been violated in a way that affects funding, the planning body may need to turn to grievance procedures to resolve the situation (See the Grievance Procedures chapter in this section)

X. Ch 9. Grievance Procedures

A. Introduction

Grievance procedures within the Ryan White Program provide an orderly and fair process for addressing dissatisfactions or complaints related to how Ryan White planning bodies and grantees/administrative agencies make decisions related to funding. The intent is to prevent or address such complaints before they reach the stage where the affected party seeks a formal approach to their resolution.

There are several situations that can lead to grievances involving a Ryan White Part B planning body or grantee. Examples include alleged failure of a planning body or grantee to follow its decision-making procedures, particularly planning body decisions about service priorities and funding allocations and grantee decisions about procurement and use of allocated funds.
Ideally, the best way to deal with grievances is to prevent them by using clear decision-making processes, making decisions in public view, and using a variety of informal methods to resolve potential problems early on. Informal methods can save time and help build positive relationships between the planning body, consumers, and the community. When grievances cannot be resolved in this manner, more formal procedures can provide an orderly and fair process for addressing them. Well-crafted grievance procedures include both informal mechanisms (e.g., dispute prevention, opportunities to ask questions about decision-making criteria) and formal methods (e.g., non-binding and binding arbitration).

**B. HAB/DSHAP Expectations**

While Part A is legislatively mandated by the Ryan White Program to establish a grievance process with respect to funding decisions, Ryan White Part B grievance procedures are not specifically required by the Ryan White or HAB/DSHAP. However, Ryan White Part B grantees and consortia are strongly encouraged to have grievance procedures in place. The Part A requirements can be used as a sound practice model for Ryan White Part B.

Each Ryan White Part B grantee and consortium should have a written set of procedures for resolving grievances related to a specific set of issues. Having a grievance process in place provides an orderly and fair process for addressing such dissatisfactions. A grievance process also deters individuals from airing their complaints inappropriately.

HAB has developed model grievance procedures (these can be found in subsection E. below) to guide local efforts in adequately addressing potential grievances. Many localities had such procedures in place long before Ryan White requirements. Areas are urged to use or adapt them. There should be periodic local review of grievance procedures and their implementation to ensure that grievances are being resolved in a timely and appropriate manner.

**C. Steps in Dealing With Grievances**

The best way to deal with grievances is to avoid them through various dispute prevention measures. When grievance cases arise, first steps to resolve them should involve non-binding negotiations. For cases that cannot be resolved in this manner, subsequent steps should be undertaken, with binding arbitration as a last resort. Each of these areas is described below.

**D. Dispute Prevention**

Disagreements can be minimized through dispute prevention, which entails creating a climate of cooperation and open decision making. Dispute prevention measures (which are not a part of the grievance process itself) should be incorporated into bylaws and operating procedures. They include, but are not limited to:

- Clear written statements on how decisions are made.
- Open communication during the grantmaking process, allowing groups to obtain clarification and an understanding of criteria used.
- Opportunities for interested parties to provide feedback on ways to improve the decision-making process.
making process.
- Training on ways to make decision-making processes inclusive.
- A designated advocate or ombudsman on staff or on call to work internally with questions or concerns.
- Conflict of interest policies and procedures that are available to the public.

E. Model Grievance Procedures

The following model grievance procedures outline minimum elements that might be addressed in local grievance procedures. They include:

- Who may bring a grievance.
- Types of grievances covered.
- Non-binding procedures for resolving conflicts.
- Use of binding arbitration for conflicts that cannot be resolved using non-binding procedures.
- Rules governing the grievance process.

Each element is described below.

Who May Bring a Grievance

Individuals or entities directly affected by the outcome of a decision should be eligible to bring a grievance. “Directly affected” should be defined and might include, depending upon the nature of the grievance: providers eligible to receive Ryan White funding; consumer groups/PLWHA coalitions and caucuses; the planning body, individual PLWHA, and other affected entities and individuals as determined locally.

Careful consideration should be given to the inclusion of other affected individuals. A balance must be struck between restricting the process too narrowly, which can create tension and distrust, and opening the process too widely, which can overburden and delay the decision-making process.

Types of Grievances That Might Be Covered

Grievance procedures under Ryan White programs are generally used to address decision-making processes that affect funding, and typically cover the following:

For the planning body:

- Deviations from an established, written priority-setting or resource-allocation process (e.g., failure to follow established conflict of interest procedures).
- Deviations from an established, written process for any subsequent changes to priorities or allocations.
For the grantee – or for an administrative agency or a consortium if it does direct contracting with providers;

- Deviations from the established contracting and awards process (e.g., the selection of a particular provider in a manner inconsistent with the grantee or consortium’s established procurement process).
- Deviations from the established process for any subsequent changes to the selection of contractors or awards.
- Contracts and awards that are not consistent with priorities and resource allocations made by the planning body.

Note that under these guidelines, a grievance can be filed if the processes used are not consistent with established procedures. A grievance cannot be filed simply because the grievant does not agree with the funding decision.

Often, other kinds of disputes, such as problems related to violations of the planning body’s code of conduct, should be addressed through planning body dispute resolution procedures, not through the grievance process.

**Non-Binding Procedures**

Non-binding procedures are designed to resolve grievances. One such procedure is *mediation*—a process in which a third party assists the parties to a dispute in airing concerns and perspectives, finding areas of agreement, and reaching a conclusion that they can accept. Another approach is *facilitation*, which is similar to mediation except that the facilitator does not typically become as involved in the substantive issues. Yet another technique is an *ombudsman*, who investigates a grievance and makes a non-binding report to the parties involved.

Non-binding procedures:

- Designate a person or organization to receive grievances on behalf of the planning body.
- Provide a form to initiate non-binding dispute settlement that includes at least the following (A sample form is attached):
  - Names, addresses, and telephone numbers of the parties involved.
  - Issue(s) to be resolved and how the person or organization seeking resolution (the grievant) has been directly affected by the decision of the planning body or grantee
  - Remedy sought by the grievant.
  - Place where or person to whom the form should be delivered.
  - Designated person or position to register the form and notify the grievant of any determinations or decisions that are made.
  - Statement of any reasonable administrative fee to be paid by the grievant, and whether payment must be made when the form is filed.
- Specify rules that will apply to non-binding dispute settlement processes (See “Rules for the Grievance Process,” below).
- Provide a mechanism to inform the grievant of the rules that will apply to the process.
- Outline steps the grievant should take if there is no resolution of the grievance within the
appropriate time period and the grievant wishes to initiate binding arbitration.

**Binding Arbitration**

Arbitration resolves disputes when other methods have failed. Arbitration, the use of an independent and impartial third party to decide disputes, is the final stage in the dispute resolution process. Under the grievance process, the decision of the arbitrator is binding on the parties to the dispute.

If the non-binding approach selected by the parties is not successful within a designated time period, or if the third party determines that there is no further purpose to continuing the non-binding process, the grievant has the option of continuing to seek resolution through binding arbitration. Any party that has initiated a grievance that has not been resolved in whole or in part through non-binding procedures should have access to the arbitration process.

At a minimum, arbitration procedures should include the following:

- A designated person or organization to receive a request for binding arbitration on behalf of the planning body or grantee.
- A form to initiate binding arbitration that includes at least the following:
  - Names, addresses, and telephone numbers of the parties involved.
  - Issue(s) to be resolved and how the person or organization seeking resolution has been affected by the decision of the planning body or grantee.
  - Remedy sought by the grievant.
  - Place where or person to whom the form should be delivered.
  - Designated person or position to register the form and notify the grievant of any determinations or decisions.
  - Previous steps taken under non-binding procedures that have not resulted in agreement.
  - Acknowledgment of the binding nature of the process.
  - Statement of any reasonable administrative fee to be paid by the initiator and whether payment must be made when the form is filed.
- Rules that will apply to the binding arbitration process (See “Rules for the Grievance Process,” see below).
- A mechanism for informing the grievant of the rules that will apply to the process.

**Rules for the Grievance Process**

Both non-binding procedures and binding arbitration must have rules. They provide both the grievant and other parties, including the third party, with a common understanding of how the procedures will be conducted, what is expected of each party, and the time limits and costs of the procedures. Some third parties, or the organizations sponsoring them, have their own set of rules. Third parties that do not have their own rules may wish to designate an existing set of rules such as those summarized below.

**Non-Binding Rules**
Non-binding rules should specify at least the following:

- Degree of confidentiality of the process.
- Maximum time period between filing the form and response from the other party.
- The process and time period for designating a third party.
- Time period for holding a meeting of the parties, if necessary.
- Designation of a place for that meeting.
- Maximum length of time that a non-binding process can continue without agreement, after which the third party must end the process and inform the parties of any additional steps (e.g., arbitration) that are available to them.

**Binding Arbitration Rules**

Binding arbitration rules should specify at least the following:

- Steps in the arbitration process.
- Maximum time period allowed between filing the form and response from the other party.
- Time period set aside for holding a hearing, if necessary.
- Designation of a place for that hearing.
- Time period allocated for the arbitrator to render a decision.
- How the decision will be presented.
- Whether the decision will apply retrospectively to the decision that led to the grievance or only to future decisions.

**Timing**

Grievance procedures that contain time limits on various activities allow for an effective use of the process without resulting in undue delay in the delivery of needed HIV/AIDS services. Time periods should be specified for at least the following:

- Length of time after a decision related to funding has been made, during which a grievance may be brought—the time limit after which an award can no longer be challenged.
- Time periods for conducting various non-binding processes, including the maximum time allowed to complete the process once initiated.
- Length of time after the conclusion of non-binding processes for the grievant to initiate binding arbitration.
- Time period for conducting the arbitration process.

It is up to the planning body and grantee to decide the time period after a decision is made during which a grievance may be filed. Thirty calendar days or 20 business days after the decision is made, or after the decision is announced or made public, probably provides sufficient time for a potential grievant to decide whether to challenge the decision-making process.
Non-binding Resolution. After the request for a non-binding resolution is received, the following time periods, which run consecutively, should be considered for inclusion in local rules (All these are business or working days):

- Determination that the grievance or grievant falls within scope of the procedures: 2-5 days.
- Notification of the other party: 1-2 days.
- Selection of a third party: 5-10 days.
- Meeting(s) with parties: 10-15 days.
- Resolution or decision by the third party not to continue (impasse): 5 days.

Binding Arbitration. After the form requesting binding arbitration is received, the following time periods, which run consecutively, should be considered for inclusion in local rules:

- Determination by the grievant to use binding arbitration: 5-10 days.
- Notification of the other party: 1-3 days.
- Agreement of the parties to arbitrate and selection of an arbitrator: 5-10 days.
- Hearing (if necessary): 10-15 days.
- Decision by arbitrator: 5-10 days.

Costs

Because grievance procedures typically entail costs, rules should address costs of administering the process, including at least:

- Reasonable costs that may be involved for administering the process and for the services of the third party, how they will be allocated between the parties, and when they are due.
- Costs or transfers of funds that may be called for in any settlement agreed to by the parties or a decision of an arbitrator.

Administrative fees are to recover reasonable costs of administering the grievance process but should not be so burdensome that they discourage filing of legitimate grievances. A grievant can be required to pay a reasonable administrative fee to initiate the process and share in the costs of mediation and arbitration. Third parties (e.g., arbitration services) may also charge a fee for their services. Local procedures should specify any costs that might be involved and how the costs will be allocated in the absence of agreement among the parties.

Funding of Projects After a Grievance Is Filed

Grievance procedures should address how to handle the funding of projects after an award has been made but while a grievance is pending. Procedures should not unduly disrupt the expeditious distribution of Ryan White funds or the delivery of services. Procedures should clearly address whether the results of the grievance should be prospectively addressed (i.e., not requiring reversals of decisions such as approved expenditures), or allow for retroactive resolution (e.g., changes in funding decisions).
**Review of Grievance Requests**

A process should be defined for determining what issues can be grieved and whether the grievant is eligible to bring the grievance. A broadly inclusive committee can be used for this purpose. The purpose of the review is not to add an extra step to the grievance process, but to provide a broader consideration of filed grievances to ensure that decisions are consistent with the purposes and spirit of the grievance procedure as called for in the Ryan White HIV/AIDS Program.

**Selection of Third Parties**

Procedures must identify how third parties will be selected for non-binding dispute settlement procedures and for arbitration. Among the factors that should be considered in the third party selection procedures are:

- Conflicts of interest.
- Training and experience.
- Cost.
- Availability during the required time period.

Third parties should be independent of the specific process that is the subject of the dispute and should not have a direct interest in the decision.

Procedures should specify the time period and process for selecting third parties for both non-binding processes and arbitration. Methods for selecting a third party include:

- Advance naming of independent and impartial third parties who can be drawn on to resolve a particular grievance.
- Advance designation of an organization that identifies and provides independent and impartial third parties to resolve a particular grievance.
- Appointment of an independent and impartial third party by the chief elected official (CEO).
- Submission of the names of several third parties, with each party asked to cross off unacceptable names, and the remainder considered acceptable by both. If after several lists, no third party acceptable to both parties has been identified, a designated person or organization should select the third party.

Selecting a group or entity in advance reduces administrative burden but may involve administrative costs for the group selected. Normally, arbitrators and other third parties are approved by all the parties to the dispute. However, a third party may be appointed in a manner that is consistent with these model procedures. A third party should complete a written statement disclosing any potential conflicts of interest that might exist between the third party and the parties to the grievance. The parties should be given the opportunity to review the statement.
An issue of concern to many groups or individuals seeking third-party resolution of disputes is where to find third parties. For example, the following organizations maintain lists of trained and impartial mediators and arbitrators and/or organizations that mediate disputes:

- The American Arbitration Association (AAA), which maintains a National Register of Arbitrators and Mediators (http://www.adr.org).
- The Better Business Bureau (BBB), which operates several dispute resolution programs (http://www.bbb.org/us/Dispute-Resolution-Services/); local offices can provide lists of trained volunteer mediators and arbitrators.
- The National Association for Community Mediation (NAFCM), which has a membership of mediation centers (http://www.nafcm.org), typically nonprofit or local government agencies that mediate disputes either free or for reduced fees.
- The Association for Conflict Resolution (http://www.acrnet.org), a professional association of arbitrators, mediators, and other dispute resolution professionals that has an Advanced Practitioner roster.

Many State and Federal court systems run alternative dispute resolution programs, some States have offices of dispute resolution, and both Federal executive Boards and university-based conflict resolution programs may be able to identify neutral third parties.

Costs and fees for these third parties vary; as noted above, some are volunteers.

Definitions

Terms commonly used in grievance procedures and other dispute resolution processes are defined below. Local grievance procedures can modify these definitions or add others. Terms should be used consistently to avoid uncertainty and enhance implementation of the procedures.

Arbitration: The submission of a dispute to an impartial or independent individual or panel for a decision that is generally binding on both parties. Arbitration is usually carried out under a set of rules. The decision of an arbitrator generally has the force of law, although it generally does not set a precedent on how future disputes will be resolved.

Arbitrator: An individual or panel of individuals (usually three) selected to decide a dispute or grievance. Arbitrators may be selected by the parties or by another individual or entity.

Binding: A process in which parties agree to accept as final the decision of an arbitrator or other third party.

Costs: Charges for administering a dispute settlement process.

Day: Refers to a calendar day or a business or working day. Either reference point can be used, as long as the grievant and the person or group against which the grievance is brought understand the applicable time frame.
**Dispute Prevention:** Techniques or approaches used by an organization to resolve disagreements at an early and informal stage, to avoid or minimize the number of disputes that reach the formal grievance process.

**Facilitation:** A voluntary process involving the use of techniques to improve the flow of information and develop trust between the parties to a dispute. Involves a third party (facilitator) who uses a process to assist the parties in reaching an agreement that is acceptable to them.

**Facilitator:** A third party who works with the parties to a dispute, providing direction to a process. A facilitator may be independent or may be drawn from one of the parties, but must be impartial on the topics under discussion.

**Grievance:** A complaint or dispute that has reached the stage where the affected party seeks a formal approach to its resolution.

**Grievant:** A person or entity seeking a formal resolution of a grievance.

**Impartiality:** Freedom from favoritism or bias in word or action; a commitment to aid all parties, as opposed to a single individual, in reaching a mutually satisfactory agreement.

**Mediation:** A formal process in which a neutral person, the mediator, assists the parties in reaching a mutually acceptable resolution to their dispute. Mediation may involve meetings with the parties together and separately. The results of mediation can become binding if the parties agree.

**Mediation/Arbitration:** A mixed approach in which parties agree to mediate their differences and submit issues that cannot be resolved through mediation to arbitration. This technique helps to narrow the issues submitted to arbitration. The parties may agree to use separate mediators and arbitrators for different stages of the process, or they may use the same third party.

**Mediator:** A trained impartial and usually independent third party selected by the parties to the dispute or by another entity to help the parties reach an agreement on a determined set of issues.

**Neutral:** A term used to describe an independent third party, including a mediator or arbitrator, selected to resolve a dispute or grievance. The term is used because the person should not favor either side in the dispute.

**Non-binding:** Techniques in which the parties to a dispute attempt to reach an agreement but are not required to accept the results. The agreement must be voluntarily accepted by both parties; results are not imposed by a third party as they are in binding arbitration or in a judicial proceeding.

**Ombudsman:** An individual selected by parties in a dispute who investigates the facts of a situation and makes recommendations to the parties. The recommendations of ombudsmen are not binding and their effectiveness depends in large measure on their ability to persuade the parties to accept their recommendation.
**Party:** A participant in the grievance process. This includes the grievant (the person or group that brings the grievance action) and the person or group against which the grievance is brought.

**Remedy:** The relief or result sought by a grievant in bringing a grievance. It can include money damages, a process change, or a reversal of a decision. Whether it applies prospectively (to future funding-related decisions) only or retroactively (to past funding decisions) is determined by each local grievance procedure.

**Standing:** A term referring to the eligibility of an individual or entity to bring a grievance. In the case of grievance procedures under the Ryan White reauthorization, a person or entity that is directly affected has standing to challenge a planning body or grantee decision with respect to funding.

**Third Party:** A term used to describe an independent or impartial person, including a facilitator, mediator, ombudsman, or arbitrator selected to resolve a dispute or grievance or assist the parties in resolving it.

### F. Sample Grievance Form

Grievances may be filed for the following deviations from policy: [List scope of allowable grievances]

- Deviations from an established, written priority-setting or resource-allocation process (for example, failure to follow established conflict of interest procedures); and
- Deviations from an established, written process for any subsequent changes to priorities or allocations.

The procedures that will govern the handling of this grievance are attached.

If you wish to file a grievance with the _____________, this form must be completed, submitted, and received by the [identify designated position and/or office for receiving grievance forms] within twenty (20) working days of the date of the alleged deviation or within twenty (20) working days after the decision was made public. You will be contacted within ten (10) working days following receipt of this form by [specify position]. There is no administrative fee associated with filing this grievance. [Or specify fee.]

When completed, submit this grievance form to the [specify office and address].

Name(s) of Person(s) or Organization(s) Filing the Grievance):

__________________________________________________________________________

Address:

__________________________________________________________________________
X. Ch 10. Needs Assessment

A. Introduction

Ryan White HIV/AIDS Program needs assessment is a process of collecting information about the needs of PLWHA—both those receiving care and those not in care. Steps involve gathering data—from multiple sources—on the number of HIV and AIDS cases, the needs and service barriers of PLWHA, and current resources (Ryan White HIV/AIDS Program and other) available to meet those needs. This information is then analyzed to identify what services are needed, what services are being provided, and what service gaps remain, overall and for particular groups of PLWHA.

For Ryan White Part B, States and territories are required to undertake needs assessment, priority setting and resource allocation activities as integral parts of the Ryan White planning process. Specific components such as consortia are required to assure that need are demonstrated in its priority setting and resource allocation process. Results from the needs assessment should be used in developing the consortia plans, statewide coordinated statement of needs, and the State’s comprehensive plan, and in crafting the annual implementation plan and specific strategies for addressing needs. Needs assessment results can also provide baseline data for evaluation and help the State and its sub-grantees improve services.
It is important to first determine the kinds of information needed for each component of the needs assessment, and then to decide the most appropriate methods for obtaining those data. Often, the same method can be used to collect data for several needs assessment components.

Needs assessment steps include identifying:

- **Data on HIV cases and AIDS cases.** HIV/AIDS epidemiologic data indicate the current size and characteristics of the populations living with HIV and AIDS as well as trends in the epidemic.
- **Needs of PLWHA in and out of care.** Insights on needs can be obtained through comorbidity and socioeconomic data and such methods as surveys, focus groups, community meetings, and individual interviews.
- **Existing services available to PLWHA.** A resource inventory can show what services and organizations currently exist. An assessment of provider capacity/capability can determine provider ability to deliver HIV/AIDS care overall and to specific populations. Both the inventory and the provider profile should include core services and support services.
- **Unmet needs/service gaps that Ryan White projects should address.** Comparing available services to identified needs reveals unmet needs and service gaps (see definitions below). This should include an examination of unmet needs for HIV-positive individuals who know their status but are not in care; service gaps for those who are currently in care; disparities in care; and capacity development needs of providers and the overall system of care. Analysis of unmet needs/service gaps might include not only a determination of overall needs but also identification of particular service needs for specific PLWHA populations.

### DEFINITIONS OF UNMET NEED AND SERVICE GAPS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet need</td>
<td>The unmet need for HIV-related primary health care among individuals who know their HIV status but are not receiving such care (not “in care”).</td>
</tr>
<tr>
<td>Service gaps</td>
<td>All service needs not currently being met for all PLWHA except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for health services for those already receiving HIV-related primary medical care (“in care”).</td>
</tr>
</tbody>
</table>

A person is considered to be **in care** if receiving HIV-related primary medical care within the past 12 months.

To avoid confusion, the term **unmet need** is used only to denote the need for primary health care by **PLWHA not in care**, and **service gaps** are used for all other service needs.

**Table 6: Definitions of Unmet Need and Service Gaps**

**B. HAB/DSHAP Expectations**
Needs assessment is expected to generate information about:

- The size and demographics of the HIV/AIDS population within the service area.
- The needs of PLWHA, with emphasis on individuals with HIV/AIDS who know their HIV status and are not receiving primary health care, individuals with HIV/AIDS who do not know their status, and disparities in access and services among affected subpopulations and historically underserved communities.

<table>
<thead>
<tr>
<th>Definitions and Descriptions Related to Individuals Who Do Not Know Their HIV/AIDS Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with HIV/AIDS Who Do Not Know Their HIV Status: Any individuals who have NOT been tested for HIV in the past 12 months, any individuals who have NOT been informed of their HIV result (HIV positive or HIV negative), and any HIV-positives individual who have NOT been informed of their confirmatory HIV result. These individuals are not in HIV-related primary medical care because they are unaware of their status.</td>
</tr>
<tr>
<td>Early Identification of Individuals with HIV/AIDS (EIIHA) Process: The identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to care.</td>
</tr>
<tr>
<td>HRSA/HAB uses the term EIIHA to refer to the process of addressing legislative requirements related to individuals with HIV/AIDS who do not know their HIV status.</td>
</tr>
</tbody>
</table>

HAB/DSHAP expects Ryan White Part B needs assessments to meet all legislative requirements and to provide a sound information base for planning and decision making.

Planning bodies and grantees are expected to apply the following principles and strategies in their needs assessment efforts:

- **Needs assessment is a partnership activity** of the planning council, grantee, and community, with the planning council taking the lead role.
- **Needs assessment is the basis for other Ryan White HIV/AIDS Program planning activities.** Assessment plays an important role in the development of an array of services for PLWHA. Ryan White programs use its results to help prioritize service needs and allocate funds, develop a comprehensive plan, and craft strategies to address these needs through the implementation plan and appropriate service models.
- **Needs assessments focus on particular areas of need,** with an emphasis on reaching those not in care or not aware of their status, identifying disparities in care, and identifying ways to enhance the service delivery system. Areas for attention are as follows:
  - **Focus on PLWHA not in care and disparities in care.** Many needs assessments have primarily targeted PLWHA who were receiving HIV-related services.
(individuals already “in care”). The Ryan White HIV/AIDS legislation requires planning bodies to expand their needs assessments to also determine the needs of those individuals who know their HIV status but are not in care and to determine strategies for identifying HIV-positive unaware people and ensuring that they are tested and linked to care. Particular attention must also be paid to identifying disparities in access and services among affected subpopulations and historically underserved communities. [Section 2617 (b)]

- **Identify capacity development needs.** Capacity development needs exist when disparities in the availability of HIV-related services are identified, particularly in historically underserved communities. In planning for capacity development, State planning bodies must determine the number and characteristics of subpopulations experiencing disparities in access and services. If the needs assessment identifies gaps in its ability to reach and address the needs of underserved populations or communities (e.g., insufficient access points, cultural or language barriers), the planning council and grantee must address capacity development needs. Ryan White funds can be allocated for capacity development only if they are tied to a specific service category or categories. [Section(2617(b)(5)(A)]

- **Address coordination with HIV prevention and substance abuse prevention and treatment.** Because Ryan White resources are only one source of HIV/AIDS care, needs assessments should identify where coordination across services is needed. Of particular importance is coordination with HIV prevention and with substance abuse prevention and treatment programs, including programs that provide comprehensive substance abuse treatment. Coordination with these services can enhance efforts to identify individuals with HIV who do not know their status and individuals who know their status but are not receiving primary health care, provide risk reduction services to these individuals, enable them to access and remain in care, and result in better attention to the full range of their needs. [Section 2617 (b)(5)(C)]

- **Identify need for early intervention services (EIS).** The Ryan White legislation allows Ryan White Part B areas to fund EIS. In order to consider this service for funding, the entity must demonstrate to the satisfaction of the chief elected official for the State involved that Federal, State, or local funds are otherwise inadequate for the early intervention services that the entity proposed to provide; and the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available. These services should be provided at “public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites,” as well as federally qualified health centers, and other points of access to health services. [Section 2612(d)(1)]

- **Obtain PLWHA input.** The Ryan White legislation requires States to use methods such as community/public meetings for obtaining input on community need and priorities. Such input enables them to fulfill the legislative requirement to establish priorities for the allocation of Ryan White funds with attention to the needs of PLWHA. [See Section 2617 (b)(7)(A)]
• **States should establish a needs assessment cycle.** Ryan White Part B programs are not expected to conduct a comprehensive needs assessment each year. Given limitations in administrative funds, most programs do not have sufficient funds to conduct such a needs assessment in a single year. In addition, needs assessment is extremely time consuming and can lead to “consumer fatigue” as well as grantees and planning council overload, given other responsibilities such as comprehensive planning (which is generally done every three years). HAB/DSHAP recommends a three-year needs assessment cycle, with a schedule for collecting updated information to address special areas and support priority-setting and resource allocation activities. Epidemiologic data should be obtained annually, information on new populations added, and special circumstances—such as the impact of advances in medical treatments on service needs or the impact on health care reform on coordination of care—addressed promptly. The estimate of unmet need should be updated at least every two years. [See Attachment 1, Sample Three-Year Needs Assessment Schedule.]

• **Needs assessment should include analysis of the impact of changes in the health care system and the HIV/AIDS continuum of care.** Especially during times when considerable changes are occurring in the health care system and in the HIV/AIDS continuum of care and payers, needs assessment should include efforts to understand the implications of such changes on PLWHA. For example, if more PLWHA become eligible for Medicaid or for subsidized private insurance under the health insurance exchanges authorized by the Affordable Care Act, what are the implications for the demand for Ryan White services? What services will not be available through the State Medicaid system or through the exchange, and therefore will continue to be needed from Ryan White? If the transition is causing some PLWHA to fall out of care, then Ryan White services may need to be restructured to address this problem.

<table>
<thead>
<tr>
<th>HOW “DEMONSTRATED NEED” RELATES TO NEEDS ASSESSMENT</th>
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<tr>
<td><strong>Ryan White Part B applications for supplemental funding should use data in documenting demonstrated need—and thus the need for supplemental funding.</strong> The 2006 and 2009 legislation use the term “demonstrated need” in place of what earlier legislation referred to as “severe need.” Demonstrated need is the degree to which providing primary medical care to people with HIV/AIDS in any given area is more complicated and costly than in other areas, based on a combination of the adverse health and socio-economic circumstances of the populations to be served. Section 2620(b) lists factors to be considered for demonstrating need.</td>
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Table 7: How “Demonstrated Need” Relates to Needs Assessment

**HOW THE EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) RELATES TO NEEDS ASSESSMENT**

The 2009 legislation requires Ryan White Part B applications for funding to provide the Ryan White Part B EIIHA strategy (including goals); its plan for identifying individuals, informing them of their status, and referring and linking them to care; and data on its progress using an EIIHA data matrix provided by HRSA/HAB. The strategy and plan should be based on an understanding of what groups of PLWHA are most likely to be unaware of their status—which is a part of needs assessment.
**HIV/AIDS TREATMENT CASCADE**

The HIV/AIDS Treatment Cascade helps identify gaps in care and retention. This concept is a model being used by Federal, State and local agencies in the U.S. to identify issues and opportunities related to improving the delivery of services to PLWH across the entire continuum of care—from diagnosis of HIV infection and active linkage in care to initiation of antiretroviral therapy (ART), retention in care, and eventual viral suppression—meaning no detectable virus in the blood.

At the State and local levels, program planners apply the treatment cascade—using local data—to assess where resources are needed and then to target them accordingly enabling them to take steps to improve engagement at each step in the continuum of HIV care.

The Centers for Disease Control has estimated that only 28 percent of the more than 1 million individuals in the U.S. who are living with HIV/AIDS are getting the full benefits of the treatment they need to manage their disease and keep the virus under control. *MMWR* Ensuring success at each step in the HIV treatment cascade will move us closer to achieving the vision of the National HIV/AIDS Strategy ([http://blog.aids.gov/2012/07/hivaids-treatment-cascade-helps-identify-gaps-in-care-retention.html](http://blog.aids.gov/2012/07/hivaids-treatment-cascade-helps-identify-gaps-in-care-retention.html)).

**STATEWIDE COORDINATED STATEMENT OF NEED (SCSN) AND COORDINATING NEEDS ASSESSMENTS**

Coordination among needs assessment efforts is extremely important and is increasing, both among Ryan White Parts and between Ryan White and HIV prevention community planning processes. In particular, the Statewide Coordinated Statement of Need (SCSN) represents an opportunity to coordinate needs assessment activities that are conducted across Ryan White Parts.

The SCSN is a collaborative process used to identify and address significant HIV/AIDS care issues related to the needs of PLWHA, and to maximize coordination, integration, and effective linkages across Ryan White HIV/AIDS Program Parts. It is a process convened in the State by the Ryan White Part B grantee. The result of the SCSN process is a written SCSN document that reflects the input and approval of all Ryan White HIV/AIDS Program Parts. All organizations funded under the Ryan White HIV/AIDS Program are required to coordinate with each other in the delivery of core and supportive services and are expected to participate in the SCSN process.

The SCSN is not a comprehensive community-based needs assessment requirement nor is it a requirement for a comprehensive plan of HIV care and service delivery. The SCSN also does not override or supersede local autonomy and decision making. However, the SCSN must reflect existing needs assessments and identify cross-cutting service delivery gaps/issues and broad goals.

SCSN development is greatly enhanced by cross-Part collaboration in the needs assessment process. This occurs, for example, when Part A and Ryan White Part B bodies collaborate within...
a regional service area, when consortia across a State cooperate or collaborate on their individual needs assessments, or when Part C or Part D programs participate in Part A or Ryan White Part B needs assessment efforts. [For more information, see the chapter on SCSN in this manual (X. Ch 13).]

C. Components of a Needs Assessment

A comprehensive needs assessment includes specific components. On an annual basis, select components should be expanded and/or updated, depending on trends and special issues facing the Ryan White Part B program. The major components of a comprehensive needs assessment are:

**Epidemiologic profile**, which describes the current status of the epidemic in the Ryan White Part B State/Territory, specifically the prevalence of HIV and AIDS overall and among defined subpopulations. [The Centers for Disease Control and Prevention (CDC) and HRSA’s *Integrated Guidelines for Developing Epidemiologic Profiles* provide guidance for preparing such a profile and is available on the CDC website (See [http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/pdf/epi_guidelines.pdf](http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/pdf/epi_guidelines.pdf)].

The profile should also describe trends in the epidemic. In States without complete and reliable HIV reporting, States and territories should determine the number of individuals living with HIV by using epidemiologic measures developed by HHS through HRSA/HAB, Centers for Disease Control and Prevention (CDC), and others. The epidemiologic profile should provide the best available information to better understand the probable characteristics of individuals who have HIV/AIDS but are unaware of their status, such as percent of late testers and their characteristics and place of residence. It should also provide data on the

1. **Estimates of the number and characteristics of PLWHA with unmet need and of individuals with HIV/AIDS who are unaware of their status.** It is important to understand approximately how many people in the EMA/TGA are unaware of their status and how many are out of care, who they are, and where they are most likely to live. Methods for making these estimates are discussed later in this chapter. Needs assessment based on analysis of epidemiologic data can provide an understanding of populations most likely to be undiagnosed, including their race/ethnicity, age, gender, risk factors, and places of residence. Analysis of epidemiologic data can provide profiles of people who know their status and are not in care.

2. **Assessment of service needs** (including core services and support services) among affected populations, including barriers that prevent PLWHA both in and out of care from receiving needed services or from continuing in care. A needs assessment should gather an array of information in order to identify trends and common themes. States and territories should collect this information from multiple sources, among them PLWHA and other community members, health departments, the State Medicaid agency, community-based providers and, where applicable, grantees of other Ryan White Parts.
Information must be obtained from and about HIV-positive individuals who know their status and are not in care.

3. **Resource inventory**, which describes organizations and individuals providing the full spectrum of services available to PLWHA. The goal of the resource inventory is to develop a comprehensive picture of services, regardless of funding source. At a minimum, the resource inventory includes for each provider a description of the types of services provided, number of clients served, and funding levels and sources. (Note: A resource inventory can often be turned into a resource for clients and providers to use in locating services, especially online. In this format, data on number of clients served and funding levels is usually removed).

4. **Assessment of unmet need/service gaps**, which brings together the quantitative and qualitative data from all the other components on service needs, resources, providers, and barriers. This should include an assessment of unmet needs for PLWHA who know their HIV status but are not in care and an assessment of service gaps for all PLWHA—both in and out of care. This should include identification of both categories of service that are unavailable or insufficiently available, or service gaps for specific population groups.

D. **The Needs Assessment Process**

A needs assessment sets the stage for the planning process by identifying the needs of the HIV/AIDS community, the services available to meet those needs, and the gaps between needs and services. This is a meaningful exercise only if it is planned and implemented carefully and inclusively.

To develop a needs assessment in a timely and efficient manner, begin by outlining a needs assessment process. The typical steps in needs assessments are as follows:

1. Plan for the needs assessment.
2. Design the needs assessment methodology.
3. Collect the information required for the needs assessment.
4. Analyze the information and present the results in useful formats.

Analyze the information and present the results in useful formats.

Each of these steps is summarized below. (Please refer to the Needs Assessment Guide for detailed information that will help guide you through needs assessment design and implementation.)

**Step 1. Plan for the Needs Assessment**

The first step is to reach consensus on the scope, timetable, budget, and responsibilities for the needs assessment.
Scope

Decide on needs assessment scope by posing and answering the following questions:

- What is the desired scope of the needs assessment? If you use a three-year needs assessment cycle that meets legislative requirements and local planning needs, your needs assessment efforts each year will focus on one or two specific components plus perhaps updating or expanding components carried out during the past two years. Which components will be your focus this year? [See Attachment 1 for a sample three-year schedule.]

- Are there any special issues that should be considered because of changes in the system of care or other current topics (e.g., impact on availability of mental health services following severe cuts in non-Ryan White-funded services, probable impact of health care reform on Ryan White enrollment and types of services most needed after PLWHA enroll in expanded Medicaid programs or health insurance exchanges)?

- Whose needs are being assessed and what information will be sought about each of these populations? Based upon the epidemiologic profile for the area, what target populations are essential for the assessment? Does the State or territory need to better understand the service needs of particular PLWHA groups that represent a growing proportion of the PLWHA population (e.g., PLWHA over 55), or are particularly likely to delay testing or be out of care (e.g., young MSM of color, Latino or African immigrants, or residents of a particular geographic area within the State/Territory? It is important to assess the needs of the entire PLWHA population in the State or territory, but data need to be collected and analyzed so that there is adequate representation of specific PLWHA populations. One cannot make decisions about service needs of specific populations (e.g., women, Latinos/as, gay men of color) unless collecting information about these groups is an integral part of the needs assessment. This means being sure that information can be analyzed and presented separately for important population groups or geographic areas as well as combined to give an overall picture of PLWHA in your service area. The analysis should present, compare, and contrast all components of the service population.

- Which are the groups you will target to obtain information for your assessment?

Knowing whom to target can present challenges. Some areas make the mistake of targeting sub-grantees/providers as the primary source of needs data. The assumption here is that sub-grantees/providers have intimate knowledge of their clients’ needs. While this may be true, the priorities of sub-grantees/providers may be different from the priorities of their clients. Sub-grantees/providers also may be less knowledgeable about the needs of populations not in their care system, or not receiving any HIV-related services.
The Ryan White legislation requires and a sound needs assessment ensures that needs assessment information is sought directly from PLWHA. This means locating PLWHA throughout the service area (in and out of care) and asking them about their needs using well-designed data collection tools. It also means consulting with diverse service providers serving varied client populations, since they are part of the solution. The challenge and goal is to structure a process that allows for an appropriate balance, including information from diverse PLWHA about their perceived service needs.

- What programs and services will be addressed and which will receive the most attention?

Over time, your needs assessment should cover all the HIV-related services that are part of your continuum of care (both core and support). When you develop the needs assessment plan and tools for any particular year, you will need to identify what programs and services should be given priority. It may be helpful to use several focus groups early in the process to determine priorities. Developing a resource inventory will also help point to service areas that may need particular attention. This helps in developing questions for PLWHA surveys or interviews and determining which providers to focus on including in provider panels or surveys.

- What specific tables or narrative information for the comprehensive plan or for your Ryan White Part B application must be developed based on needs assessment data? Does the latest HAB/DSHAP application guidance call for new tables or additional information or analyses?

- Application requirements around unmet need, other “demonstrated need,” and EIHA, as well as descriptions of emerging populations, depend upon sound, current needs assessment data.

**Timetable and Budget**

Determine the timeline and budget by addressing the following questions:

- What is the timetable for the needs assessment? What are the deadlines for specific tasks such as collection of information, analysis of data, and preparation of the needs assessment report?

The key question is by what date must the planning or decision-making body that will use needs assessment receive the report and a presentation in order to allow time for review of information and use of results in priority setting and resource allocation, comprehensive planning, and/or preparation of an application for Ryan White HIV/AIDS Program funding? For example, the Ryan White Part B application is usually due in January, and will require area specific needs assessment, priority setting and resource allocations activities to be conducted during the previous summer to begin the process. The comprehensive plan is due every three years, but timing varies. If several Ryan White Parts (or Parts and other planning structures such as the HIV Prevention Planning
Group) are collaborating, what are the differing timetables and how can they be coordinated?

- What is the budget for the needs assessment? Are funds available for a consultant? What in-kind resources can be used, such as assistance in conducting interviews or focus groups from staff of provider agencies or assistance in data analysis? How can joint funding (e.g., across Ryan White HIV/AIDS Program, with HIV prevention community planning) be coordinated?

**Responsibilities for Conducting and Overseeing the Needs Assessment**

Agree on responsibilities for conducting and overseeing the needs assessment by posing the following questions:

- Can some parts of the needs assessment be conducted jointly with other Ryan White Parts, and/or the HIV Prevention Planning Group? If so, how can funds and efforts best be pooled?
- Who will conduct and monitor the needs assessment? Will it be conducted and overseen by a planning body, a needs assessment committee, a consultant, or paid staff? If a consultant is to be used, what criteria will be used to select the consultant (e.g., social science research background, experience with community needs assessment, understanding of HIV/AIDS core medical and support services) and how will the consultant’s work be monitored? What will be the division of responsibility between the planning body and the grantee or administrative agency, and how much help will be available from health planners or surveillance staff?
CROSS-PART COLLABORATION

HAB strongly encourages cross-title collaboration in needs assessment.

For example:

- Part C and Part D require grantees and applicants to collaborate in State and/or local HIV-related needs assessments.
- The Ryan White Part B Manual encourages coordination of needs assessment activities with other entities including Part A planning councils and Part C and Part D providers.
- Part A planning councils are required to include representatives of area Part C and Part D programs among their voting members.
- Representatives of all Parts must participate in the Statewide Coordinated Statement of Need.
- Planning bodies are urged to share needs assessment findings and reports with other area planning bodies and other programs serving some of the same populations (e.g., Medicaid, State Children’s Insurance Program (CHIP), Social Security).

Table 8: Cross-Part Collaboration

Obtaining Community Input

Establish a process for community input by posing the following questions:

- What procedures will be used to obtain broad PLWHA and other community input from individuals who are not part of the planning bodies or needs assessment committee? What additional efforts are needed to help ensure that the needs assessment results will be accepted by the community?
- How will the needs assessment be used to help determine the “priorities for the allocation of funds within the State” (as required by Section 2617(b)(5) of the Act)?
- How will the needs assessment reach and obtain input from HIV-positive individuals who know their status but are not in care? What links with prevention programs, substance abuse treatment programs, homeless shelters, counseling and testing sites, EIS providers, and other community sites will help in reaching these individuals?

Analysis, Presentation, and Use of Results

Look ahead to what will be done once results are obtained by addressing the following questions:

- How will the Ryan White Part B program summarize and present needs assessment results? Will results be a part of an annual data presentation as input to the priority setting and resource allocations process?
- If this is a collaborative needs assessment, how will the specific information needed by each Part or program be analyzed and presented? Will separate reports be required?
- How will the results be linked to and supportive of the development of a comprehensive plan for the State or for an annual operating plan?
What tables and narrative information need to be prepared for the annual Ryan White Part B application?

How will needs assessment results be used? For example, what information is most critical for priority setting? What separate analyses are needed by population group, risk factor, service category, and/or geographic area?

How can results best be presented so they are easy to use? In addition to a narrative report, will a PowerPoint presentation be used? Can results be summarized in other ways that help ensure that they are used for decision making?

It is important that plans be made to ensure that results are presented in plain language, with technical terms defined. Laying out “dummy” tables at this stage helps ensure that all needed information is collected.

**Hints for Managing the Needs Assessment Process**

Conducting a well-organized needs assessment entails assigning responsibility for both implementation and monitoring of the data collection and analysis process. The experiences of Ryan White planning bodies and grantees suggest several different ways to divide responsibilities.

**“Staffing” the needs assessment.** The needs assessment may be conducted and overseen by a needs assessment committee, staff, a consultant, the full planning body, or some combination of volunteers and paid staff. Typically, planning body members or other volunteers do not have the time – and may lack the expertise – to carry out a comprehensive needs assessment themselves. At a minimum, they can and should provide oversight, help plan the needs assessment and provide input to design of data collection tools, arrange town halls or community forums, ensure that all affected populations are reached and included in the needs assessment process, and carefully review draft results. Some members may be able to help with specific activities such as contacts with entities with clients needed for PLWHA surveys, conducting of client focus groups, or outreach to people not in care. Planning council and grantee staff will also need to devote time to the needs assessment. An epidemiologist typically prepares the epidemiologic profile and updates it annually.

The technical expertise of both the Ryan White HIV/AIDS Program and other staff can be particularly helpful, especially in initial planning. Many health departments have staff with extensive needs assessment experience. Grantees can also help ensure that Ryan White-funded providers cooperate with needs assessment efforts, providing clients the opportunity to participate in PLWHA surveys and assisting with recruitment of PLWHA for focus groups, town halls/community forums, or other information-gathering efforts.

Typically, consultants or non-Ryan White staff will be needed to work with the needs assessment committee and staff in planning and implementing the needs assessment. If so, the State/Territory will need to prepare an appropriate scope of work and select consultants using its contracting procedures.
Dealing with conflict of interest. Responsibility for implementing a needs assessment process entails recognizing and managing conflict of interest. Be sure that the committee or task force reviewing the needs assessment tool and overseeing the needs assessment process is broadly representative and balanced. Include individuals knowledgeable about the range of Ryan White services, so that no one individual or group has control of questionnaire design or data analysis.

Be aware of the possibility of unintended biases. For example, a clinic director is likely to focus on information about primary health care needs, a substance abuse provider on the need for drug treatment, and a gay rights organization on the needs of GLBT PLWHA. Have a neutral party (such as a consultant) design, or at least carefully review, all instruments to be sure that individuals do not overemphasize a particular service need or approach that may be of special interest to their organization or reflect their personal priorities, or exclude other important services or issues.

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<th>FREQUENTLY USED DATA SOURCES</th>
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| **Secondary source (already existing) data** that are typically used in Ryan White needs assessments include the following; the data are mostly quantitative (numerical):

- Epidemiologic data obtained primarily from local and State health departments and the CDC (e.g., AIDS cases, HIV cases or estimates, late testing, data on co-morbidities)
- Data on PLWHA treatment participation, performance measures, and clinical outcomes, often collected by the grantee as part of Clinical Quality Management (CQM) or “treatment cascade” analyses
- Monitoring data on PLWHA, such as EIIHA data required by HAB, often maintained by surveillance staff or other health department personnel
- Client service utilization data obtained from providers and aggregated by the grantee and/or HAB (Ryan White Services Report or RSR)
- Aggregate data on HIV/AIDS clients from Medicaid, the State ADAP program, and/or other health care providers, and
- Socio-demographic data obtained from public sources such as the Census Bureau (e.g., overall population characteristics, poverty status, health insurance status).
FREQUENTLY USED DATA SOURCES

<table>
<thead>
<tr>
<th>Primary source (newly collected) data</th>
<th>are often collected, using such methods as:</th>
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<tr>
<td>PLWHA and provider surveys</td>
<td></td>
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<tr>
<td>Interviews with PLWHA</td>
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<tr>
<td>Focus groups</td>
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<td>Key informant interviews</td>
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<td>Community forums or town hall meetings</td>
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<tr>
<td>Public hearings or informal public input sessions</td>
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<tr>
<td>Informal discussions with groups of program clients</td>
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Often, special studies will use a mix of primary and secondary data collection approaches, from chart reviews to interviews and focus groups.

Surveys and structured interview results, which consist largely of quantitative data, can be presented in user-friendly tables, charts, and graphs, with narrative explanation. The other methods often produce primarily qualitative data, which is usually presented in narrative summaries.

Table 9: Frequently Used Data Sources

Step 2. Design the Needs Assessment Methodology

The next step is to develop a specific design for the needs assessment (see Components of a Needs Assessment). Keep in mind that the focus is on identifying the needs of PLWHA in and out of care, the Ryan White and other services currently available to meet those needs, and service gaps. An analysis of this information is then used to help set priorities and allocate resources.

The needs assessment methodology may be designed by a needs assessment committee, staff, or consultants with committee oversight. Representatives of affected communities should be invited to review the design of the needs assessment. Focus on the following questions:

- What existing information (secondary source data) is available? What populations does it address or not address? Have the grantee, planning body, and/or individual providers carried out epidemiologic studies, client satisfaction studies, or evaluations that can contribute to the needs assessment?
- What new information (primary source data) is needed and what approaches are planned to collect this information? Will there be a PLWHA survey using probability sampling techniques, so that findings can be generalized to (assumed to represent) the entire population with HIV/AIDS? How will PLWHA not in care be identified and included? Will providers of HIV/AIDS-related services be surveyed to obtain their perceptions of need as well as information about the service network and its capacity and capability? Will qualitative information be obtained from specific PLWHA groups, providers, or other target groups through such methods as focus groups, community forums, or key informant interviews?
• Who will develop and review the instruments for collecting new information? Can tools from others be used or refined?
• What common set of questions should be asked so that responses can be compared across sources and methods in order to identify trends or themes?
• Who will collect the information collected, and how will these people be trained?
• How will confidentiality be protected? Will PLWHA be able to participate anonymously?
• How will quality control be maintained? What procedures will be used to ensure that findings are valid and activities are completed on time? How will data collection staff be monitored to ensure that information is collected appropriately? Has time been built in to revise data collection instruments based on pilot test results? Who will monitor expenditures and completion of tasks?
• How will data be analyzed? How will quantitative and qualitative information be integrated? How will data be analyzed according to desired data characteristics—such as by populations or services—and how will quantitative and qualitative data be compared and interpreted in order to gain a deeper understanding of service needs and gaps?
• When, how, and in what form will information be presented?

At the end of the design phase, the grantee and planning body should have a clear plan for every part of the needs assessment process, including the kinds of information that will be available, who will collect it, what tools will be used, and the kinds of analysis that will be done. The timeline for each step in the process should be clearly stated.

Step 3. Collect the Information Required for the Needs Assessment

The required information must be collected—quantitative and qualitative, primary and secondary—and then reviewed in “raw” (not aggregated) form. The data collection should follow the procedures determined during the design phase.

Be sure that those responsible for data collection consult with the planning body regularly. The entire planning body should hear progress reports from this group during any major needs assessment effort. In overseeing the information collection process, be sure to consider questions and issues such as the following:

• Is comprehensive information about the present extent, distribution, and impact of HIV/AIDS on defined populations being obtained and analyzed? Does the data collection ensure that information about different PLWHA groups and geographic locations can be analyzed separately and compared?
• Is available information about the characteristics of recent and late testers being reviewed to obtain a sense of the probable profile of individuals with HIV/AIDS who are unaware of their status (HIV-positive/unaware)? [See Section F below for more information on needs assessment for this population.]
• Are the needs of PLWHA in and out of care being assessed, by contacting them directly or through other methods? Is there a specific plan for identifying and assessing the needs of individuals who know their HIV status but are not receiving primary health care? Are PLWHA surveys reaching PLWHA who reflect the diversity of the epidemic in the service area?
• Are existing community resources being inventoried and their service capacity determined?
• Has there been careful quality control of the entire information collection process?

Hints for Successful Data Collection

The following are insights gained by various Ryan White planning bodies and grantees through experiences conducting needs assessment data collection activities.

• Obtain copies of survey instruments and methodologies used by others rather than “starting from scratch.” Some resources are available from HAB (see TARGET Center website); also contact other Ryan White programs within the State and Ryan White HIV/AIDS Program-funded providers.
• In developing data collection tools, use consistent terminology to describe service categories, using the services defined in the HAB/DSHAP application guidances, the National Monitoring Standards, and the Appendices section of this manual. This will maximize the usefulness of surveys and allow for comparisons across geographic areas and Parts.
• Focus groups can provide valuable qualitative information from specific groups (e.g., factors that influence whether women of color or youth do or do not access and remain in care). Findings can be used to determine key questions for surveys or to look more in-depth at survey results. However, this information does not necessarily represent the views of the entire subpopulation and should not be your primary source of data about PLWHA needs. The number of individuals in a focus group is small and the participants are not randomly selected, so results cannot be “generalized” to the population targeted.
• Fears about visibility and negative repercussions may make some PLWHA unwilling to publicly disclose their status or to criticize the continuum of care or discuss barriers affecting access to specific providers. Ryan White HIV/AIDS Program experience suggests that in-depth information about the service needs of PLWHA, especially women, minorities, and other severe need populations, is usually best obtained through other methods, such as focus groups and key informant interviews. However, useful information can be obtained through a well-planned town hall meeting or a session that is based on carefully developed questions, provides for in-depth discussion, and controls participation by working through a PLWH caucus or permitting only PLWHA and the facilitator to be present.
• Client satisfaction surveys are not the same as PLWHA needs assessment surveys. A client satisfaction survey may focus on the perceived quality of services received. A needs assessment survey should ask about an individual’s met needs and service gaps and priorities; it may also ask about client satisfaction with current services, but this is not its primary purpose. A limitation of client satisfaction surveys is that they reach only those already receiving services from Ryan White HIV/AIDS Program providers. Client satisfaction surveys are generally considered a part of quality management efforts rather than needs assessments.
• Many Ryan White projects have found that providing needs assessment survey forms at a provider site can influence the information provided, especially if the completed surveys are left at the site where staff may see them. Sometimes there is a perception that the
survey will not be anonymous, and clients may fill out the form in a way that reflects perceived provider needs and priorities rather than those of the client. *For these reasons, it is very important that needs assessment surveys be administered or provided to PLWHA at locations other than provider sites and/or by a researcher not associated with the provider.* Anonymity also needs to be ensured by having the survey either given to that external person or mailed back to a central location unassociated with the provider. Provider staff must not see the surveys, and survey forms must be anonymous.

- Surveys of PLWHA should target both those currently receiving care from funded providers and individuals who are not receiving HIV-related services. Their service needs may be quite different from those of current clients. Individuals not in care are often more difficult to reach than current clients and need to be sought out at a variety of locations, using a mix of street, service provider, and media outreach techniques, as described in Section E, below.

**Step 4: Analyze the Information and Present the Results in Useful Formats**

Information tabulation and analysis should focus on answering the major needs assessment questions and generating the necessary tables and summaries, as determined during the planning phase. The process should also include organizing information and analyzing it (as collected from multiple sources) in order to identify key needs, trends, and critical issues. The results of the analysis must then be presented in narrative and/or chart form for use in priority setting, resource allocation, and developing the comprehensive plan. Usually, this is a multi-stage process, requiring at least the following activities:

- Catalog or otherwise order information, including secondary source materials, by topic and subcategory (e.g., data on PLWHA overall, by race/ethnicity, and by mode of transmission, individuals receiving primary medical care and those not in care). Sometimes this includes grouping findings by service category. In carrying out this process, be specific about what information was obtained and from what populations, to prevent attempts to generalize findings to populations that were not surveyed using probability sampling.
- Tabulate primary source data into useful data tables or qualitative information summaries.
- If multiple or different analyses are to be done for different Parts, prepare for these differing analyses.
- Analyze the information—compare and contrast information by population group (e.g., gender, race/ethnicity), geography (e.g., zip code, city or county), or other characteristics of interest. Compare the reported service needs of individuals in care and out of care.
- Prepare summaries, tables, and charts that are clear and easily understood.

Ensure that tabulations and comparisons of quantitative and qualitative data match the analyses you wish to undertake and present results in the format you desire. Do not apply findings to populations that were not surveyed or were minimally represented in the needs assessment process – and be sure to identify these data limitations in your report. Be sure that representatives of various communities – ideally, planning body members from diverse population groups— see
the data very early in the analysis process to check the accuracy of assumptions and interpretations.

Be sure that findings are presented in a format and level of detail that is understandable and useful for all planning body members, funders, and others in the community who will be using the results. Make sure information can be readily used in priority setting and resource allocation. Consider variations among members in technical background and familiarity with epidemiologic data.

Use of charts and tables can help make findings understandable. Some planning bodies prepare a summary matrix of needs assessment data – including epidemiologic data and client utilization data – by source, highlighting findings by service category, PLWHA population group, geographic area, and other factors. It is very helpful to compare perspectives on a particular service category or populations as obtained through different needs assessment methods and sources.

E. Estimating and Assessing Unmet Need

CDC and HRSA/HAB estimates suggest that about one-third of those who know their status are not receiving regular HIV-related primary health care. These data demonstrate the need to get more PLWHA into primary health care.

Since 2000, Part A and Ryan White Part B programs have been responsible for estimating the number of PLWHA in their service areas who know their status but are not in care. The Ryan White legislation also requires assessment of the unmet needs of PLWHA who “know their HIV status and are not receiving HIV-related services,” particularly those from “disproportionately affected and historically underserved populations.”

Estimating Unmet Need. HRSA/HAB has adopted an Unmet Need Framework that provides an operational definition of unmet need. The definition was chosen to ensure that every State, EMA, and TGA has access to the data necessary data for estimating the number of PLWHA in its service area who know they are HIV-positive but are not in care. For purposes of this estimate – which is not designed to indicate “quality care” – a person has unmet need if s/he has not had any of the following during the past 12 months:

- A CD4 count.
- A viral load test.
- A prescription for anti-retroviral therapy (ART).

The approach for estimating unmet need is straightforward: determine the number of PLWHA in the service area as of a specified recent date. Subtract the number of PLWHA in the service area who are known to have had a CD4 count, viral load test, or ART. The remaining people have unmet need.

Data Challenges in Estimating Unmet Need. Estimating unmet need is not easy. Limitations in data availability and access to existing databases include the following:
HIV reporting. The total number of individuals who are HIV-positive and know their status is the starting point for estimating unmet need for this population. As more and more States have mature name-based HIV reporting, this information is becoming widely available, although concerns may exist about data completeness. All States now collect name-based data on HIV prevalence, but challenges exist around methodologies, reporting delays, and other technical factors.

Limitations of surveillance data/databases. CDC surveillance data provide information from all States about reported HIV and AIDS cases and deaths. However, available data vary by State and EMA/TGA. Many States and cities have supplemental data available through CDC’s Medical Monitoring Project (MMP).

Cross-Part issues regarding data collection and data sharing. Ryan White data reporting has been revised to improve comparability and sharing of data across Parts. Data on people receiving ADAP services through Ryan White Part B may not be available to a Part A program.

Incomplete laboratory reporting or data entry. Some States require all CD4 counts and viral load test results to be reported to and entered into the surveillance system. In such States, it is relatively straightforward to estimate unmet need. However, many States require reporting only of CD4 counts below 200 or of detectable viral loads, or may not enforce reporting from all sources. In such cases, it is difficult to determine whether people with higher CD4 counts or undetectable viral loads are in or out of care.

Lack of access to data from non-Ryan White HIV/AIDS Program sources/providers including other Federal agencies. Many people who receive Ryan White HIV/AIDS Program services obtain their primary care and their laboratory tests from other sources and/or through providers using other funding, such as Medicaid and Medicare, private health insurance, or Veterans Affairs. Some PLWHA, including the incarcerated and individuals with both private insurance and relatively high incomes, receive no Ryan White services. They are in care, but grantees may have no access to data about them unless the State HIV surveillance system requires that all laboratory test results be reported and entered into the system. Ryan White HIV/AIDS Program grantees often face great difficulties in obtaining access to primary care data on clients whose medical care is not supported through the Ryan White HIV/AIDS Program, even if the primary care provider receives other funding through the Ryan White HIV/AIDS Program or if the individual obtains medications through ADAP.

Lack of client-level data. A client-level database greatly facilitates efforts to estimate and assess unmet need/service gaps. It provides a unique client identifier and the ability to determine the unduplicated number of clients receiving primary care and other specific services through Ryan White. Lack of client-level data will diminish over time because – although there have been some delays – all Ryan White HIV/AIDS Program grantees were expected to begin collecting client-level data as of January 2009.

Problems in matching data from different databases. One way to estimate unmet need is to compare client data with surveillance data from CDC consumer and provider surveys or to link Medicaid, ADAP, and Ryan White client-level data. However, to match data from different databases is challenging, even if they use common client identifiers, because of differences in definitions, the exclusion of individuals who received anonymous testing, and difficulties with matching and unduplicating clients who may be included in more than one database.
Confidentiality concerns. Database matching, access to client-level data, and many other aspects of needs assessment may be complicated by concerns about client confidentiality. HHS has provided considerable guidance with regard to client confidentiality and the disclosure of client data for reporting and evaluation purposes. However, some providers are unwilling to provide access to any information that might permit client identification, despite these protections. Sharing of data is complicated by the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which includes security standards protecting the confidentiality and integrity of “individually identifiable health information,” past, present or future. Confidentiality is often a factor in cross-Part data sharing problems and in difficulties in obtaining data on Ryan White clients who receive their primary care from non-Ryan White sources.

Use of Multiple Data Sets. Given data limitations, many grantees estimate and assess unmet need by using information from multiple data sources. They may, for example, combine general surveillance data on HIV and AIDS cases and other data from the CDC with their own surveys of PLWHA, and other special studies of particular populations or geographic areas. This approach typically involves a number of estimations, with the result that estimates may be incomplete or imprecise.

Resource Limitations in Estimating and Assessing Unmet Need. Grantees and providers often have financial and personnel limitations in documenting unmet need, as follows.

- Limited financial and personnel resources. Planning bodies and grantees must budget funds for needs assessment out of their administrative funds.
- Limitations of surveys and other needs assessment methods designed to assess unmet need. Assessing unmet needs and service gaps of those not in care is more complex than for individuals already in the Ryan White or other public care systems because out-of-care individuals are difficult to find. Locating such individuals requires, for example, coordinating with HIV counseling and testing facilities and using outreach workers to link with providers of services other than direct HIV/AIDS services. Such other services might include homeless shelters and drug treatment facilities. Surveys based on random samples drawn from the population of PLWHA are generally feasible only in States with full laboratory reporting, through links with the CDC surveillance system. Without such links, it is difficult to use probability sampling. (Probability sampling gives every person in the population a known chance of being included in the sample and makes it possible to generalize from the sample to the total population.).

Locating PLWHA who are not in care. Assessing the service needs, barriers, and gaps of PLWHA who are not in care requires finding both individuals who have never been in care and individuals who have received HIV-related primary medical care in the past, but dropped out of care and remained out of care for at least 12 months. Following are some methods used to identify such individuals as part of needs assessment.

- Some planning bodies and grantees have been successful in locating PLWHA not in care by working with a wide range of service providers that may not be funded through the Ryan White HIV/AIDS Program but are likely to be providing services to PLWHA. They
include public and private clinics, substance abuse treatment programs, maternal and child health programs, mental health programs, and runaway and homeless shelters. Many of these are considered “points of access” into care, and some provide early intervention services.

- PLWHA caucuses or committees can often help in identifying PLWHA who are not in care. Most consumers know PLWHA who are not in care.
- Outreach workers can conduct brief interviews with PLWHA not in care as part of their ongoing activities.
- Often, PLWHA not receiving HIV-related medical care are receiving support services such as food baskets, and are a part of the Ryan White system. Sub-grantee/providers with client-level data can identify and interview or survey current clients who are not shown as receiving medical care.
- “Surrogate” (substitute) approaches can be used. For example, a PLWHA survey can ask people answering the survey who are currently in care to indicate whether they were out of care for a year or more during the last 3-5 years. It so, the survey can ask why they were out of care, what barriers they faced in entering or re-entering care, and what caused them to become linked to care.
- Often, the most effective way to identify such individuals and assess their service needs is to look for them and obtain this information on a continuing basis throughout the year, then aggregate and analyze the information quarterly.
- Planning bodies and grantees can encourage PLWHA participation in such surveys by providing incentives (such as grocery vouchers) if allowed by their Part or paid for through non-Ryan White funds. Generally, incentives of this type can be provided if the gift card specifies that the card may not be used to purchase alcohol or tobacco products. Ryan White programs are generally not permitted to provide cash incentives. States/Territories should consult with their Project Officers to be sure they understand DSHAP requirements.
- Media can provide valuable publicity, including public service announcements (PSAs) targeting PLWHA and giving them a voice-mail number to call, with PSAs in several languages and special telephone numbers for Spanish- or other limited-English speakers as needed. Use of appropriate community newspapers, newsletters, and/or radio stations can help in reaching specific target populations. Involving people from these communities is an important way to identify where and how PLWHA from targeted communities can be reached.
- Some PLWHA not in care can be reached through social media and asked to complete online surveys. However, because many PLWHA do not have Internet access, this method should not be used as a primary method of reaching PLWHA who are not in care.

**METHODOLOGIES FOR ESTIMATING UNMET NEED**

Consult the TARGET Center Web site at [http://careacttarget.org](http://careacttarget.org) to obtain methodologies and other resources to aid programs in assessing unmet need. Materials include resources developed by HRSA/HAB as well as grantee-developed materials.

**Table 10: Methodologies for Estimating Unmet Need**

Estimating the Number and Assessing the Needs of Individuals Who Are HIV-positive but Unaware of their Status
CDC estimates that over one million Americans are living with HIV/AIDS, of whom 21% are unaware of their status. As such, they are not getting care for their HIV disease. The 2009 Ryan White legislation requires Ryan White Part A and Ryan White Part B programs to determine the approximate number of HIV-positive/unaware people living in their service areas, using the CDC’s 21% estimate, determine their probable characteristics, develop and implement strategies and a plan to help them learn their status and enter care, and report on progress made.

It is, of course, challenging to assess the needs of this population, because they do not know their own status. It is, however, possible to analyze existing epidemiologic data that can provide an understanding of the probable characteristics of the HIV-positive unaware. For example:

- An analysis of the characteristics (age, gender, race/ethnicity, risk factor, and place of residence) of late testers identified over the past 2-3 years suggests what PLWHA groups appear most likely to delay testing – and therefore be HIV-positive/unaware.
- A similar analysis of recently diagnosed PLWHA may suggest populations with increased HIV/AIDS incidence.
- Geomapping of recent cases can help target communities likely to have high rates of HIV-positive unaware.
- Community viral load analyses suggest locations where people are most likely to be infected and out of care – including HIV-positive/unaware individuals.

In addition, needs assessment requires reviewing EIIHA data in order to identify needed changes in the continuum of care to encourage earlier testing and greater success in informing such individuals of their status, referring and linking to care, and retaining them in care. This includes overall data and data for particular populations regarding, on an annual basis:

- Number of HIV tests conducted.
- Number of individuals informed of their status.
- Number of individuals not informed of their status.
- Number of HIV-positive test results.
- Number of HIV-positive individuals informed of their status.
- Number of HIV-positive individuals not informed of their status.
- Number of HIV-negative individuals linked to prevention services.
- Number of HIV-positive individuals linked to care services.

An analysis of this information should be a part of needs assessment, and should help the planning council and grantee identify improved plans and strategies for addressing EIIHA.

**Attachment 1: Sample Three-Year Needs Assessment Schedule**

<table>
<thead>
<tr>
<th>Needs Assessment Component</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Epidemiologic Profile</td>
<td>Full written epi profile</td>
<td>Updated epi profile</td>
<td>Updated epi profile</td>
</tr>
</tbody>
</table>
### Needs Assessment Component

<table>
<thead>
<tr>
<th>2. Estimates of the Number and Characteristics of PLWHA with Unmet Need and Individuals with HIV/AIDS Who Do Not Know Their Status (HIV+/unaware)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet need estimate and profile</td>
<td>Updated estimate of number and probable characteristics of HIV+/unaware</td>
<td>Updated unmet need estimate and profile</td>
<td>Updated estimate of number and probable characteristics of HIV+/unaware</td>
</tr>
<tr>
<td>Estimate of number and probable characteristics of HIV+/unaware</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Assessment of PLWHA Service Needs</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLWHA Survey</td>
<td>Assessment of service needs of PLWHA who are out of care</td>
</tr>
<tr>
<td></td>
<td>Assessment of number and probable characteristics of HIV+/unaware</td>
</tr>
<tr>
<td></td>
<td>In-depth review of client utilization data from grantee or HRSA RSR</td>
</tr>
<tr>
<td></td>
<td>Special studies of 2-3 PLWHA groups and their service needs</td>
</tr>
<tr>
<td></td>
<td>PLWH community meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Provider Inventory</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider inventory</td>
<td>Update of inventory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Profile of Provider Capability and Capacity</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider panels for selected service categories</td>
<td>Provider profile survey and interviews</td>
</tr>
<tr>
<td></td>
<td>Provider community meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Assessment of Unmet Need/Service Gaps [using data from all other needs assessment components]</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of unmet need/service gaps</td>
<td>Updated assessment of unmet need/service gaps</td>
</tr>
<tr>
<td></td>
<td>Updated assessment of unmet need/service gaps</td>
</tr>
</tbody>
</table>

**Table 11: Attachment 1: Sample Three-Year Needs Assessment Schedule**

### X. Ch 11. Priority Setting and Resource Allocation

#### A. Introduction

Ryan White HIV/AIDS Program resources are limited and need is severe. With effective antiretroviral treatment, PLWHA are living longer, and increasing numbers of newly diagnosed individuals are entering care as a result of successful efforts to identify HIV-positive/unaware individuals and bring them into care along with individuals who know their status but have not been receiving HIV-related primary medical care. This heightens the responsibility of States and Territories to use sound information and a rational decision-making process when deciding which services categories are priorities (priority setting) and how much funding to provide them (resource allocation).

The process of priority setting and resource allocation (PSRA) is linked to other planning tasks because it draws upon information compiled from those efforts. For example, data compiled...
through the needs assessment identifies service needs and gaps. A thorough PSRA process can help States/Territories address these information gaps when they make crucial decisions about which services to fund.

For the purpose of this Section, planning bodies are defined as entities that are either mandated through legislation, such as consortia, or convened by the State in order to conduct important needs assessment, priority setting, and resource allocation processes.

B. A Model for Priority Setting and Resource Allocation

Overview

The following decision-making model is intended to help plan and implement decision-making processes to set Ryan White priorities and allocate resources among service categories and other program-related activities. It suggests steps that use documented needs in making decisions.

Examples are provided. The model is designed to meet legislative requirements and address HAB/DSHAP expectations. Also provided are guidelines and additional considerations for those with more experience, information, and/or resources. The model recognizes that the process used locally may vary based upon these factors.

Assumptions

This model includes the following assumptions:

- There is no “right” way to set priorities and allocate resources. This model provides a flexible approach that meets Ryan White requirements and HAB/DSHAP expectations and reflects actual planning body experience. Case study examples illustrate the process. For purposes of this document, one approach is carried through all the required steps. However, alternative approaches are suggested.
- Decisions about priorities and allocations should be data-based.
- Priority setting must be guided by Ryan White requirements for planning and priority setting, particularly the emphasis on determining the unmet need for services and eliminating disparities in access and services.
- Emphasis must be on sound practice, not merely meeting legislative requirements.
- Priorities should be reviewed annually, though decisions may be continuation of existing services.
- The decision-making process should consider many different perspectives. It should be responsive to identified consumer needs and preferences across diverse populations and address the needs of those Ryan White clients.
- Ryan White planning bodies are official decision-making entities. Their priority setting and resource allocation decisions are subject to public scrutiny and to grievance procedures. The process used to reach these decisions must therefore be public and fully documented in writing. Conflict of interest requirements must be fully addressed.
Priority setting is the responsibility of the whole planning body. While much of the preliminary work may be delegated to a committee, the entire planning body should make decisions about priorities and the allocation of resources among service categories. This model therefore assumes that committees will plan and oversee the process, make sure needed information is available, and make some recommendations, actual decision making will be done by the full planning body.

C. Steps in Priority Setting and Resource Allocation

The following steps outline how to prepare for and conduct priority setting and resource allocation. These activities should be carried out over a period of several months, by committees and the full planning body.

For purposes of this document, priority setting and resource allocation are described as separate steps, carried out in sequence with leadership by a committee and participation by the full planning body. Each planning body should view the steps provided as one example of a sound process and should feel free to adapt it as appropriate, given their unique circumstances.

<table>
<thead>
<tr>
<th>STEPS IN PRIORITY SETTING AND RESOURCE ALLOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agree on the priority setting and resource allocation process, its desired outcomes, and responsibilities for carrying out the process</td>
</tr>
<tr>
<td>2. Determine and obtain available information “inputs,” such as comprehensive plan, needs assessment, and client utilization data</td>
</tr>
<tr>
<td>3. Review core medical and support service categories, including service definitions</td>
</tr>
<tr>
<td>4. Agree on the principles, criteria, and decision-making process to be used in priority setting</td>
</tr>
<tr>
<td>5. Implement the process: set service priorities, including how best to meet them</td>
</tr>
<tr>
<td>6. Agree on principles, criteria, decision-making process, and methods to be used in allocating funds to service categories</td>
</tr>
<tr>
<td>7. Estimate needs and costs by service category</td>
</tr>
<tr>
<td>8. Allocate resources to service categories</td>
</tr>
<tr>
<td>9. Provide decisions to the grantee for use in the application and procurement</td>
</tr>
<tr>
<td>10. Identify areas of uncertainty and needed improvement</td>
</tr>
</tbody>
</table>

Reallocate funds across service categories as needed

Table 12: Steps in Priority Setting and Resource Allocation

1. Agree on the priority setting and resource allocation process, its desired outcomes, and responsibilities for carrying out the process.

First, agree on the scope of the entire priority setting and resource allocations process, then determine the specific tasks to be carried out and the expected outcomes. Usually the tasks will be decision making to set priorities and allocate resources to those priorities and to provide guidance to the grantee on how best to meet each priority. The planning body may prioritize and
allocate funding to any of the legislatively specific core medical services and to any support service categories approved for funding by the Secretary of Health and Human Services.

The grantee may set aside up to 10 percent of the total grant for administrative costs and up to 5 percent or $3 million, whichever is less, for Clinical Quality Management (CQM). The planning body’s responsibility is priority setting and resource allocations for the remaining funds, or a portion thereof in the case of local consortia, which are to be used for program services. For the State, not less than 85% of the total grant are to be used for program services.

Before deciding on the process, the group responsible for coordinating the priority setting and resource allocations process should review legislative requirements and HAB/DSHAP guidances to ensure that the decision-making process developed is compatible with them. For example, the process needs to:

- Base priorities on the size and demographics of the population of individuals living with HIV/AIDS, needs of individuals who are in care and out of care, disparities in access and services, the priorities of communities with HIV/AIDS, coordination with HIV prevention and substance abuse prevention and treatment programs, and compliance with the core medical services funding requirement,
- Comply with HAB/DSHAP guidance regarding the core medical and support service categories that may be funded, and
- Adhere to conflict of interest policies (State and local as well as Ryan White legislative requirements).

Because Ryan White policies may change over time, planning bodies should consult the Ryan White Part B Manual and on-line list of HAB policies and the most recent application guidance from HAB/DSHAP to identify other legislative factors and HAB/DSHAP expectations. Information obtained should be summarized in writing and used in developing the PSRA process and criteria for decision making.

Once legislation and HRSA/DSHAP expectations are understood, the responsible committee can lay out the PSRA tasks and desired outcomes, assign responsibilities, and agree on a format and level of detail for the completed priorities and resource allocations. In doing so, look back to the previous year and identify any changes or improvements needed in the service categories to be considered or the level of detail to be specified. For example, the following specific outcomes might be selected:

- A prioritized list of service categories.
- Directives to the grantee on how to meet these priorities, including a description of populations to be served, geographic areas in which services are delivered, or service models that will be used to provide these services
- An explanation regarding any core service the planning body did not prioritize, to include in the Ryan White Part B application.
- A chart showing the actual dollars and percent of service funds to be allocated to each service category or subcategory.
A fully documented description of the steps and decision-making processes used, which can be shared with the community and used to support decisions. The priority setting and resource allocations process should be developed before the process begins, to guide the work, and then revised each year based on experience.

The PSRA process must be documented in writing and used to guide deliberations and decision making. Use the following outline as a starting point. Such documentation will make it clear at the end of the process how decisions were made. Since a grievance can be filed if the planning body deviates from its established process, this documentation will be very important.

| DOCUMENTING THE DECISION-MAKING PROCESS: |
| SUGGESTED LIST OF MATERIALS TO BE COMPILED |
| I. OVERVIEW |
| A. The Task and Desired Outcomes: Service Priorities and Resource Allocations |
| B. Legislation and HRSA/HAB Guidance |
| C. List of HRSA-approved Core and Support Service Categories, with HRSA-approved definitions |
| D. Service Categories and Priorities for the Past Year |
| E. Policies and Procedures for Managing Conflict of Interest |
| F. Information Inputs (e.g., epidemiologic data, needs assessment, cost and utilization data, performance measures) |
| I. THE DECISION-MAKING PROCESS |
| A. Committee and Full Planning Body Roles and Responsibilities |
| B. Ground Rules and Overall Approach |
| C. Principles |
| D. Criteria |
| E. Agreed-upon Process and Decision-making Methods |
| II. RESULTS |
| A. Chart of Service Priorities and Resource Allocations |
| B. Explanations/Rationale for the Grantee or Administrative Agent |
| C. Adjustments for Increased or Decreased Funding (or use of multiple funding scenarios: flat funding, increase, and decrease) |

Documentation of the Actual Process and Any Deviations from the Planned Process

Table 13: Documenting the Decision-Making Process

Next, decide who will be responsible for carrying out various steps. The full planning body must make final decisions, however, preliminary work can be delegated to a committee, usually a standing committee. If a committee approach is chosen, ensure that the committee:
Is diverse enough to reflect the various population groups, geographic areas, and types of technical skills and experience needed for sound planning.

Documents its work and brings process decisions such as proposed procedures and criteria for decision making to the full planning body for review and approval (see below).

Leads a decision-making process with participation from the entire planning body in determining priorities and/or resource allocations.

Priority setting and resource allocation is generally done by a committee including only planning body members, because of the background information required and the issues around conflict of interest.

2. Determine and obtain available information “inputs,” including comprehensive plan, needs assessment,* and client utilization data.

Priority setting and resource allocation should be data-based, and many types and sources of data can be used. Ideally, most or all of the information listed in the table below will be available as “inputs” to decision making. This information will help in making decisions about service priorities and resource allocations. HAB/DSHAP does not expect all of these data components to be used, but many planning bodies find that using a combination of data provides the best results.

Identify missing information before priority setting begins to avoid conflict over any limitations in the process caused by a lack of data. Identifying information gaps will also help to improve the information inputs for next year’s decision making.

Often, the information listed will be available but not in an easily usable form. For example, the needs assessment may be quite lengthy. An important task is to determine the kinds of information needed from each of these inputs and prepare summaries in narrative or chart form for use in decision making. For example:

- Needs assessment information might be summarized to provide a prioritized list of service needs as identified by the various needs assessment activities.
- Non-Ryan White funding might be presented in terms of dollars available for each service category, broken down by service model, target group, and/or geographic location where available.
- Where possible, data from all these sources should be prepared into a user-friendly summary and presented to the entire planning body during a data presentation held before priority setting begins. A matrix can be used to summarize needs assessment and other data from multiple sources for each service category, as well as for various geographic areas, and target populations within the State/Territory.

Often, the annual PSRA process begins with a detailed data presentation, which provides PowerPoint presentations, charts and other handouts, summary information that may be in a matrix format (See Needs Assessment Chapter in this manual) and allocates significant time for discussion of the data. The data presentation often lasts several hours, and ensures a shared knowledge base for decision making.
<table>
<thead>
<tr>
<th>Check if used</th>
<th>Data/Information Used for Priority Setting and Allocation of Funds</th>
<th>Current as of (Mo./Yr.)</th>
<th>Used by:</th>
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<tbody>
<tr>
<td></td>
<td><strong>Epidemiologic Data/Profile</strong></td>
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<td></td>
<td>Number and characteristics of individuals living with HIV/non-AIDS and living with AIDS in the service area (prevalence)</td>
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<td>Number and characteristics of newly diagnosed people with HIV/non-AIDS and AIDS (incidence)</td>
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<td>Trends/changes in HIV/non-AIDS incidence and/or prevalence</td>
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<td></td>
<td>Trends/changes in AIDS incidence and/or prevalence</td>
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<td></td>
<td>Changes in the demographics of HIV/AIDS cases in relation to the total State/Territory population as a measure of disproportionate impact on specific populations</td>
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<td>Information regarding populations with special needs, including barriers to care and other access issues</td>
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<td></td>
<td>Information on the number, percent, and characteristics of late testers (individuals who had AIDS at diagnosis or within one year after diagnosis)</td>
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<td>Early Identification of Individuals with HIV/AIDS (EIIHA) matrix data – number and characteristics of individuals tested, testing positive, informed of their results, and linked to care</td>
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<td>Estimate of unmet need – quantitative data regarding the number and profile of persons living in the EMA/TGA who know they have HIV but are not receiving HIV/AIDS primary medical care</td>
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<td>Other:</td>
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<td><strong>Performance and Outcomes Evaluation Data (e.g., effects on clients receiving specific services).</strong></td>
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<td>Performance measures (as provided by HRSA)</td>
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<td>Client-level health status outcomes – primary medical care (e.g., viral suppression)</td>
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<td>Other health status outcomes</td>
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<td></td>
<td>System-level health status outcomes, such as available “treatment cascade” data showing number and characteristics of individuals diagnosed with HIV/AIDS, entering care, retained in care, given antiretroviral therapy, and showing viral suppression</td>
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<td>Other:</td>
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<td><strong>Service Utilization Data (by service category)</strong></td>
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<td>Numbers of unduplicated clients and their characteristics; numbers of units of service provided</td>
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</table>
Check if used | Data/Information Used for Priority Setting and Allocation of Funds | Current as of (Mo./Yr.) | Used by:
---|---|---|---
| Demographic information regarding who is and is not accessing care | | |
| What percent of previous year’s funding was spent | | |
| Existence of a waiting list for services | | |
| Other: | | |
| **Service Cost Data** | | |
| Unit costs for each service, known or estimated; if unavailable, costs per client per year for each service category | | |
| Cost-effectiveness data, if available | | |
| Other: | | |
| **Needs Assessment Data** (other than epidemiologic data, listed earlier) | | |
| Service needs as determined through methods such as PLWHA surveys, focus groups, key informant interviews, or town hall meetings | | |
| Assessment of unmet need – service gaps and barriers for PLWHA not in care | | |
| Assessment of probable characteristics of PLWHA who are unaware of their status | | |
| Profile of Provider Capacity and Capability findings | | |
| Results of any special needs assessment studies | | |
| Identification and analysis of service gaps | | |
| Other: | | |
| **Other Relevant Data** | | |
| Co-morbidity, poverty, insurance status data | | |
| Information on other funding streams | | |

Table 14: Checklist of Data/Information for Priority Setting and Resource Allocation

3. Review core medical and support service categories, including service definitions.

States/Territories are permitted to prioritize and fund only the 13 legislatively specified core medical service categories plus the support service categories approved by the Secretary of Health and Human Services (16 categories as of the end of 2012)
### Ryan White Service Categories

#### Core Medical-Related Services
1. Ambulatory/outpatient medical care
2. AIDS Drug Assistance Program (ADAP treatments)
3. AIDS pharmaceutical assistance (local)
4. Early intervention services (EIS)
5. Health insurance premium & cost-sharing assistance
6. Home health care
7. Home and community-based health services
8. Hospice services
9. Mental health services
10. Medical nutrition therapy
11. Medical case management
12. Oral health (dental) care
13. Substance abuse services—outpatient

#### Support Services
1. Case management (non-medical)
2. Child care services
3. Emergency financial assistance
4. Food bank/home-delivered meals
5. Health education/risk reduction
6. Housing services
7. Legal services
8. Linguistic services (interpretation and translation)
9. Medical transportation services
10. Outreach services
11. Psychosocial support services
12. Referral for health care/supportive services
13. Rehabilitation services
14. Respite care
15. Substance abuse treatment services—residential
16. Treatment adherence counseling

These service categories are defined in the Ryan White Part B Program Standards, a part of the National Monitoring Standards. A State/Territory may choose a more limited definition than specified in the HAB/DSHAP service category definitions, but may not use a more expansive definition or fund service categories not on the approved list. For example, the State/Territory or a consortium might choose to limit Home and Community-based Services to home health aide and personal care services, excluding other allowable activities such as durable medical equipment. Following are helpful steps in defining the service categories:

- Review the approved list of service categories and definitions provided by HAB/DSHAP in the National Monitoring Standards or the annual application guidance.
- Review service priorities from the previous year.
- Consider components and delivery mechanisms that are important to your continuum of care. They may need to be separately identified for consideration in priority setting and (more often) in resource allocation. These might include types of service interventions or activities included in a single category. For example:
  - The category of Food Bank/Home Delivered Meals/Nutrition Supplements might include home-delivered meals, food banks or food pantries, and food vouchers and nutritional supplements, and the planning body may choose to separately prioritize – and allocate resources to – these types of interventions.
  - The category of Emergency Financial Assistance can include essential services such as utilities, housing, food, or medications provided with limited frequency or for a limited period or time. These services may be separately prioritized and should have separate resource allocations, since funds spent on each must be separately reported to HRSA/HAB. The State/Territory or consortium may choose to prioritize or fund only a subset of these services.

Service categories provide options for consideration in meeting documented needs. For each HIV health care need identified, you will want to prioritize the service interventions that work best in your area. For example, your needs assessment might indicate that PLWHA need to have their care coordinated. This might be accomplished through medical or non-medical case management, two different service categories, or through some other service intervention, such as co-located services (which would be addressed through a directive on how best to meet the care coordination priority). The planning body should give greatest priority to the service categories it considers most needed by PLWHA in your State/Territory.

Once a list of service categories and any desired subcategories is developed, the committee should provide it to the full planning body with definitions for use for review and approval – and for use in priority setting.

4. Agree on the principles, criteria, and decision-making process to be used in priority setting.

Sound priority setting must be based on principles and criteria for decision making, which must be clearly stated and consistently applied. A first step is to identify-and obtain any needed review and approval of the principles that will be used in guiding the decision-making process (see examples below). Often, such principles have been discussed and reflected in the area’s comprehensive HIV services plan. In making decisions about priorities, the decision-making body should consider whether proposed priorities are consistent with these principles.

Sometimes documentation may not exist to apply all these principles. Where the lack of information limits the quality of decision making, specify additional information needed in future years and be sure the appropriate committee (e.g., Needs Assessment) is informed of data gaps.
POSSIBLE PRINCIPLES TO GUIDE DECISION MAKING

| 1. Decisions must be based on documented needs. |
| 2. Services must be responsive to the epidemiology of HIV in this service area. |
| 3. Priorities should contribute to strengthening the agreed-upon continuum of care. |
| 4. Decisions are expected to address overall needs within the service area, not narrow advocacy concerns. |
| 5. Services must be culturally appropriate. |
| 6. Services should focus on the needs of low-income, underserved, and disproportionately impacted populations. |
| 7. Equitable access to services should be provided across geographic areas and subpopulations. |
| 8. Services should meet Public Health Service treatment guidelines and other standards of care and be of demonstrated quality and effectiveness. |

Table 15: Possible Principles to Guide Decision Making

In addition to principles, agree on the criteria to be used in setting priorities. These criteria should be “weighted” to determine which ones are most important in making decisions. Suggest a limited number of criteria and indicate which are most important. The box below provides sample criteria.

An experienced planning body with extensive information “inputs” may want to add more criteria, based on the principles agreed upon. The criteria and their relative weight should be discussed and agreed upon by the full planning body.

Note that these sample criteria do not include financial considerations, such as availability of other funding streams or unmet demand. Priorities should reflect the planning body’s judgment concerning what services are needed to provide a continuum of care, regardless of how these services are being funded. Funding availability and unmet needs and service gaps associated with these service priorities are considered as part of the resource allocation process.
Sample Criteria for Priority Setting

1. **Documented need**, based on:
   - The epidemiology of the local epidemic
   - Service needs specified in the needs assessment including unmet needs of individuals who are HIV-positive but not in care and of historically underserved communities
   - Other structured sources of information

2. **Quality, cost effectiveness, and outcome effectiveness of services**, as measured through outcomes evaluation, clinical quality management programs, client satisfaction surveys, and other evaluation methods.

3. **Consumer preferences or priorities**, including services and interventions for particular populations, especially those with severe need, historically underserved communities, and individuals who know their status but are not in care.

4. **Consistency with the continuum of care**, and its underlying priorities.

5. **Balance between ongoing service needs and emerging needs**, reflecting the changing local epidemiology of HIV/AIDS.

Table 16: Sample Criteria for Priority Setting

Once you have an overall PSRA process, understand service categories, and have agreed on principles and criteria to guide decision making, you are ready to decide on how priorities will be agreed upon. There is no single best decision-making process or method for priority setting. However, the considerations described below, reflecting the experience of many planning bodies, can help you develop a practical method for your State/Territory.

**Issues to Consider in Defining the Priority Setting Process**

Consider the following issues in defining a decision-making process:

- **Openness of Process.** All decisions should be made in an open forum, preferably by the full planning body. The public may provide input through needs assessment and public meetings, but because of conflict of interest issues and the need for in-depth understanding of the data, generally will not participate in the decision making. It should, however, be free to observe it as well as the resource allocations decision making. Therefore, a calendar of meetings should be agreed upon and publicized within the community, and all decision-making meetings should be held in large and accessible locations and at scheduled times designed to encourage community attendance. An appropriate committee of a planning body serving a large geographic area might hold meetings in several different locations to obtain input before making its final decisions about priorities.

- **Information Base for Decision Making.** Documented information in the form of summaries of the needs assessment and other information inputs should be made available to everyone through a single source, or ideally through a data presentation just before priority setting. All members should have access to the same summary information and be able to request full copies of documents if desired before the data
presentation. Training or other assistance should be provided to members less familiar with the Ryan White HIV/AIDS Program so they will feel comfortable using the information.

- **Quorum Requirements.** Explicit quorum requirements should be stated for the committee and the full planning body.

- **Minimizing Conflict of Interest.** The decision-making process may create temptations for members to advocate narrowly for service categories or for interventions for populations and/or geographic areas served by a member’s agency (public or private). It is important to define conflict of interest and establish mechanisms to minimize it. This is particularly important because many planning bodies have a high proportion of members who are service providers. Mechanisms might include:
  o Require full disclosure at the beginning of the meeting of relationships with HIV/AIDS service providers and the types of services they provide.
  o Limit involvement in discussion by members with conflicts of interest by: not allowing them to participate in discussion of service categories in which they have a conflict of interest, allowing them to answer questions but not initiate discussion, or allowing them to participate in discussions but not vote.
  o Exclude providers with potential conflicts of interest from serving on the Priority-Setting Committee or ensure that individuals with a potential conflict constitute a minority on the committee.
  o Begin each meeting by reminding members of the mission of the planning body and the purpose and importance of priority setting.

The challenge is to manage conflict of interest without excluding from the discussion those with needed service knowledge and experience. [For additional guidance, see the Conflict of Interest chapter in this manual.]

- **Voting Procedures.** Voting procedures should be agreed upon in advance and approved by the full planning body.

- **Decision-making Method.** The procedure to be used in making decisions should be specified “up front.” Examples include a consensus method, a nominal group process, or some other procedure.

**Other Considerations**

**Leadership.** The planning body should decide who will lead the decision-making process. Co-chairs might provide leadership to ensure that everyone is heard, the agreed-upon process is followed, and time limits are placed on discussion.

- **Decision-making Responsibility.** Responsibilities of the committee and the full planning body should be defined. The committee might begin by reviewing its definition of the task and planned outcomes and the agreed-upon responsibilities of the committee and full planning body, as decided in Step 1.
  o **Committee Responsibilities.** The committee might be charged with preparing and managing the data presentation and with reviewing the past year’s priorities and making recommendations for changes based on the available data. It might lead
discussion of the data, identified needs, and service interventions to best meet these needs, and time-limited discussion of recommended priorities.

- **Full Planning Body Responsibilities.** The full planning body is ultimately responsible for approving the priorities. If preliminary work is done by a committee, the planning body should be the final decision makers. Ideally, it should discuss review the committee’s recommendations, discuss the data, and then use one of the methods to make final decisions. This might involve voting or obtaining the consensus of the full body, resolving any areas of disagreement.

- **Meeting Schedule.** Meetings necessary to carry out the process should be scheduled well in advance and widely publicized.
  - The first full planning body meeting on PSRA might be held after the planning body has approved a decision-making process, to review the process, criteria, and information “inputs” as a group and to train the planning body on the decision making method.
  - The committee might then hold on or more meetings, as needed, to prepare for the priority setting process and develop recommendations to the full planning body.
  - The entire planning body should participate in a data presentation providing the information base for decision making.
  - The entire planning body might then meet to set priorities, beginning with suggestions from the committee or decision making led by the committee to reach agreement on a final list of service priorities. Note: This meeting could be the first part of a combined priority setting and resource allocations session.

- **Providing guidance to the grantee on how best to meet the priorities.** The development of this guidance, or Directives, may be done as part of the priority setting or as a separate process. Directives often address populations or geographic areas to be served, promising service models, or needed provided capability and experience. Often, needs assessment helps to identify populations or communities in need of additional services and/or service strategies that seem particularly promising. They may also be identified during discussion related to the data presentation or priority setting. Sometimes a committee responsible for care strategies develops suggested guidance during the program year. These ideas need to be put into written form and discussed with the grantee as part of the PSRA process. Since they may have funding implications which affect allocations, they should be identified and discussed in the priority setting phase of PSRA.

5. **Implement the process: set service priorities, including how best to meet them.**

Once the planning body has adopted a priority setting process, including an agreed-upon method to make decisions, implement the priority setting process, with staff or consultant support.
A PLANNING BODY MEETING TO SET SERVICE PRIORITIES

1. Prior to the meeting, the planning body receives the following from the committee overseeing the PSRA process:
   - A summary of key findings from the data presentation that occurred the previous month.
   - A list of the agreed-upon decision-making principles and criteria,
   - The service priorities for the prior year and the committee’s recommendations for changes in service priorities, along with a summary documenting the rationale for their recommendations, and other issues they feel need to be considered in setting priorities.
   - The committee’s recommendations on how best to meet the priorities.

2. At the beginning of the meeting, the chair addresses possible conflict-of-interest concerns by asking members to disclose any relationships with current and potential Ryan White HIV/AIDS Program service providers and indicate the categories of AIDS-related services these providers offer. All members indicate whether they have such conflicts. Several provider representatives identify conflicts for specific service categories. They are informed that they may not initiate discussion about the service categories where they have a conflict of interest, but may answer direct questions from other committee members. They may not participate in any individual vote regarding a service category where they have a conflict of interest, but are permitted to vote on a slate of priorities.

3. The chair reads the principles and criteria adopted to guide the priority setting process and ensure that all members understand them. The chair also reminds the committee members that they are expected to represent the interests of all PLWHA in the service area when they set service priorities.

4. Committee representatives then take responsibility for managing the session. They present the following:
   - A summary of key findings from last month’s data presentation, with a focus on those most relevant to priority setting
   - The service priorities from the prior year, along with recommended priority changes, which includes moving up EIS and Non-Medical Case Management to reflect the needs assessment findings and epi data. Other possible changes are identified, including that do not have consensus are identified.

5. Planning body members raise issues and concerns, and committee members justify their recommendations by explaining how they reflect the decision-making criteria and principles.
### A PLANNING BODY MEETING TO SET SERVICE PRIORITIES

6. Planning body members suggest refinements to the priorities, including specific ranking changes for EIS and Non-Medical Case Management. One member also urges higher priority for Treatment Adherence Counseling as a way to improve retention in care, and someone suggests that Psychosocial Services should be higher-ranked to reflect the key findings. They are asked to justify their recommendations through the agreed-upon criteria. Changes to EIS and Non-Medical Case Management rankings are made by consensus.

7. Consensus is not reached on changes to the rankings of Treatment Adherence Counseling or Psychosocial Services. Planning body members are asked to individually re-rank the priorities as they appear following consensus on the other service categories, to address the last two service categories in question, using a scoring sheet. Results are tabulated, and the revised priorities are reviewed. The chair indicates that if one-third or more of members feel further refinement is needed, time-limited discussion will be permitted and members will be asked to vote on the ranking of specific categories about which there is no consensus. Only a small number of members feel more discussion is needed, so the revised list of priorities is approved by consensus.

8. The planning body reviews the four proposed directives providing guidance to the grantee, asks for clarification on costs for all directives, and makes some revisions to the language. Then they are approved unanimously.

9. The planning body ensures adequate written documentation throughout the process, including specific notation of areas for possible improvement, such as missing or incomplete information. Follow-up discussion is planned to be sure that these needs are adequately recognized in the resource allocation process, to improve the amount and quality of information available for the following year’s priority setting process.

### Table 17: Planning Body Meeting to Set Service Priorities

6. Agree on the principles, criteria, decision-making process, and methods to be used in allocating funds to service categories.

The extent of the resource allocation effort depends upon the planning body’s scope of responsibility. Some planning bodies are responsible for allocating funds from multiple sources – for example, both regular Part A and MAI funds, and sometimes Ryan White Part B funds for their region, local HIV/AIDS service dollars, and/or Housing Opportunities for Persons Living with AIDS (HOPWA) funds.

The resource allocation process typically requires the following activities:

- Specify the sources and categories of funds to be allocated.
- Use the results of the priority setting process to specify the service categories to which funds may be allocated.
- Determine funding gaps for prioritized services by reviewing both last year’s service utilization and needs assessment data and the sources and amounts of funding allocated by other sources to support particular services. This will enable the planning body to determine if there is a funding gap to which it should respond.
• Determine the probable amount of funding (overall and from each source) that must be allocated, usually based on the level of actual funding received for the current program year (“flat funding”). This requires separate assumptions about regular Ryan White Part B and Ryan White Part B MAI funds.

• Allocate a specific number of dollars to the service categories, based on the identified need, projected number of PLWHA to be served, and the cost per client. Ensure that at least 75% of service dollars are allocated to core medical services and not more than 25% to approved support services.

• Present the resource allocations in summary form. Most often this means preparing a chart indicating service priorities and resource allocations to each of those services, including both dollars and percent of funds, with a separate column for each funding stream for which the planning body is responsible.

• Resource allocations must be done before final figures are available on funding level, since they are included in the funding application to HRSA/HAB. Therefore, allocations can be based on various funding assumptions or multiple “scenarios,” such as:
  o Funding will be unchanged from the prior year
  o Funding will be a specified percent—such as 5 percent or 10 percent—below the prior year, or
  o Funding will be a specified percent—such as 5 percent or 10 percent—above the prior year.

Alternatively, allocations can be based on an expected minimum level of funding, with information about how additional funds will be allocated, as in the first scenario described in Step 8.

Factors to use in resource allocation are usually similar to those used for priority setting, with some additions or refinements. The committee responsible for managing the resource allocations process should recommend and the planning body should review and approve these factors.

**Regarding principles,** the planning body might want to add the following, which reflect Ryan White legislative requirements:

- Ryan White will be considered the funder of last resort.
- Ryan White will not be able to meet all identified needs.

**Regarding criteria,** the planning body might want to add the following:

- **Lack of other funds.** Resources from other sources are not available to meet this service need.
- **Cost-benefit.** The service provides a high level of benefit for PLWHA relative to its cost.

**Regarding the decision-making process,** many issues need to be considered. The complexity of the resource allocation process makes it especially important that it be carefully developed by a committee, supported by staff work, then implemented with final decision making at a full planning body meeting. Often, the committee works closely with the grantee to develop estimates of the number of PLWHA likely to need each service and the costs involved. Where
the actual allocations process is done by the full planning body, the committee’s responsibilities are to manage the process and ensure that needed information is available to the planning body for its decision making.

As with priority setting, the committee should recommend the process to the planning body, and the planning body should review and approve it. Many of the considerations are identical to those identified for priority setting; some additional considerations are described below.

### ADDITIONAL ISSUES TO CONSIDER IN DEFINING THE RESOURCE ALLOCATION PROCESS

- **Baseline or Starting Point for Resource allocation Decisions.** Several different starting points can be used for resource allocation decisions. For example:
  - The planning body can use a “zero-based budgeting” approach, which means that all allocations are determined without using last year’s allocations as a starting point. If this approach is used, be sure to consider multi-year commitments and the content of your three-year comprehensive plan, as well as HAB/DSHAP requirements that 75% of service funds go to core services.
  - Allocations from the previous year can be used as a starting point, if you believe that last year’s allocation process was sound. Remember that those will be the allocations used for the current program year, and final expenditures will not be available. For this reason, some planning bodies look at both the most recent allocations and the prior year, for which final expenditure and costs per client information are available.

- **The second approach is likely to be easier for most planning bodies.** Its use requires attention to changes in service priorities as established in Step 5, planning body confidence that it implemented a fair process the past year, no large changes in the epidemic within the service area, and availability of updated information about service costs.

- **Decision-making Methods.** Methods such as consensus, nominal group process, and/or discussion and voting might be used in making decisions about resource allocations. This should be determined “up front,” as with priority setting.

- **Minimizing Conflict of Interest.** Conflict of interest is generally managed and minimized the same way for priority setting and resource development. However, because allocation decisions help determine funding opportunities, the decision-making process may create greater temptations for members to advocate narrowly for allocations for the service interventions, populations, and/or geographic areas served by a member’s agency, public or private, or to a member’s own community. Members may also oppose funding to a particular category of service or population based on personal viewpoints. Those leading the allocations process must ensure continuing attention to conflict of interest to avoid such issues.

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<th>Table 18: Additional Issues to Consider in Defining the Resource Allocation Process</th>
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</table>
7. Estimate needs and costs by service category.

Thoughtful resource allocation depends upon information available on:

- **The need and demand for specific services.**
- **The costs of those services:** Some planning bodies consider service gaps in setting their priorities. If your planning body uses this approach, you may already have compiled this information (described below) by the time you begin the resource allocation process. If so, make sure the materials are available for review as you determine resource allocations.
- **The availability of other resources to support them:** Several of your analyses will require an inventory of the sources and levels of other governmental and nongovernmental resources available to support HIV/AIDS-related services in your community. Such information is also necessary to assess and, to the extent possible, quantify gaps in services. This inventory of other funding streams may be a part of your needs assessment or may be compiled by the grantee for inclusion in the funding application.
- **Capacity development needs of providers:** These must be associated with service gaps or lack of appropriate services for particular populations or in particular geographic areas, and must be identified by service category.

A planning body that has incomplete information on these topics can make best use of available information by compiling it in a summary format and examining it alongside approved service priorities.

The planning body should gather available information by service category. If information is available only for some types of services, use what is available and identify information gaps. It is particularly helpful to prepare charts that list service priorities in order and provide information needed for the allocations process. Examples of particularly useful analyses and charts follow.

Prepare a comparison of the service priorities for the upcoming year with the priorities and allocations identified for the current year. The chart format might look like this:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Priority for Next Year</th>
<th>Priority for Current Year</th>
<th>Percent of Current Year’s Allocation</th>
<th>Amount of Current Year’s Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient/Ambulatory Medical Care</td>
<td>1</td>
<td>1</td>
<td>39.5</td>
<td>$1,020,000</td>
</tr>
<tr>
<td>AIDS Drug Assistance Program (ADAP treatments)</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AIDS Pharmaceutical Assistance (local)</td>
<td>3</td>
<td>3</td>
<td>5.8</td>
<td>150,000</td>
</tr>
<tr>
<td>Oral Health Care</td>
<td>4</td>
<td>5</td>
<td>7.8</td>
<td>200,000</td>
</tr>
</tbody>
</table>
Obtain information on the units of service provided and the costs per unit of service or per client for the service categories or components within them. The most easily obtainable information might be the number of clients served in a year and the estimated costs per client per year. Your chart might look like this:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>No. of Clients Served Per Year</th>
<th>Average Cost Per Client Per Year</th>
<th>Funding for Current Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient/Ambulatory Medical Care</td>
<td>1,008</td>
<td>$1,012</td>
<td>$1,020,000</td>
</tr>
<tr>
<td>City X</td>
<td>734</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County A</td>
<td>170</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County B</td>
<td>104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS Drug Assistance Program (ADAP treatments)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AIDS Pharmaceutical Assistance (local)</td>
<td>360</td>
<td>$576</td>
<td>$200,000</td>
</tr>
<tr>
<td>Oral Health Care</td>
<td>207</td>
<td>$725</td>
<td>$150,000</td>
</tr>
<tr>
<td>Medical Case Management</td>
<td>991</td>
<td>$444</td>
<td>$440,000</td>
</tr>
</tbody>
</table>

Table 20: Services and Costs

If available, provide a more extensive analysis of your most recent completed program year funding levels. For example, did funds for certain services (e.g., oral health care) run out before the end of the year, or were funds reallocated because of under-expenditure or low demand? Obtain the grantee or administrative agent’s projection of the unspent funds for each service category. If this information is available, make it a separate column on your chart.

Estimate current service gaps in terms of unmet service demand by priority. For example, given the current funding situation, estimate the number of PLWHA with unmet need who are not receiving primary care, medical case management, etc., and should be receiving such services. If possible, provide this information by service priority, and estimate the costs for meeting that need. Review costs per client or unit costs for the past year, and modify as needed to project for next year. Use a format such as the following:
### Table 21: Service Gaps and Cost Estimates

Prepare a combined chart of estimated total needs by service priority, both met and unmet, and available funding. Use the format shown in the chart below, and include the following:

- Service priorities, including specific components like subpopulations and geographic area needs (Column 1).
- Total need (including met and unmet need), in terms of either number of clients or service units (as shown in Column 2).
- Average cost per client estimated for the next year (Column 3).
- Total funds required to meet the need (Column 4).
- Identification of other available funds to meet service needs, by service priority, or (if dollar amounts are not available) the number of individuals served (Column 5).
- The level of gaps in service by needs category (Column 6), which is the difference between total funds required to meet the need (Column 4) and other available funds (Column 5) — or the total number of clients not served by other sources (Column 2 minus Column 5) multiplied by the Part A cost per client (Column 3).

<table>
<thead>
<tr>
<th>Service Priority</th>
<th>Estimated Number of Persons Needing But Not Receiving Service</th>
<th>Estimated Additional Cost of Meeting Need (Above Current Funding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Pharmaceutical Assistance (local)</td>
<td>125</td>
<td>$72,000</td>
</tr>
<tr>
<td>Substance Abuse Treatment – women-focused</td>
<td>85</td>
<td>$97,155</td>
</tr>
<tr>
<td>Medical Case Management—Family-Centered; for Spanish-speaking clients</td>
<td>55</td>
<td>$24,420</td>
</tr>
<tr>
<td>Ambulatory Medical Care in Outlying County X</td>
<td>80</td>
<td>$80,960</td>
</tr>
</tbody>
</table>

[List other unmet service needs or service gaps]
<table>
<thead>
<tr>
<th>Service Priority</th>
<th>2 Total Need Per Year (Number of Clients)</th>
<th>3 Average Cost Per Client Per Year</th>
<th>4 Total Funds Required to Meet Need</th>
<th>5 Other Available Funds/Clients Served</th>
<th>6 Unmet Need or Service Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Pharmaceutical Assistance (local)</td>
<td>471</td>
<td>$576</td>
<td>$271,296</td>
<td>0</td>
<td>$271,296</td>
</tr>
<tr>
<td>Oral Health Care</td>
<td>622</td>
<td>$725</td>
<td>$450,950</td>
<td>300 clients served through Medicaid, Part F dental clinic</td>
<td>$233,450</td>
</tr>
<tr>
<td>Medical Case Management</td>
<td>1,546</td>
<td>$444</td>
<td>$686,424</td>
<td>396 clients - Part C and D grantees</td>
<td>$510,600</td>
</tr>
<tr>
<td>Emergency Financial Assistance (Housing)</td>
<td>420</td>
<td>$796</td>
<td>$334,320</td>
<td>$38,000 private funding</td>
<td>$296,320</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>80</td>
<td>$1,620</td>
<td>$129,600</td>
<td>$75,000 - State funds</td>
<td>$54,600</td>
</tr>
<tr>
<td>Food Pantry/Food Bank</td>
<td>350</td>
<td>$582</td>
<td>$203,799</td>
<td>$155,000 private funding</td>
<td>$48,799</td>
</tr>
<tr>
<td>Food Vouchers</td>
<td>200</td>
<td>$160</td>
<td>$32,000</td>
<td>$5,000 faith-based groups</td>
<td>$27,000</td>
</tr>
</tbody>
</table>

Table 22: Estimated Service Needs

Once you have prepared this information for all prioritized service categories, you are ready to carry out your agreed-upon resource allocation process.

8. Allocate resources to service categories.

To allocate resources to the established priorities, you will need to agree upon and review the principles, criteria, and processes described in Step 6, and to develop and review the information described in Step 7. The allocations process might then proceed to the development of alternative scenarios or funding formulas, such as the following:

- Flat funding (same amount as prior year).
- Increased funding (5%).
- Decreased funding (5%).
Based on the Step 7 information charts, you can develop alternative scenarios or allocation formulas for the planning body’s review. Following are four possible resource allocation scenarios. Whichever scenario you use, be sure that at least 75% of funds are allocated to core medical services as specified in the legislation.

**Sample Approaches for Resource Allocations**

**Approach 1**

Divide priorities into tiers of services and other activities, as follows:

- First-tier categories that are considered “core” or “essential” services, including the most important core services and the most important support services.
- Second-tier priorities that should be funded if funds permit.
- Third-tier categories that should not receive funding this year, unless the program receives a funding increase.

Start by using Approach #1 (the flat funding scenario). First allocate the funds needed to ensure continuation of first-tier services for the same number of clients as the current year, if continued funding is needed. Once these “essential” services have received needed funding, allocate a specified proportion of additional expected funds (e.g., 60 percent) to second-tier service categories, deciding on amounts per category based on number of clients to be served and costs per client. Divide funds among categories based on your priorities and needs assessment results. Use the remaining funds to expand funding for first-tier categories towards the estimated total need. When you use the second (increased funding scenario, first increase first-tier service categories to fill identified service gaps, then allocate funds to the second-tier services using the same allocations procedure as before. See how much money is left, and decide which, if any, of the third-tier categories to fund. When you use the third (decreased funding) scenario, consider which second-tier categories you may want to zero-fund in order to maintain essential services.

**Approach 2**

Using the first (flat funding) approach, decide which services are most important — perhaps your first 5-7 categories), and begin by allocating full needed funding to those categories. Determine how much funding remains, and allocate it to other prioritized services based on the number of people you need to serve in each service category and the cost per client per year. Under this scenario, you will provide most of your funding to the service categories you define as “essential,” and therefore will fund fewer service categories. Under the increased funding scenario, you will add service categories to the funding list. Under the decreased funding scenario, you will eliminate additional categories.

**Approach 3**

Continue to fund at the same level those services with high priority rankings, or those identified in the continuum of care as essential to life or essential to providing access to care. Cut other services by a specified percent (e.g., 21 percent). Use the pool of funds created by the cuts to
fund new priorities or unmet components of high-priority service categories (e.g., substance abuse treatment services for women, medical case management services for Spanish-speaking PLWHA, ambulatory medical care in an outlying county). If the funding level is higher than expected, a set percentage of increased funds might go to new services, high-priority existing services, and lower-priority existing services. If the funding level is lower, a set percentage in cuts might be applied across all services, or smaller cuts to high priority services.

**Approach 4**

Divide services into tiers as in Scenario #1. Continue to fund existing services in first and second tier, but decrease funding levels for second-tier services. Base these reductions on a careful review to identify services that are lower in priority, level of unmet need or service gap, and/or availability of other resources. Make sufficient cuts to generate a pool of $X dollars to allocate to new service priorities and to increase allocations to specific high-priority services that have high levels of unmet need and low availability of other resources.

In any scenario or approach, the highest-priority services within the State/Territory are not always the services that receive the largest allocations. The highest-priority services may cost less than other services and/or other Ryan White or non-Ryan White resources may be available to fund them. With the expected expansion of Medicaid in some States and establishment of health insurance exchanges in all States as of 2014, planning bodies may find that they will need to allocate less funding for outpatient/ambulatory medical care, ADAP, and other service categories covered through these programs. Similarly, a service category that is relatively lower priority but is not funded through other available grant funding streams or included in Medicaid or private health insurance might be allocated a larger proportion of Ryan White funds.

This approach to priority setting and resource allocation has the advantage that it applies regardless of changes in other funding streams. For example, if severe cuts were to occur in other funding for outpatient primary health care, the planning body would reallocate some of its resources. Similarly, if the demand for medications grew beyond the Ryan White Part B State ADAP’s capacity to meet it, a planning body might choose to allocate additional funds for ADAP rather than other services.

Resource allocations are best made at a full planning body meeting. As with priority setting, it is helpful for a committee to present data on service needs and costs and make recommendations for service categories in particular need of increases, as well as categories where funds were underspent the prior year. The committee may make recommendations about resource allocations, and may ask the grantee to provide recommendations as well. Often, the committee and grantee provide their input, and the full planning body uses the three funding-level scenarios to do the allocations at an open meeting. Principles, criteria, needs and resource data, and the selected scenarios and approach should be presented and discussed at the beginning of the meeting. The full planning body reviews the information provided and recommendations made, and then does the final allocations using the agreed-upon process. It is important that the planning body discuss allocations choices and underlying data, based on the criteria and the needs and resource information. The planning body either reaches consensus on the resource allocations, or adopts them through a formal vote. Usually, votes are done for all groups of
service categories – such as all core services or all support services – but individual votes may also be taken for a single service category.

Staff document the resource allocation process and decisions along with the priority setting process and results (See Step 1 for a sample format for documentation). Once this process is completed, these priority setting and resource allocation decisions are reported to the community. The planning body publicizes its decisions through its own meetings and often through public hearings or meetings in several locations. Since the allocations are likely to be refined after the Ryan White Part B award is made and the precise funding level is known, some Ryan White Part B planning bodies wait to present their allocations until after they have been finalized.

9. Provide decisions to the grantee for use in the application and procurement.

The planning body must provide the grantee or administrative agent with the results of the priority setting and resource allocation process, both to include in the Ryan White Part B application and as a basis for the selection of providers (the procurement process). The planning body’s priorities and accompanying directives on how best to meet the priorities will reflect specific population groups, geographic areas, and service delivery mechanisms.

10. Identify areas of uncertainty and needed improvement.

Once the entire process has been completed for the year, the committee and the full planning body should review the experience and identify ways to improve the process in future years. A designated group should:

- Obtain written or oral feedback from the responsible committee and the full planning body.
- Identify missing or incomplete information that affected decision making, with emphasis on recent legislative requirements, policies, or guidelines.
- Review the decision-making process for weaknesses or problems and seek solutions, with special attention to any aspects of the process that might make the planning body vulnerable to a grievance.
- Review how conflict of interest was managed, and whether additional efforts are required.
- Make recommendations and plans for improvement, then assign responsibility for follow up to be sure they are carried out in the following year’s PSRA process.

11. Reallocate funds across service categories as needed.

Allocations happen before the annual Ryan White Part B application is submitted. Reallocation occurs after funds have been awarded, often at several times during the program year.

The Ryan White Part B Grantee almost always needs to do some. The first occurs when the Grantee gets its Notice of Grant Award from HRSA/HAB. Usually the amount will not be precisely what was requested. Often, the Ryan White Part B Grantee will need to make some
adjustments to its allocations to fit the actual funding received, using the appropriate funding scenario.

Additional reallocation is generally needed during the program year. Under the 2009 Ryan White legislation, the Ryan White Part B will lose future funding if it does not spend at least 95% of its formula grant. This means that the grantee must very carefully monitor provider expenditures.

X. Ch 12. Comprehensive Planning

A. Introduction

Planning is central to the Ryan White HIV/AIDS Program’s focus on local and State decision-making in developing HIV/AIDS care systems. The Division of State HIV/AIDS Programs (DSHAP) requires Ryan White Part B grantees to submit an updated Comprehensive Plan every three years. The purpose of this multi-year Plan is to assist grantees in the development of a comprehensive and responsive system of care that addresses the needs and challenges that change over time.

The Plan answers four basic questions:

1. Where are we now?
2. Where do we need to go?
3. How will we get there?
4. How will we monitor progress?

The Comprehensive Plan is a living document that serves as a roadmap for grantees and should be continually updated, as needed. The Comprehensive Plan should reflect a community’s vision and values regarding how best to deliver HIV/AIDS services, particularly in light of cutbacks in Federal, State, and local resources.

Comprehensive HIV services planning goes beyond the annual planning process for the use of Ryan White HIV/AIDS Program funding. It provides an opportunity for planning bodies to step back from short-term tasks, examine the current system of care, and envision an “ideal” system of care. Planning bodies develop a 3-year plan for achieving this vision through the review of needs assessment data; the review of existing resources to meet those needs; and the review of barriers to care. This planning process includes the consultation and collaboration with a community to collect diverse perspectives regarding the system of care.

Requirements and instructions for developing and submitting the updated Plan for the organization and delivery of health and support services are provided in the “Comprehensive Plan Instructions for Ryan White HIV/AIDS Program, Ryan White Part B Grants” issued by HRSA/HAB to Ryan White Part B grantees on a 3-year cycle as required by legislation.

B. HAB/DSHAP Expectations
The Division of State HIV/AIDS Programs (DSHAP) requires Ryan White Part B grantees to submit an updated Comprehensive Plan every three years. The purpose of this multi-year plan is to assist grantees in the development of a comprehensive and responsive system of care that addresses needs and challenges as they change over time. The Comprehensive Plan is a living document that serves as a roadmap for the grantee and should be continually updated as needed. The comprehensive plan should also reflect input from area stakeholders on how best to plan, prioritize, and deliver HIV/AIDS services, particularly in the light of limited Federal, State and local resources.

**Focus of Comprehensive Plans.** HAB/DSHAP expects States/Jurisdictions to develop multi-year comprehensive plans that will:

- Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities.
- Ensure the availability and quality of all core medical services.

Address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

- Address performance measures and other clinical and outcome measures.
- Address the goals of the National HIV/AIDS Strategy.
- Outline how efforts are coordinated with and adapt to changes in the health care system, such as those occurring because of health care reform.
- Include strategies that:
  a. Identify individuals who know their HIV status but are not in care and inform these individuals of services and enable their use of HIV-related services.
  b. Identify individuals with HIV/AIDS who do not know their HIV status, make them aware of their status, and enable them to use HIV-related services, with particular attention to reducing barriers to routine testing.
  c. Provide goals, objectives, and timelines (as determined by the needs assessment).
  d. Coordinate services with HIV prevention programs including outreach and early intervention services.
  e. Coordinate services with substance abuse prevention and treatment programs.

For additional information on HIV care, access and services through the Ryan White Program, please refer to the HIV Service Delivery System Section of this Manual.

**Relationship to the SCSN.** The Comprehensive Plan must be compatible with existing State and local service plans including and in particular the Statewide Coordinated Statement of Need (SCSN). The SCSN is a collaborative mechanism coordinated by the Ryan White Part B program that is designed to identify and address significant HIV/AIDS care issues related to the needs of PLWHA, and to maximize coordination, integration, and effective linkages across all Ryan White HIV/AIDS Parts. It is updated every three years, often at the same time comprehensive planning is occurring. For additional information on the SCSN, please refer to the Statewide Coordinated Statement of Need Section and the Coordination between Parts, Payers and Programs Section of this Manual.
**Relationship to ECHPP.** States/Territories which contain jurisdictions delineated by HAB/DSHAP in the Comprehensive Plan Instructions for Ryan White HIV/AIDS Program, Ryan White Part B Grants are expected to describe in their Comprehensive Plan the role of the Ryan White program in collaborating with the Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas (MSAs) Most Affected by HIV/AIDS (ECHPP) Initiative.

**C. Contents of a Comprehensive Plan**

The Comprehensive Plan should guide the planning body in the development of a coordinated system of care for PLWHA. It should include clear goals, objectives, and strategies for action as well as mechanisms for assessing progress. This section presents suggestions to help planning bodies and consortia organize their planning information in a logical format to support decision-making about HIV service priorities and funding allocations.

The content of a comprehensive plan document should be organized to provide clear answers to the four basic questions identified in the introduction to this chapter.

**Where Are We Now? (What does our epidemic look like and what is our current system of care?)**

This section of a comprehensive plan should describe the local HIV/AIDS epidemic to include the status of HIV services and the needs of PLWHA. It should include the following, plus any additional content specified in the Guidance from HRSA/HAB:

- An epidemiologic profile of the community, including the current epidemic and emerging populations.
- An estimate of the number of people who know they are HIV-positive but are not receiving HIV-related primary medical care (estimate of unmet need).
- An estimate of the number of individuals who are HIV-positive but unaware of their HIV/AIDS status (Early Identification of Individuals with HIV/AIDS estimate).
- The assessed health care needs of the affected population, both in and out of care, including prevention and care needs.
- A description of capacity development needs resulting from disparities in the availability of services in historically underserved communities and rural communities.
- A description of the current response to the epidemic.
- A description of the current continuum of care.
- An inventory of community resources available to PLWHA in the service area (by core and support service categories), both Ryan White and non-Ryan White funded.
- An assessment of provider capacity and capability.
- An assessment of service gaps and barriers to care.
- An evaluation of progress towards the goals and objectives of the existing Comprehensive Plan.

For additional information on needs assessment, please refer to the Needs Assessment Section of this Manual.
Where Do We Need To Go? (What is our vision of an ideal system?)

The purpose of this section is to provide an opportunity for the planning body to discuss the jurisdiction’s vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system. The Early Identification of Individuals with HIV/AIDS (EIHA) initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH, and 3) reducing HIV-related health disparities.

This section of the plan should describe an ideal continuum of care for high-quality core services, and should include:

- **A description of a plan to meet the challenges identified in the evaluation of progress towards the goals and objectives of the existing comprehensive plan**, so that the jurisdiction is better able to meet goals and objectives of the new comprehensive plan.
- **A shared vision of what the planning body would like its system of care to look like.** This description may be an operational definition of the local “continuum of care,” reflecting the specific circumstances and needs of the jurisdiction). This approach makes the “continuum of care” concept a central focus of planning at an early stage.
- **How the jurisdiction will ensure coordinated efforts with other programs**, such as Ryan White services provided through other Ryan White Parts (A, C, D, F), Private Providers (Non-Ryan White funded), Prevention Programs (Partner Notification Initiatives and Prevention with Positive Initiatives), Substance Abuse Treatment Programs/Facilities, STD Programs, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), Community Health Centers.
- **Shared values or guiding principles that shape the HIV-related system of care in the region.** Values may include immediate access to care, high-quality services, integration of HIV/AIDS into the larger health care system, the role of the grantee as the payer of last resort, etc. Goals, objectives, and strategies should be consistent with these values.
- **Proposed program goals** to help address needs and work towards the ideal system of care. Long-term systems, planning, evaluation, and service-related goals provide the foundation for the action plan to implement your comprehensive plan. You may not be able to meet these goals in three years, but your comprehensive plan should lead to towards the goals.

How Will We Get There? (How does our system need to change to assure availability of and accessibility to core services? What steps will we take to develop this ideal system?)

This section of the plan should provide a specific action plan including objectives, strategies, and activities to help reach comprehensive goals and work towards the ideal continuum of care. It may include the following information:
• **Goals and objectives.** The three-year systems, planning, evaluation, and service-related objectives and outcomes that help you work towards your long-term goals. The objectives need to be stated in very specific and measurable terms.

• **Action plan.** These are specific steps—strategies and activities—to undertake in implementing the plan. They should have time frames and responsibilities should be assigned.

When identifying service objectives, aim to strike a balance between addressing the community’s service needs and acknowledging the limited resources likely to be available to meet those needs. Choices may need to be made among competing needs. Comprehensive planning is more like resource allocation than priority setting. The plan should pursue a realistic plan for strengthening the HIV/AIDS care system.

### DEVELOPING OBJECTIVES FOR YOUR LONG-TERM GOALS

<table>
<thead>
<tr>
<th>Sample Long-term Goal.</th>
<th>Service integration</th>
</tr>
</thead>
</table>

**Information Needed to Address Goal.** Which services can be integrated throughout the region? How can providers share information effectively in order to make service integration possible? How would case management approaches need to change in a setting where services are integrated?

<table>
<thead>
<tr>
<th>Sample Short-term Objective.</th>
<th>Ensure the availability of HIV-related primary care that meets Public Health Service Guidelines in all outlying counties.</th>
</tr>
</thead>
</table>

**Information Needed to Address Objective.** What organizations, especially CHCs/FQHCs, currently provide primary care in outlying counties or might be able to expand their services and are interested in providing such services for PLWHA? If no providers are in the county, what are the service delivery options—e.g., a satellite center, mobile clinic, supplemental use of tele-medicine?

What types of information would they need to obtain from other providers in order to provide appropriate services that meet Public Health Service guidelines? What training would be needed if a clinic were to begin HIV-related care?

These questions will need to be answered early in the period covered by the Comprehensive Plan so that the objective can be met. Some should be answered by the planning body, while the grantee will be responsible for contracting with appropriate medical service providers.

**Strategies and Activities for Meeting Objectives:**

- Answer key questions
- Agree on desired service models/strategies
- Provide guidance to the grantee on service models and strategies
- Allocate additional funds if necessary to enable the grantee to carry out procurement to select medical providers for the outlying counties

Table 23: Developing Objectives for Long-Term Goals
ACTION PLAN

An action plan that includes strategies and activities will help achieve stated goals and objectives. Below is one approach to organizing the action plan:

Sample Goal. Increase access to primary medical care.

Sample Accompanying Objective. To offer primary medical care services at non-traditional times.

Strategies

- Arrange for alternative hours of operation by primary care providers.
- Publicize hours and services to ensure increased and appropriate utilization of services.

Activities

- Identify populations that are unable to access care during traditional hours of operation, such as employed PLWHA and caregivers who cannot leave dependents.
- Find out which alternative hours of operation would be most convenient to such consumers.
- Develop a directive to the grantee to require alternative hours of operation.
- Allocate additional resources if required.
- Together with program personnel, explore other strategies to increase access to care (such as increased access to child or dependent care)
- Develop guidelines to help increase utilization of services and reduce barriers to access.

Table 24: Action Plan

How Will We Monitor Our Progress? (How will we evaluate our progress in meeting our short- and long-term goals?)

This section should outline a plan to assess progress in achieving goals and objectives and to update the comprehensive plan. The monitoring and evaluation plan should describe a process for tracking changes in a variety of areas with a focus on improved use of client-level data, and use of performance measures and clinical outcomes such as viral suppression.

Use EIIHA matrix data and treatment cascade data to obtain valuable information about the results of changes in the continuum of care. EIIHA data looks at efforts to identify HIV-positive individuals who are unaware of their status, inform them of their status, and link them to care, and is valuable for assessing comprehensive plan objectives related to testing and linkage to care. A treatment cascade follows groups of PLWHA from diagnosis through entry into care, antiretroviral therapy, and retention in care, and determines viral suppression, and helps assess the overall clinical outcomes of your continuum of care, as well as specific components such as linkage to care, retention in care, and use of treatments. Planning bodies can also use aggregate...
quality management data in their assessment of progress towards comprehensive plan goals and objectives.

The Comprehensive Plan should include specific guidelines for evaluating the decision-making process, the Comprehensive Plan itself, and the quality, costs, and effectiveness of services to be provided or refined as a result of plan implementation.

D. Comprehensive Planning Process

While there is no single approach to comprehensive planning, all planning bodies must develop a planning process and outline planning tasks. The foundation for this is a clear understanding of what the planning body wants to accomplish; the key players or “stakeholders” who should be involved; and how the completed plan will be used.

Generally, sound Ryan White Part B comprehensive planning processes and plans:

- Balance openness and inclusiveness with timely creation of a final product.
- Provide for structured community input, especially from consumers.
- Are developed in a coordinated manner with the SCSN.
- Provide guidance to the planning body in making decisions and developing contingency plans.
- Build upon and are coordinated with the planning body’s needs assessment process.
- Reflect coordination with the planning body’s priority-setting and resource-allocations process.
- Balance service needs with the resources available to meet them.
- Include guidelines to help the planning body self-assess the planning process, and
- Provide for measurement of progress towards comprehensive plan goals and objectives. (e.g., through use of client-level data, performance measures and other evaluation data, and measurement of clinical outcomes).

Steps in the planning process and descriptions for each follow:

- Plan to Plan.
- Data Gathering and Analysis.
- Plan Preparation, Approval, and Dissemination.
- Plan Implementation.

Plan to Plan

During this phase, the responsible planning body’s committee carefully reviews the Comprehensive Plan Guidance from HRSA/HAB and agrees on the objectives, tasks, timelines, and responsibilities for the planning process. The committee is usually a standing committee of the planning body but can also be a special task force including representatives of multiple committees, with unaligned consumers, providers, and grantee representation.
PLWHAs and other community members of the planning body have a vital role to play in helping the planning body obtain community input, including identifying key contacts in the community, organizing community forums, and serving as a liaison with PLWHA caucuses. Their role should be defined at this stage.

The committee determines the planning questions to be posed about the HIV care delivery system in the jurisdiction and the tasks required to generate answers to these questions and prepare the plan. The planning committee develops a plan and criteria for obtaining and analyzing data, makes recommendations to the planning body about a timeline and budget for the planning process, and assigns responsibilities for completing planning tasks. Both planning body and grantee staff play important roles in preparing the plan, and should be closely involved in the plan to plan. Some planning bodies hire consultants to assist with data collection/analysis and preparation of the comprehensive plan, if resources are available.

The plan to plan should provide for key stakeholders to provide input during the planning process and to receive copies of the plan once it is completed. A dissemination plan should be developed during this phase.

It might take three to six months to develop a “plan to plan” (a schedule for major planning activities and tasks), and thus have a clear blueprint for planning.

**Data Gathering and Analysis**

Because the Comprehensive Plan is a guide to help the State/Territory respond to the service needs of PLWHA, these needs first must be identified. Typically, the planning body uses information from its epidemiologic profile and other needs assessment data, as well as grantee cost and utilization data, as inputs to the planning process. If the plan is developed soon after submission of the Ryan White Part B application, recent data can often be obtained from the application, including the data tables.

Existing data—called “secondary data”—such as epidemiologic data, can be obtained from public health agencies and published and unpublished studies. Original data collected by the planning body—called “primary data”—can be gathered through surveys, interviews, focus groups, and other methods.

If needed data have already been collected, they must be reviewed and organized for use in the development of the plan. Sometimes additional information is needed. This means instruments to collect data must be developed and pilot tested, and data gathered. For community input, community meetings or town halls are arranged with the help of the PLWHA committee or caucus, and specific questions developed to generate in-depth input.

The planning committee can collect data with the assistance and input of the grantee, members of the planning committee, needs assessment or other responsible committee, other planning body members, PLWHA committee or caucus, planning body staff, and/or paid consultants who have expertise in this area. If a consultant is hired, the planning body still retains responsibility for the planning process and needs to supervise the work of the consultant and ensure that the
voices of PLWHA are heard. Because the needs assessment will generate much of the needs and services information to be used in the Comprehensive Plan, needs assessment and comprehensive planning committees both benefit from coordinating their efforts.

**Plan Preparation, Approval, and Dissemination**

Once the available data have been gathered and analyzed, it is time to outline and prepare a plan document. The outline should meet all requirements specified in the Comprehensive Plan Guidance and provide a logical framework for the plan. Then the responsible committee should focus on describing an ideal continuum of care and outline possible goals, key objectives, and strategies for working towards that ideal, based on review of all the available information.

Most planning bodies set service priorities and allocate resources on an annual basis. The Comprehensive Plan should provide goals and objectives that guide and are consistent with the annual priority-setting process. When writing the goals and objectives for the plan, the planning body needs to think about needs and resources three years down the road.

The planning body should receive a presentation of key information for the plan, including an overview of the various sections of the plan, especially the sections on the ideal system of care and the plan for getting there. The presentation is usually done in an open meeting to which the public is invited. The planning body has the opportunity to provide input around goals and key strategies and offer other suggestions. The committee then further develops its ideas for the plan, especially the goals and the action plan for implementation.

The draft plan is usually drawn up by staff or consultants, based on these discussions and the decisions of the committee. The committee usually is closely involved in the development of the action plan, approving objectives and activities and deciding who should be responsible for implementing those activities. Responsibilities should be specific – with assignments to specific committees, not just “the planning body or consortia,” and clear timelines provided meeting objectives.

The plan is then reviewed by the planning committee, and revisions are made as needed. The planning body may receive public comments and feedback about the draft plan at public hearings or through other venues such as community meetings, PLWHA caucuses, and provider forums. The draft Comprehensive Plan is also provided to the full planning body for review and comments. The final plan must be approved by the full planning body and usually receives sign-off from the director of the Department of Health and/or the Chief Elected Official (CEO).

Once the plan is completed, the dissemination plan is implemented to ensure that key stakeholders receive copies of the plan and have an opportunity to provide assistance in implementing it. The completed plan can be presented at public hearings or through other venues such as community meetings, PLWHA caucuses, and provider forums.
Plan Implementation

The last and most important phase is to put the plan into action. In the implementation phase, the planning body uses the plan to make decisions about service priorities, service models, resource allocation, and other critical service delivery issues. To ensure implementation, the various activities in the action plan need to be made a part of the annual work plans for the planning body or specific committees, the grantee, or other entities.

The plan should help guide planning bodies to consider services and systems of care in the context of a range of funding sources. By gathering information about existing services and methods of service delivery, the planning process allows the planning body to examine ways to improve coordination and to increase access to care for specific populations, the efficiency of service delivery, and the use of existing funding sources. The plan should prepare the planning body to respond appropriately to changes in the epidemic and to react efficiently to changes in the availability of resources.

A comprehensive plan should cover a three-year period, based on either calendar or program years. However, changes in the epidemic or legislation may render some plans in need of change in a shorter time frame, so a review of goals, objectives, and action plans should occur either annually or more often if significant changes occur in resources or in the external environment.

Implementation requires monitoring the achievement of the plan’s goals and objectives and assessing the effectiveness and quality of services on an ongoing basis.

E. Approaches

Following are some suggestions to help in the development of a comprehensive plan that is sound, appropriate, and supported by key stakeholders.

Community Involvement

The comprehensive planning process needs input from the community, especially consumers of Ryan White services and other PLWHA. Planning bodies cannot plan for PLWHA unless they plan with them. Ensuring broad and meaningful community involvement in the planning process can be a challenge, particularly in rural areas or other communities where PLWHA and their family members are often very reluctant to identify themselves.

Encouraging Community Input to Planning

There are many ways of obtaining community involvement, from separate provider and PLWHA town hall meetings to individual input via telephone or computer. If the jurisdiction has good PLWHA involvement in needs assessment, then it will have less new information gathering to do for the comprehensive plan. However, at a minimum, there should be public meetings and other opportunities for the infected and affected community and for service providers (Ryan White and non-Ryan White) to provide input.
Creative use of incentives can be the key to increasing community participation. For example, providing transportation to meetings may be especially helpful, especially in rural areas where long distances are involved. However, this must be done in the context of the HRSA/HAB policy regarding expense reimbursement. Community resources can be used for other expenses, such as refreshments, gift certificates, and vouchers for services. These incentives may encourage attendance at meetings or focus groups.

**Confidentiality**

In some jurisdictions, especially large metropolitan areas, many PLWHA are publicly disclosed and are comfortable providing input to comprehensive planning in community meetings or other public forums. In other areas, including many smaller communities and rural areas, confidentiality may be a significant concern.

Planning bodies have identified ways to protect confidentiality by enabling PLWHA and their families to provide input without disclosing their names. For example, planning bodies can publicize their interest in receiving input from PLWHA by providing a telephone number that individuals can use to contact entities involved in the planning process without identifying themselves. Similarly, an intermediary group or individual known in the PLWHA community can identify PLWHA and arrange for them to call in for key informant interviews, again without giving their names.

A PLWHA task force that meets through teleconferencing can also provide input to the planning body before it finalizes a plan. Community meetings can be open to anyone interested in HIV/AIDS, not targeted specifically to PLWHA, so attendance does not constitute a public disclosure of HIV status. Input can be obtained from established support groups or other entities whose members are already disclosed to each other. States/Territories need to identify the most appropriate mechanisms for obtaining broad PLWHA input regarding service needs and barriers and how well the current continuum of care is working for consumers.

**F. Planning Committee Issues**

The comprehensive planning process is demanding and requires a diverse group to work together and achieve consensus regarding both the planning process and the final document. If the members of the committee have worked together as planning body members, they may already feel like a team. If not, a group with diverse cultural or social backgrounds, professions, sexual orientation, HIV status, or work styles is likely to need some time to begin working together effectively.

Planning body members may contribute to the planning process in different ways and with varying degrees of intensity. The diversity of the planning body membership can enhance the planning process if appropriate steps are taken to address potential challenges related to member participation. The use of a standing committee that adds members for this task permits interested people to volunteer their participation. This level of choice can help ensure a high level of participation for the group that needs to be most deeply involved. Some tasks can be delegated to other committees to lessen the burden on the planning body as a whole.
Planning bodies should consider the following factors before embarking on the planning process.

**Diversity of the Planning Committee**

The more diverse the planning committee, the more inclusive and representative your planning process. The group should not be limited to members of the planning body. It should include community members who can enhance the expertise of the group, including people with planning experience, expertise in specific topics such as health care reform or the National HIV/AIDS Strategy, consumers with varied backgrounds, and providers and health care professionals.

**Varying Expertise in Group Process and HIV Service Delivery**

Participants working on comprehensive planning bring different levels of education and expertise. There may be participants who have not been involved with HIV-related services for very long or who may be less familiar with committee meeting procedures and Ryan White legislation. PLWHA who have known about their HIV status for several years and serve on the planning body or are provider personnel, on the other hand, may be very familiar with both the planning process and the continuum of care.

If the planning committee consists of a significantly diverse group in terms of expertise and experience, there may be a need for some group process work prior to planning, as well as facilitation and support for members new to the planning process.

Throughout the process, planning committees may have to work with differences of opinion between groups such as providers, HIV-positive members, and individual health care professionals. People who are HIV-positive may emphasize the many immediate needs of PLWHA as they face the disease. Providers may be concerned with establishing a set range of services. Other participants may stress the need to create a methodically planned, well-orchestrated service system that is sustainable in the long run and actively involves non-Ryan White providers and non-HIV-specific services.

All of these perspectives can contribute to developing a realistic and effective comprehensive plan to guide the planning body. The planning committee leadership needs to integrate all these perspectives and voices into the final product and establish an effective planning team. This means establishing and enforcing ground rules, maintaining an environment of mutual respect in which all members listen to the opinions of others, and all recognize that their responsibility is to develop a plan that meets the needs of all PLWHA that depend on Ryan White for services.

**Special Needs of PLWHA**

The effectiveness of current HIV medications means that many PLWHA will be in good health. However, some PLWHA members may not have the same amount of physical energy as other planning committee members. Planning bodies need to consider this factor when they arrange meetings, set deadlines, and assign responsibilities. Reaching consensus at the beginning on roles and expectations for all participants can help avoid unrealistic expectations or misunderstandings.
later on. The planning body should provide ample opportunities for PLWHA to contribute to the planning process within the physical and psychological constraints the disease imposes on them. Those unable to serve on the planning committee should be offered opportunities to provide input through town hall meetings or participate in key review sessions.

**Maximizing Planning Resources**

Planning bodies must find ways to maximize resources for comprehensive planning. The possibility of sharing some costs with other planning bodies, Ryan White Parts, and HIV-related efforts in the region or State should be explored. For instance, in some cases, the State develops an epidemiologic profile that the planning body can use for planning.

Planning bodies may also be able to share the cost and effort of developing an epidemiologic profile with the HIV Prevention Planning Group (PPG). The profile can be used by the local planning body and the State Ryan White Part B program and may be useful to other Ryan White grantees as well.

Some States have already combined comprehensive planning for prevention and care, and are producing combined or closely linked plans. This enables them to respond to the interrelated goals of the National HIV/AIDS Strategy, the 2009 Ryan White legislative requirements around EIIHA, ECHPP, and the national prevention strategy announced in 2011 that emphasizes high-impact prevention, large-scale testing and prevention for positives. There is a growing overlap in roles between prevention and care, enhanced by a growing focus on “treatment as prevention.” Getting PLWHA into care and onto anti-retroviral therapy as quickly as possible after diagnosis has been shown not only to improve their clinical outcomes, but also to prevent HIV transmission. Shared comprehensive plans can be both cost-effective and beneficial in contributing to coordination of resources and services.

Planning bodies need not “start from scratch” when designing a comprehensive planning process. Much information is available about other State/Consortia methods and their successes and shortcomings. Many States have websites that include copies of their most current Comprehensive Plan available as a resource. Reports and survey instruments from other planning bodies are available on the TARGET Center website (http://www.careacttarget.org), and requests for technical assistance may be made to HRSA/HAB. Planning bodies do not learn how to plan in a few weeks. The best ways to learn are by developing a plan and by learning from others with more experience.

States can support comprehensive planning by developing suggested comprehensive planning processes and formats, providing training sessions on comprehensive planning, bringing Part A planning councils and Ryan White Part B consortia together to jointly address comprehensive planning responsibilities and needs, and encouraging coordinated efforts involving multiple planning bodies.

Grantees can assist planning bodies in obtaining epidemiologic data and support coordinated needs assessment and comprehensive planning activities that ensure the availability of the information needed to conduct effective planning. Often, much of the epidemiologic and needs
assessment data needed for the Comprehensive Plan have already been developed and used for priority setting and resource allocations, and for the Ryan White Part B application to HRSA/HAB. To fill information gaps, the grantee may also be able to provide the services of a planner or person skilled in data analysis who can help planning body members make sound planning decisions. Such individuals may be available within State or local agencies or at universities.

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<th>TIPS</th>
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<td>Keep the following in mind when developing comprehensive plans:</td>
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- **Don’t re-invent the wheel.** There is a lot to be learned from the successes and shortcomings of other States and EMAs/TGAs. Many assessments have been done around the country and related assistance has been provided through the Ryan White Technical Assistance Contract. Look for sample comprehensive plans and tools on the TARGET Center website (http://www.careacttarget.org) or consult with your HAB/DSHAP Project Officer. Use data already collected and analyzed in your needs assessment. Collect new information only if specifically needed for the plan.
- **Pool resources.** Think about what costs can be shared with other HIV-related efforts in your community or State.
- **Collaborate.** Work with other Ryan White programs and other local and State HIV planning institutions.
- **Allow extra time in rural areas.** Distance and confidentiality issues may present additional challenges in obtaining community input in rural areas.

**Table 25: EMG/TGA Planning TIPS**

**X. Ch 13. Statewide Coordinated Statement of Need**

**A. Introduction**

The purpose of the Statewide Coordinated Statement of Need (SCSN) is to provide a collaborative mechanism to identify and address significant HIV/AIDS care issues related to the needs of PLWHA, and to maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program Parts (A, B, C, D, and F). In addition, the SCSN process is expected to result in a document that reflects the input and approval of all Ryan White HIV/AIDS Program Parts. The State Ryan White Part B program is responsible for coordinating the SCSN, but all Parts and grantees are expected to participate.

An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status. The early intervention of individuals living with HIV/AIDS (EIHA) Initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH, and 3) reducing HIV-related health disparities.
Requirements and instructions for developing and submitting the updated SCSN are provided by HRSA/HAB every three years to Ryan White HIV/AIDS Program Ryan White Part B Grantees.

B. HAB/DSHAP Expectations

Purpose

The Division of State HIV/AIDS Programs requires Ryan White Part B grantees to submit an updated Statewide Coordinated Statement of Need (SCSN) every three years. The purpose of the SCSN is to provide a collaborative mechanism to identify and address the most significant HIV needs of PLWHA and to maximize coordination, integration, and effective linkages across all Ryan White HIV/AIDS Program Parts (A, B, C, D, and F). The SCSN process is expected to result in a document that reflects the input and approval of all Ryan White HIV/AIDS program Parts.

The Health Resources and Services Administration (HRSA) strongly encourages grantees to use the SCSN to support statewide HIV planning. This may include using the goals outlined in the SCSN to set measurable objectives, inform resource allocation decisions, create a statewide plan, as well as conduct other activities to enhance HIV care and service delivery statewide. The SCSN cannot supplant local needs assessment, planning, and priority setting processes.

The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH, and 3) reducing HIV-related health disparities.

Planning

HRSA encourages its grantees to use the SCSN to support HIV planning statewide. This may include using the goals outlined in the SCSN to set out measurable objectives, inform resource allocation decisions, create a statewide plan, or any other activity that would enhance HIV care and service delivery statewide. The SCSN is not intended to supplant local needs assessment, planning, and priority setting processes.

The SCSN is a collaborative process and must be developed with input from all Ryan White HIV/AIDS Programs Parts. The Ryan White Part B grantee is responsible for periodically convening a meeting for the purpose of developing a SCSN. All Ryan White Parts are equally responsible for the development of the process, participation in the process, and the development and approval of a SCSN. The mechanism for developing a SCSN can be a statewide meeting or may be some other locally developed process.

Definition

The Statewide Coordinated Statement of Need (SCSN) is a written statement of need developed through a locally chosen collaborative process with other Parts of the Ryan White HIV/AIDS Program. The SCSN must reflect, without replicating, a discussion of existing needs assessments.
and should include a brief overview of epidemiologic data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV/AIDS care and service delivery in the State. Important elements in assessing need include a determination of the population with HIV who are aware of their status but not in care (unmet need), individuals who are unaware of their HIV positive status, a comprehensive understanding of primary care and treatment in the State, and a consideration of all available resources.

The SCSN process should consider all Ryan White HIV/AIDS Program resources in the State, both the amount of funds and what services the funds are supporting. Where possible, the value of non-Ryan White HIV/AIDS Program resources in the State should be considered in determining need. The SCSN must identify broad goals and critical gaps in life-extending care needed by PLWHA both in and out of care.

In developing a SCSN, States are expected to use needs assessments and comprehensive plans completed by other Parts of the Ryan White HIV/AIDS Program in an effort to identify cross-cutting issues in the State. The cross-cutting issues and goals identified by this process will form the basis of the SCSN. The issues and goals identified in the SCSN should not be prioritized, but assessed equally. Some examples of cross-cutting issues and/or broad goals may include access to medications, increasing the number and percentage of cervical cancer screenings provided to women living with HIV/AIDS, developing and evaluating a clinical quality management program, and decreasing unmet need.

Contents of the SCSN

At a minimum, the SCSN should contain:

- The most recent State HIV/AIDS epidemiology profile.
- A description of the process used to develop the SCSN.
- A list of participants in the process.
- A description of identified gaps and/or overlaps in services.
- A description of the needs of individuals who are unaware of their HIV status.
- A list of priorities identified, including addressing Unmet Need and gaps in Core Medical Services.
- A description of priorities addressing identified barriers to care for underserved populations in the State.

For additional information on HIV care, access and services through the Ryan White Program, please refer to the HIV Service Delivery System Section of this Manual.

**Relationship to the Comprehensive Plan.** The Comprehensive Plan must be compatible with existing State and local service plans including and in particular the Statewide Coordinated Statement of Need (SCSN). The SCSN is updated every three years, often at the same time comprehensive planning is occurring. For additional information on the Comprehensive Plan, please refer to the Comprehensive Plan Section and the Coordination between Parts, Payers and Programs Section of this Manual.
Process

The Ryan White HIV/AIDS Program assigns Ryan White Part B Grantees the responsibility for periodically convening a meeting for the purpose of developing a SCSN and submitting the SCSN to HRSA/HAB, Division of State HIV/AIDS Programs. However, HRSA views all Ryan White HIV/AIDS Program Parts equally responsible for the development of the process, their organization’s participation, and the development and approval of a collaborative SCSN. The mechanism for developing the SCSN can be a series of statewide meetings, meetings organized based on epidemiologic data or some other locally developed process, as long as the criteria meets HAB/DSHAP requirements. The mechanism must ensure participation of all other Parts (A, B, C, D, and F).

Participation in the Development of the SCSN

The SCSN must be developed with input from: (1) representatives of all Ryan White HIV/AIDS Programs, including administrators of the AIDS Education and Training Centers, the Dental Reimbursement Program and Special Projects of National Significance Demonstration Grants operating in the State; (2) PLWHAs; (3) members of a federally recognized Indian tribe as represented in the State; (4) providers; and (5) public agency representatives. Part A representation should include grantee and Planning Council representatives. Ryan White Part B should include Consortia, direct care providers, and grantee administrators. In cases where there are multiple grantees from a Ryan White HIV/AIDS Program, such as a State with multiple Part C programs, the State in concert with those grantees, should determine a mechanism of representation allowing a variety of interests and views to be fairly represented in the SCSN process.

For the purpose of this guidance “provider” is defined as any individual or institution either receiving Ryan White HIV/AIDS Program funds or generally involved in the provision of health care and/or support services to PLWHA.

In addition to Ryan White HIV/AIDS Program representation, States are also encouraged to include representation from other major providers or funders of services needed by PLWHA such as substance abuse, mental health, Medicaid, Medicare, Community Health Centers, Veteran’s Administration, HIV prevention, as well as other entities that may be appropriate for developing a coordinated strategy to link newly identified PLWHA to appropriate health and support services.

Special Considerations

Part A – In instances where the eligible metropolitan area (EMA) or transitional grant area (TGA) crosses a State border, the Part A applicant will be given the option to use the SCSN that most appropriately applies to their population based on the epidemiological profile of that area.

Ryan White Part B – States with only Ryan White Part B funds will be required to develop a SCSN with participation from PLWHA, providers, and public agency representatives such as
State Medicaid Officials and Officials from local public health agencies. The final document should reflect efforts made to meet new legislative requirements.

**Funding for the SCSN Process**

The use of Ryan White funds to assure participation in the SCSN must be consistent with each individual program’s requirements with regard to program expenditures.

**Timetable**

The SCSN should be reviewed and updated at least every three years and submitted to HRSA.

**SCSN Review**

HAB reviews each SCSN submitted and provides comments back to the Ryan White Part B grantee. Review of the SCSN allows HAB/DSHAP to identify cross-cutting issues across jurisdictions.

**X. Ch 14. References, Links, and Resources**


**For More Information**

Please refer to the HAB Target Center at [https://careacttarget.org](https://careacttarget.org).
Section XI. Consortia

XI. Ch 1. Overview

The Ryan White HIV/AIDS Program Ryan White Part B has five program areas under which States can deliver HIV/AIDS care as mandated under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and earlier reauthorizations. These programs reflect the importance Congress has given to the differences between States and how each State needs flexibility in responding to unique issues and needs within their jurisdictions. The five programs identified under Section 2612 are:

1. Services Provided Directly by States or State Contracts
2. HIV Care Consortia
3. Home- and Community-based Services
4. Health Insurance Coverage
5. Provision of Treatments

If a State chooses to implement a consortia model for planning, the following information is relevant:

The consortia is an association of public and nonprofit health care and support service providers as well as concerned community members that develops plans for and may, in some cases, deliver services for Persons Living with HIV/AIDS in areas receiving Ryan White Part B funding. Some consortia act as fiduciary entities that not only plan for local and regional services, but also contract with providers to deliver such services.

The role of the Ryan White Part B consortia varies but many engage in medical care planning and establishment of primary medical care service delivery system in an effort to improve the quality, availability, and organization of medical care and support services to individuals infected with HIV and their families. As a funded service provider, consortia, as defined in the legislation, can provide essential support services as defined in the current Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), Section 2613. All services provided or contracted through consortia are considered support services and must be counted as part of the maximum 25% of service dollars that may be expended for such services.

Regional and Statewide Ryan White Part B consortia vary in size and composition of regions served. For example, the service area may include a single county, a metropolitan area, or a large multi-county area.

In making these consortia work effectively, the Ryan White HIV/AIDS Program establishes basic duties of Ryan White Part B grantees and consortia, as well as lead agencies that administer consortia. Many States have developed their Ryan White Part B consortia structures and relationships based on experience gained since the Ryan White HIV/AIDS Program was established in 1990. There is no single structure or division of responsibilities that all consortia must use. Rather, they are guided by the legislation, State policies and guidelines, HAB, Division of State HIV/AIDS Programs guidance, the unique characteristics of a State, the epidemic as it...
affects a State or region, and sound practice (e.g., efficient and effective service delivery, program management, flexibility, regular oversight, and open communication within and across States).

XI. Ch 2. Legislative Background

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 and subsequent reauthorizations have specified the role and responsibilities of Consortia as part of a comprehensive system of medical, therapeutic, and supportive service delivery system. The changes over the years have added provisions related to comprehensive planning and who participates in the consortia planning bodies. The current Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides the current specifies responsibilities of Ryan White Part B consortia in terms of services, consortia duties, and composition of consortia, under the following provisions:

Section 2613(a) describes consortia as “an association of one or more public, and one or more nonprofit private, (or private for-profit providers or organizations if such entities are the only available providers of quality HIV care in the area) health care and support service providers and community based organizations operating within areas determined by the State to be most affected by HIV disease.” Consortia have service planning, development, and delivery responsibilities that can be provided directly or through agreements with other entities. Specific services that may be provided by consortia include comprehensive outpatient health and support services for individuals with HIV disease as described in Section 2613(a)(2)(A) as follows:

“(A) essential health services such as case management services, medical, nursing, substance abuse treatment, mental health treatment, and dental care, diagnostics, monitoring, prophylactic treatment for opportunistic infections, treatment education to take place in the context of health care delivery, and medical follow-up services, mental health, developmental, and rehabilitation services, home health and hospice care; and

(B) essential support services such as transportation services, attendant care, homemaker services, day or respite care, benefits advocacy, advocacy services provided through public and nonprofit private entities, and services that are incidental to the provision of health care services for individuals with HIV disease including nutrition services, housing referral services, and child welfare and family services (including foster care and adoption services).”

Section 2617(f) defines expenditures of consortia services as support services and not core services but does not limit the provision of core services as described below:

“(f) Allocation of Funds; Treatment as Support Services- For purposes of the requirement of section 2612(b)(1), expenditures of grants under section 2611 for or through consortia under this section are deemed to be support services, not core medical services. The preceding sentence may not be construed as having any legal effect on the provisions of subsection (a) that relate to authorized expenditures of the grant.”

Under Section 2613(b), consortia must, as the single coordinating entity, provide the State with certain assurances related to its serving underserved populations of individuals and families with HIV disease and establishing a service plan consistent with the State’s comprehensive plan under 2617(b)(4). The legislation does include an exception to the single coordinating entity provision where subpopulations exist with unique service requirements that cannot be adequately and efficiently addressed by a single consortium serving the entire community or locality.

Consortia must assure representation in their membership as described under 2613(c) to include agencies and community-based organization with a record of service to populations and subpopulations with HIV disease requiring care within the community to be served; and that are representative of populations and subpopulations reflecting the local incidence of HIV and that are located in areas in which such populations reside.

Under Section 2613(c) planning activities and responsibilities through consortia must demonstrate that the consortium has carried out an assessment of service needs within the geographic area to be served and that the assessment of service needs and the planning of the delivery of services will include participation by individuals with HIV disease. Consortia must also demonstrate that they have created a mechanism to evaluate periodically their success of the consortium in responding to identified needs; and the cost-effectiveness of the mechanisms employed by them in delivering comprehensive care;

XI. Ch 3. Consortia Services

The Ryan White HIV/AIDS Program enables—but no longer requires—States to use Ryan White Part B funds to support HIV care consortia within areas most affected by HIV disease and to provide a comprehensive continuum of care to individuals and families with HIV disease. (Prior to the 1996 Ryan White HIV/AIDS Program amendments, States with more than one percent of total national AIDS cases were required to use at least 50 percent of their award to fund consortia.) Under the amended Act, the grantee may do the following:

- Fund consortia to provide support services within areas determined by the State to be most affected by HIV disease, or
- When justified, use Ryan White Part B funds to directly plan, develop, and deliver such services.

Section 2613 of the Ryan White HIV/AIDS Treatment Extension Act of 2009 specifies the following categories of services, which may be provided through consortia or directly by the grantee:

- Essential health services such as case management services, medical nursing, substance abuse treatment, mental health treatment, dental care diagnostics, monitoring, prophylactic treatment for opportunistic infections, treatment education to take place in the context of health care delivery, medical follow-up services, mental health, developmental and rehabilitation services, and home health and hospice care.
Essential support services such as transportation services, attendant care, homemaker services, day or respite care, benefits advocacy, and advocacy services provided through public and nonprofit private entities, and services that are incidental to the provision of health care services for individuals with HIV disease including nutrition services, housing referral services, and child welfare and family services (including foster care and adoption services).

In States with established consortia, the consortia usually contract for or deliver these services, but the State may provide services directly if it can demonstrate that other delivery mechanisms would be more effective. In making such a determination, the State is required to consult with representatives of service providers and with service recipients who would be affected by such a decision, and to report the findings of this consultation to HAB/Division of State HIV/AIDS Programs, as stated in the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2612. The responsibility for monitoring of sub-grantees/provider and other agencies needs to be agreed upon with the State.

XI. Ch 4. Consortia Duties

A Ryan White Part B consortium typically fulfills both the responsibilities specified in the legislation and additional roles that may be specified by the State or may be agreed upon by the consortium membership based on its stated purposes and priorities. The roles and activities required of a consortium depend upon the responsibilities delegated to it by the State, its structure and service area characteristics, and its funding level. Effective and efficient operations—“sound practice”—may require roles additional to those specified in the legislation or required by a grantee. Some functions may not be feasible in a very rural State or an area with a very limited network of service providers. A consortium should carefully consider roles and responsibilities such as the following:

Planning and Decision Making Procedures

- Develop and consistently enforce effective and clearly explained policies and procedures for managing conflicts of interest. Members must especially be aware of the potential for conflict of interest when consortia are responsible for procurement, and when a large proportion of consortium members are funded Ryan White Part B providers.
- Establish grievance procedures.

Priority Setting

- Complete an annual priority-setting process that weighs needs against available resources and informs the resource allocation process.

Other Planning-Related Tasks

- Establish mechanisms for collaboration among all HIV care and prevention agencies.
- As directed by the State Part B program, serve as an umbrella for HIV/AIDS planning in the community.
- Develop resources to obtain additional sources of funding, both public and private.
- Develop initiatives to educate the community about treatment for HIV disease, and advocate for enhanced HIV-related health care and support.
- Take a leadership role in assessment and evaluation of service quality, unit costs, effectiveness, and administrative efficiency, in cooperation with providers, the lead agency, and the grantee.
- Provide management and support services to service providers. Consortia may choose to assume responsibility for providing or coordinating capacity-building assistance in organizational management and service delivery.
- Provide advisory services to local government agencies, to encourage attention to HIV/AIDS issues and coordination and collaboration with Ryan White Part B services.

## GRANTEE DUTIES

### Planning, Management, and Coordination

In addition to providing services, the grantee has legislated planning, management, and coordination responsibilities. Among the most important are the following (the first two are often carried out in partnership with regional consortia):

- Develop a local comprehensive plan for Ryan White Part B-funded services and conduct public hearings concerning the intended use and distribution of Ryan White Part B funds.
- Provide for program assessment—a periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State.
- Coordinate the development of a Statewide Coordinated Statement of Need (SCSN) by ensuring that the public health agency administering the grant for the State periodically convenes a meeting of PLWH, representatives of grantees under each part of this title, providers, and public agency representatives for this purpose.
- Develop a Statewide Comprehensive Plan.
- Oversight and Monitoring as defined in the National Monitoring Standards (NMS).

### Grantee Assurances

The grantee must ensure that HIV-related health care and support services funded partly or entirely through Ryan White Part B funds are provided in settings that are accessible to low-income PLWH and are offered regardless of a client’s ability to pay or current or past health condition.

<table>
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<th>Table 26: Grantee Duties</th>
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### Service Delivery

- Establish service standards. Consortia may develop service or quality of care standards for their providers, and may choose to use-or have their lead agencies use-these standards as criteria for selecting providers/contractors.
- Where a continuum of care does not exist, directly provide essential services to PLWH and their families.
Lead Agency Duties

Lead agency roles relate to managing Ryan White Part B funds, not only for the consortium’s own planning and administration but also for the provision of primary care and support services for PLWH. In addition, lead agencies may have monitoring and oversight responsibilities in coordination with the consortium and the State and as defined in the NMS.

The Ryan White HIV/AIDS Program does not require the existence of a separate lead agency or fiscal agent for a consortium. All the roles and responsibilities carried out by lead agencies may be carried out directly by consortia.

In addition, because providers that receive-or would like to obtain-Ryan White Part B funding are often a major segment of the consortium membership, the potential for conflict of interest is especially great when consortia are directly involved in procurement. The Ryan White HIV/AIDS Program does not directly address this issue with regard to consortia unless they are merged with Part A planning councils, which are not permitted to do procurement. Consortia are expected to have policies that address conflict of interest, and many consortium service areas have a separate lead agency to fulfill the procurement function; sometimes the grantee requires a separate lead agency.

The lead agency may be a public agency, service provider, or some other kind of nonprofit organization. A for-profit entity may serve as lead agency only where a service area includes no nonprofit organization capable of serving as lead agency.

In some States, the consortium contracts with the lead agency through a written agreement or contract to carry out specific duties on its behalf. In other States, the grantee designates the responsibilities of the lead agencies and contracts directly with them.
**PART B CONSORTIA AND LEAD AGENCIES**

The duties of Ryan White Part B consortia and lead agencies depend upon the Ryan White Part B structure within a given State. A variety of structures and models are in use across the country. Some models include the following:

- **No consortia** – grantee does all planning and serves as lead or fiscal agent, or convenes an advisory group involved only in planning.
- **One Statewide consortium** – consortium serves as the planning body for the grantee, which retains responsibility as lead or fiscal agent. Unincorporated regional consortia – consortia serve as planning bodies but have no fiscal agent responsibilities – these remain with the State or are contracted to a lead agency, such as regional or local offices of the State health department, local health department or other public agency, a university, a foundation, an AIDS service provider, or some other local nonprofit organization.
- **Incorporated consortia** – consortia responsible for planning and serving as their own lead agency.

Sometimes a consortium is part of a combined structure with another Ryan White HIV/AIDS Program planning body such as a Part A planning council, or with an HIV Prevention Community Planning Group. This may mean that a local health department or some other agency of local government serves as the lead or fiscal agent.

Table 27: Part B Consortia and Lead Agencies

The following duties are often assigned to the lead agency:

- **Procurement.** This includes developing and implementing a competitive and/or sole source bidding process for selecting subcontractors, developing subcontract agreements, and signing subcontracts with providers and consultants.
- **Staff support to the consortium.** This may include employing, supervising, and providing office space for consortium staff, or assigning lead agency staff to support consortium functions. It may also include administrative tasks such as maintaining consortium files, organizing consortium mailings, and arranging consortium meetings.
- **Fiscal management.** This includes such tasks as establishing a bank account; receiving, checking, and paying invoices from subcontractors; invoicing the State and other funders; reimbursing subcontractors; and, submitting financial reports to the consortium and the State.
- **Subcontract management.** This includes such tasks as developing program and fiscal report formats for subcontractors, ensuring that subcontractors collect and report Ryan White Services Report and other applicable provider data (e.g. Minority Health Initiative data report) through the Electronic Handbooks (EHBs), monitoring and evaluating the work of providers and other subcontractors, modifying and terminating contracts based on approved standards and requirements, and ensuring that subcontractors have client grievance procedures.
- **Monitoring and Oversight.** This includes routine and periodic site visits, at least annually, for compliance with program and fiscal requirements as well the issuance of compliance reports and provision of technical assistance in accordance with the NMS. In this role, the lead agency may interact both with the consortium and the State.
• **Establishment and implementation of conflict of interest and grievance procedures.** This includes preventing conflict of interest in procurement and providing grievance procedures that address the procurement and contract management process.

• **Reporting.** This includes preparation and submission of regular programmatic and financial reports to the consortium, the State, and other funders.

• **Resource development.** This may include a major role in preparing the consortium’s Ryan White Part B funding application to the State and the preparation of other funding proposals to public or private funding sources. Such resource development (for example, monitoring and oversight) may be independent of Ryan White Part B activities.

Some lead agencies are also HIV disease service providers. Lead agencies may also provide direct Ryan White Part B services. However, some grantees and consortia require that lead agencies not receive Ryan White Part B funds for direct service provision, to avoid the potential for conflict of interest in the procurement process. If a lead agency is also a Ryan White Part B-funded provider, the grantee and consortium should require that procedures be established and implemented to manage conflict of interest in the procurement and contract management process.

Whether the grantee or the consortium is the decision maker, the determination of which duties should be contracted to a lead agency requires careful consideration. Factors to consider include:

- State procurement regulations.
- Legal status of the consortium.
- Whether the consortium has sufficient funds to hire full-time staff.
- Composition of the consortium’s membership.
- Frequency with which the consortium meets.
- Consortium’s capacity to maintain active committees to share the workload.
- Consortium’s ability to address issues such as conflict of interest and grievances.

Generally, the more limited the financial and human resources available to the consortium, the greater the need for a staffed lead agency. Selection of a lead agency separate from the consortium also depends on the availability of a credible, appropriate, and willing entity, with strong fiscal and administrative management capacity and an ability to manage and minimize conflict of interest, particularly in the procurement process.

**XI. Ch 5. Grantee, Consortia, and Lead Agencies: Relationships**

**The Grantee and Its Consortia**

Consortia are responsible to the State Ryan White Part B grantee. The grantee typically determines whether there will be consortia, and if so, specifies their geographic boundaries and responsibilities. The State decisions regarding consortia may include the following:
The State may decide whether consortia should operate independently or be merged with Part A-eligible metropolitan areas (EMAs) in States that have Part A EMAs, or with HIV Prevention Community Planning Groups.

The State may decide what funds consortia are to plan for and allocate: only Ryan White Part B funds or other State or Federal funds, such as Housing Opportunities for People with AIDS (HOPWA) funds or State HIV/AIDS funds.

The State may decide whether consortia will serve as decision makers with respect to the allocation of Ryan White Part B funds in their geographic area, or serve as planning and advisory entities, perhaps setting service priorities and recommending them to the grantee, which makes final decisions regarding the allocation of Ryan White Part B funds and serves as the fiscal agent, responsible for procurement and subcontract management.

The State may decide whether a consortium is permitted to serve as its own lead agency.

The State may establish any requirements regarding consortium leadership or operating procedures.

The State may define proper lines of communication. When a consortium has employees, it is important to clarify lines of communication among staff, chair, or co-chairs, and the grantee. The grantee often considers staff the first point of contact.

Coordination between Part A planning councils and local Ryan White Part B consortia, and inclusion of consortium representation among the planning council’s membership. DHS does not require that the planning council and consortium serving the same region merge into a single entity, but does encourage the respective bodies and grantees to consider this option along with other forms of coordination.

The Consortium and Its Lead Agency

Where the Ryan White Part B structure includes a consortium and a separate lead agency, the success of program planning and implementation at the local level depends to a considerable degree upon the relationship between these two entities. Experience demonstrates the importance of clearly defined and regularly monitored relationships. The different roles and shared responsibilities of consortia and lead agencies are charted in the Attachment at the end of this chapter.

To avoid overlap, perceived or actual conflict of interest, and inefficiencies due to role confusion, it is important to ensure careful definition and deliberate separation of at least certain key functions, such as financial decision making and fiscal management. To ensure appropriate separation, some grantees and/or consortia may bar lead agency staff from serving as voting members, board members, officers, or members of certain committees.

The consortium and the lead agency need a written memorandum of understanding that defines their working relationship. The following should be included in the memorandum of understanding:

- Clear written specification of responsibilities and tasks assigned to each entity, with special clarity regarding shared responsibilities.
- Applicable State procurement policies.
• An ongoing system of checks and balances using mutual reviews and discussion.
• Appropriate oversight (and in some States, periodic evaluation) of the lead agency by the consortium, including whether the lead agency adheres to priorities established by the consortium.
• Clarity regarding the relationship of each entity to the grantee.

The grantee should provide oversight of lead agency policies, procedures, and performance, with emphasis on procurement, subcontract management, grievance policies and procedures, and conflict of interest management, as well as periodic evaluation of the lead agency.

**The Grantee, Consortia, and Lead Agencies**

States differ in their formal and informal relationships with consortia and lead agencies, and in their points of contact within the consortia. These relationships are determined by factors including the State’s consortium and lead agency structure, the level of resources at the grantee and consortium levels, whether consortia have paid staff, and the number of consortia in the State.

In many States, the grantee emphasizes the importance of frequent and direct communication between consortia, lead agencies, and grantee. However, the demands on staff created by frequent direct contact with many consortia can lead some States to seek ways to reduce or manage direct contacts. Grantees may expect to receive reports and to address administrative and fiscal matters directly with the lead agency.

It is important for grantees, consortia, and lead agencies to share a common understanding of expected lines of communication and reporting. For example, there should be explicit agreement on the following:

• Desired lines of communication between the grantee and its consortia and lead agencies, including whether the grantee expects to deal directly with both entities and on what issues.
• Reporting requirements, including what kinds of written information will be provided directly to the grantee from the lead agency and what information must be submitted to or through the consortium.
• Points of communication-chairs versus staff of consortia, and when and under what conditions the State will talk to individual consortium members other than chairs or co-chairs and/or to funded providers.
### ATTACHMENT: Lead Agency and Consortium Roles

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<thead>
<tr>
<th>CONSORTIUM</th>
<th>LEAD AGENCY</th>
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<tr>
<td>Needs Assessment (assess both needs and resources)</td>
<td>Implementation</td>
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<tr>
<td>Prioritize Gaps</td>
<td>Contracts</td>
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<tr>
<td>Comprehensive Planning</td>
<td>Fiduciary</td>
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<tr>
<td>• Where are we?</td>
<td>Procurement of Services</td>
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<tr>
<td>• Where do we want to go?</td>
<td>• Write / issue RFP</td>
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<tr>
<td>• How do we get there?</td>
<td>Staff Support - Consortium</td>
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<tr>
<td>• Did we get there?</td>
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<tr>
<td>Evaluation</td>
<td>Fiscal Management</td>
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<tr>
<td>• Evaluate process</td>
<td>Subcontract Management</td>
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<tr>
<td>Evaluation</td>
<td>Reporting</td>
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<tr>
<td>Consortium and Lead Agency Collaborate to Evaluate:</td>
<td>Resource Development</td>
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<tr>
<td>• Cost Effectiveness</td>
<td>Contract Monitoring</td>
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<tr>
<td>• Efficacy of Meeting Need</td>
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<td>• HRSA Ryan White Part B Requires that Consortia Evaluate:</td>
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<td>• Cost Effectiveness of Service Delivery Mechanism</td>
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<td>• HRSA Recommends Evaluation of:</td>
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<td>• Quality of Service</td>
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<td>• Consortium Process</td>
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<td>• Consortium Cost Effectiveness</td>
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Table 28: Attachment: Lead Agency and Consortium Roles

#### XI. Ch 6. References, Links, and Resources

For More Information

Please refer to the HAB Target Center at https://careacttarget.org.
Section XII. Coordination Between Parts and Programs

XII. Ch 1. Overview

Ryan White Part B program planning efforts should be coordinated with all other public funding for HIV/AIDS to ensure that Ryan White HIV/AIDS Program funds are the payer of last resort; maximize the number and accessibility of services available; and reduce any duplication of services. For Ryan White HIV/AIDS Programs, the goal of coordination is to enhance access to a range of services in order to both achieve better client health outcomes and use Ryan White resources wisely. Coordination within the Ryan White community occurs through specific efforts of grantees to work together, such as the collaborative planning process to develop the Statewide Coordinated Statement of Need (SCSN) which includes input from all Ryan White HIV/AIDS Program Parts.

The Ryan White legislation contains requirements for coordination with all Ryan White Parts (A, B, C, D, and F) and non-Ryan White programs and payers from multiple sectors. Driving these requirements is not only the funding represented by these entities but also the potential to coordinate planning and service delivery. The anticipated outcome is better services for PLWHA with complex care demands, such as substance abusers and PLWHA who are not in care.

Among the non-Ryan White programs where coordination is required are Medicaid and Medicare. Both are much larger public sources of funding than Ryan White. Others—defined by their services as well as their payer status—include Veterans Affairs, substance abuse prevention and treatment services (funded extensively through State block grants and other public and private mechanisms), maternal and child health care, and HIV prevention. The latter includes Centers for Disease Control and Prevention (CDC) HIV prevention. CDC also funds outreach and early intervention services, both of which are also fundable under Ryan White but distinguishable because Ryan White must target PLWHA.

Private health insurance is yet another payer that has great potential to cover some of the service needs of Ryan White clients. Although many Ryan White primary care clients do not have private health insurance, mechanisms such as health insurance continuity payments and risk pools are potential payers of care. The Patient Protection and Affordable Care Act (ACA), signed into law in 2010 (Public Law 111-148), aims to expand access to affordable health coverage and reduce the number of uninsured Americans.

Coordination—with both programs and payers—can occur in the following areas:

1) Planning. Coordination in Ryan White planning involves consideration of other programs in such areas as assessment of needs, priority setting, and resource allocation. Required representation of other Federal programs on planning councils is designed to ensure their participation in Part A planning. To illustrate, needs assessments should determine existing resources, regardless of funding stream, as part of efforts to identify areas of unmet need. In setting priorities, other resources must be considered in terms of how they help meet service demands so that Ryan White resources can be used to fill gaps.
2) Funding of Services. Ryan White grantees, including Part A programs, are required to coordinate their services and seek payment from other sources before Ryan White funds are used. This makes the Ryan White HIV/AIDS Program the “payer of last resort,” meaning that funds are to fill gaps in care not covered by other resources. Major payers include, for example, Medicaid, Medicare, the Children’s Health Insurance Program (CHIP), and private health insurance.

3) Service Delivery. Ryan White requires coordination with specific services (i.e., outreach, substance abuse prevention and treatment, HIV counseling and testing, and early intervention services). Many are funded by other Federal, State, and local sources. For example, HIV prevention is funded through the CDC, while State substance abuse programs are supported partially through block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA).

XII. Ch 2. Legislative Background

Participation in Public Planning Processes

Planning body requirements for States are outlined in Section 2617(b)(6) and (7). States and territories are required to engage in “a public advisory planning process” to secure broad input in the development and implementation of the comprehensive plan from grantees under each Part, PLWHAs, federally recognized Indian tribes as represented in the State, providers, and public agency representatives, and other agencies, similar to those outlined for Part A planning councils in Section 2602(b)(2).

“(b) DESCRIPTION OF INTENDED USES AND AGREEMENTS.—The application submitted under subsection (a) shall contain—”

“(6) an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need;

(7) an assurance by the State that—

(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (6), and the types of entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (5) and commenting on the implementation of such plan;”

Consortia

Ryan White Part B planning body requirements are also outlined for consortia. Section 2613(c)(1) requires the consortium membership to be inclusive in terms of (1) agencies with experience in HIV/AIDS service delivery and (2) populations and subpopulations of PLWH,
who are reflective of the local incidence of HIV. Such consortia are also to be located in areas where such populations reside. Section 2613(c)(2) also provides for additional involvement by diverse perspectives by requiring consortia, in establishing their service plans, to demonstrate that they have consulted with PLWHA, the public health agency or other entity(ies) providing HIV-related health care in the area, at least one community-based AIDS service provider, Ryan White Part B grantee, Part D grantees or organizations with a history of serving children, youth, women, and families with HIV, and entities such as those required to be represented on Part A planning councils (e.g., PLWHA, health and social service providers, other payers).

**Coordination With Other Payers**

Section 2617(b)(5) calls for States to establish priorities for the allocation of funds within the State based on, in part: “ii) availability of other governmental and non-governmental resources, including the State Medicaid plan under Title XIX of the Social Security Act and the State Children’s Health Insurance Program under Title XXI of such Act to cover health care costs of eligible individuals and families with HIV/AIDS;”

**Statewide Coordinated Statement of Need (SCSN)**

The Statewide Coordinated Statement of Need (SCSN) has been a requirement of the Ryan White HIV/AIDS Program since the 1996 reauthorization. The State Ryan White Part B program is responsible for convening the SCSN for all Ryan White grantees under the following provisions:

Section 2617(b)(5)(F) requires the State’s Ryan White Part B application to “provide a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding” under this title;”

Section 2617(b)(6) requires “an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this title, providers, and public agency representatives for the purpose of developing a statewide coordinated statement of need;”

**Ryan White Comprehensive Plan**

Section 2617(b)(5) requires States to: “develop a comprehensive plan for the organization and delivery of health and support services” to be funded under Section 2611 that shall include a description….that—

“(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);”
“(E) provides a description of the manner in which services funded with assistance provided under Section 2611 will be coordinated with other available related services for individuals with HIV/AIDS;

(F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title;”

**Early Intervention Services (EIS)**

Section 2612(d) of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) states that Ryan White Part B funds may be used to provide early intervention services to facilitate access to HIV-related health services. Service provision of EIS as stated in Section 2612(d)(1) can be through “public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by States, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.”

**WICY Waiver and Coordination With Payers**

Section 2612(e) discusses the provision of funds “for the purpose of providing health and support services to women, infants, children, and youth (WICY) with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV.” Specifically, Section 2612(e)(2) suggests coordination in determining use of Ryan White Part B funds for these populations in allowing for a waiver of this requirement if “the population is receiving HIV-related health services through the State Medicaid program under title XIX of the Social Security Act, the State children’s health insurance program under title XXI of such Act, or other Federal or State programs.”

**Key Points of Access**

Section 2617(b)(7)(G) requires that a Ryan White Part B application include assurances that entities that receive funds under a Ryan White Part B grant “will maintain entities within areas in which activities under the grant are carried out will maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2612(c) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care;”
XII. Ch 3. Identifying Key Entities in the Coordination of Parts, Payers, and Programs

A. Overview

Ryan White Part B planning efforts should be coordinated with all other public funding for HIV/AIDS to ensure that Ryan White HIV/AIDS Program funds are the payer of last resort; maximize the number and accessibility of services available; and reduce any duplication of services. For Ryan White HIV/AIDS Programs, the goal of coordination is to enhance access to a range of services in order to both achieve better client health outcomes and use Ryan White resources wisely. Coordination within the Ryan White community occurs through specific efforts of grantees to work together, such as the collaborative planning process to develop the Statewide Coordinated Statement of Need (SCSN) which includes input from all Ryan White HIV/AIDS Programs Parts.

The Ryan White legislation contains requirements for coordination with all Ryan White Parts (A, B, C, D, and F) and non-Ryan White programs and payers from multiple sectors. Driving these requirements is not only the funding represented by these entities but also the potential to coordinate planning and service delivery. The anticipated outcome is better services for PLWHA with complex care demands, such as substance abusers and PLWHA who are not in care.

Among the non-Ryan White programs where coordination is required are Medicaid and Medicare. Both are much larger public sources of funding than Ryan White. Others—defined by their services as well as their payer status—include Veterans Affairs, substance abuse prevention and treatment services (funded extensively through State block grants and other public and private mechanisms), maternal and child health care, and HIV prevention. The latter includes Centers for Disease Control and Prevention (CDC) HIV prevention. CDC also funds outreach and early intervention services, both of which are also fundable under Ryan White but distinguishable because Ryan White must target PLWHA.

Private health insurance is yet another payer that has great potential to cover some of the service needs of Ryan White clients. Although many Ryan White primary care clients do not have private health insurance, mechanisms such as health insurance continuity payments and risk pools are potential payers of care. The Patient Protection and Affordable Care Act (ACA), signed into law in 2010 (Public Law 111-148), aims to expand access to affordable health coverage and reduce the number of uninsured Americans.

Coordination—with both programs and payers—can occur in the following areas:

1) Planning. Coordination in Ryan White planning involves consideration of other programs in such areas as assessment of needs, priority setting, and resource allocation. Required representation of other Federal programs on planning councils is designed to ensure their participation in Ryan White Part B planning. To illustrate, needs assessments should determine existing resources, regardless of funding stream, as part of efforts to identify areas of unmet need. In setting priorities, other resources must be considered in terms of how they help meet service demands so that Ryan White resources can be used to fill gaps.
2) Funding of Services. Ryan White grantees, including Ryan White Part B programs, are required to coordinate their services and seek payment from other sources before Ryan White funds are used. This makes the Ryan White HIV/AIDS Program the “payer of last resort,” meaning that funds are to fill gaps in care not covered by other resources. Major payers include, for example, Medicaid, Medicare, the Children’s Health Insurance Program (CHIP), and private health insurance.

3) Service Delivery. Ryan White requires coordination with specific services (i.e., outreach, substance abuse prevention and treatment, HIV counseling and testing, and early intervention services). Many are funded by other Federal, State, and local sources. For example, HIV prevention is funded through the CDC, while State and some EMA/TGA substance abuse programs are supported partially through block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA).

XII. Ch 4. Care/Prevention and Collaborative Planning

A. Introduction

Federally funded HIV/AIDS prevention and HIV/AIDS care both use planning—and planning groups—to assess needs in their respective realms and develop plans on how to respond. Hundreds of care and prevention planning bodies operate throughout the nation for this purpose. Most do so independently, in part because they are separately legislated. On the prevention side are Community Planning Groups (CPGs), which plan HIV prevention, for those at risk and already infected, to prevent infection and its further spread. They operate through State and local health departments and their communities, under guidance from the Centers for Disease Control and Prevention (CDC). On the care side, planning is through Ryan White Part A and B planning bodies, as well as Part C, Part D, and Part F, as appropriate, funded through the Health Resource and Service Administration (HRSA), HIV/AIDS Bureau (HAB).

Although distinct, both care and prevention planning have common characteristics, providing a basis for collaboration. The Ryan White legislation includes provisions that seek to link PLWHA into care by bringing prevention and care closer together. They include eligibility for Part A and B funding of early intervention services (EIS) with HIV counseling and testing being part of EIS; outreach (to identify people who may need care); and requirements for better links across HIV/AIDS prevention and care systems. Coordination of care and prevention planning can help bridge gaps across prevention and care and thus help individuals learn their HIV status and enter care if infected.

Shared features of care and prevention planning provide a solid foundation for coordination in planning. Both prevention and care planning are based on the principle of inclusive participation, and each conducts such planning tasks as preparation of epidemiologic profiles and needs assessments. Frequently, public agency staff and providers working in care and prevention serve on both planning bodies. Sometimes this membership overlap is the only direct connection between care and prevention planning.
Some communities have taken steps to more closely link their planning activities, either formally or informally. Efforts range from information sharing (often facilitated by people who serve on both planning bodies) to formal collaboration on planning tasks such as preparation of a single epidemiologic profile, combined resource inventory, or joint needs assessment activities. Some have merged their care and prevention planning bodies, in whole or in part through subcommittees. The benefits can include better use of planning resources (e.g., compiling data at a single point in time, fewer planning meetings) and better services.

### FEDERAL AGENCY COORDINATED PLANNING

The Ryan White legislation requires coordination efforts at the Federal agency level designed to enhance the continuity of care and prevention services. Section 2681 specifies the following:

“(a) Requirement.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid Services coordinate the planning, funding, and implementation of Federal HIV programs (including all minority AIDS initiatives of the Public Health Service, including under section 2693) to enhance the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for assistance under this title.”

“(b) Report.—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease.”

**Table 29: Federal Agency Coordinated Planning**

#### B. HAB/DSHAP Expectation

HAB/DSHAP expects Ryan White Part B planning bodies to coordinate with prevention planning bodies and programs in the areas of planning body membership, conducting planning activities (e.g., needs assessments), and service delivery coordination (e.g., early intervention services, outreach), as follows.

**Planning Activities**

HAB/DSHAP expects Ryan White Part A and Ryan White Part B planning bodies to include in their comprehensive planning activities a strategy coordinate the provision of health care and support services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse. Additional Federal agencies’ coordination efforts are required legislatively “to enhance the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease.” (Section 2617(b)(5)(B)

**Planning of Services**
**Points of Entry**

HAB/DHAP expects Ryan White Part B programs and funded providers to establish and maintain formal, written relationships with points of entry into care—places where people with HIV who are not in care are likely to be found. Only through conscious and ongoing service coordination can Ryan White Part B programs identify people who know their status but are not receiving care and provide reliable referral channels to get them into the HIV/AIDS service system.

**Outreach**

Coordination between care and prevention should occur in the planning and delivery of local HIV outreach programs designed to identify PLWHA and help them learn about their HIV status and enter care. HRSA/HAB requires that outreach programs funded through Ryan White be planned and delivered in coordination with local HIV-prevention outreach programs and be targeted to populations known to be at disproportional risk for HIV infection. Outreach should be provided at times and in places where there is a high probability that HIV-infected individuals will be reached.

**Early Intervention Services**

If there is a shortage of early intervention services (EIS), including HIV counseling and testing and referral services, then the planning council may prioritize and allocate resources to such services. It should ensure that such funds supplement and do not supplant existing funds by doing an inventory of existing services as part of its planning process. Planning related to EIS will benefit greatly from communication and cooperation with the CPG.

**Reducing HIV Perinatal Transmission**

Coordinated planning should occur in developing outreach activities that target women of childbearing age in order to reduce HIV perinatal transmission rates. There should be a coordinated effort to reach them through HIV education programs, counseling and testing sites, and other community locations. Similarly, CPGs are expected to plan for HIV counseling and testing of pregnant women at risk for HIV and to arrange procedures to ensure that women found to be HIV-positive are referred immediately to appropriate care settings. Care programs need to work with prevention programs to ensure that women at risk have accurate information about the effectiveness of perinatal treatment and the importance of obtaining treatment early in their pregnancy.
CDC EXPECTATIONS FOR COLLABORATIVE PLANNING

Since guidance for HIV prevention community planning was issued in 1993, CDC has stated the need for collaboration and information sharing between prevention and care planning bodies. Prevention and care planning bodies are expected to be aware of each other’s activities and identify opportunities for collaboration. CDC recognizes that collaboration can occur in many ways, including fully merged joint processes, shared membership, cooperative activities, and/or information sharing. CDC guidance suggests but does not require that, when appropriate, its grantees consider merging their prevention planning activities with those of other local planning bodies that are already in place. Subsequent CDC guidances have asked CPGs for descriptions of mechanisms they are using to coordinate HIV prevention planning with other planning activities, particularly Ryan White Parts A and B, STD, and TB planning.

C. Comparing CDC HIV Prevention and Part A/B Care Planning

Care and prevention planning have several common elements. Understanding them can help Ryan White Part B planning bodies identify potential areas for working together. Among these features (outlined in the chart below) is the use of community planning processes that emphasize inclusive planning body representation reflecting the demographics and trends of the local epidemic. Both also require needs assessments that involve epidemiologic profiles, identification of target populations, resource inventories of service providers, and estimates of the unmet need for particular types of services. Both use needs assessment results to establish service priorities that address identified needs, and both require comprehensive plans. In addition, both include provisions for evaluation.

ABOUT CDC’S HIV PREVENTION COMMUNITY PLANNING

State, local jurisdictions, and territorial health departments have cooperative agreements from the CDC for HIV prevention planning and service delivery. CDC requires each grantee to convene at least one HIV Prevention Community Planning Group (CPG). CPGs are responsible for comprehensive HIV prevention planning, including the following:

- Assessing the epidemic in their jurisdiction
- Identifying HIV prevention needs
- Identifying interventions and strategies to address priority needs, and
- Developing comprehensive HIV prevention plans.

Each CPG’s membership must be representative of the HIV epidemic and reflect epidemiologic trends in its area. CDC allows grantees flexibility to determine the most appropriate structure for conducting prevention planning. Some have formed regional planning groups in addition to, or instead of, a single statewide planning group. Over 200 local and regional CPGs conduct comprehensive HIV prevention planning to guide prevention funding in their areas.

D. Examples of Coordination
Coordination may occur in planning (such as membership and planning tasks like needs assessments) and in service delivery. When care and prevention planning bodies agree to work together, they typically benefit from the development of a memorandum of agreement (MOA) or other written document describing what and how collaboration will occur. The MOA should identify specific areas for collaborative planning, call for regular meetings of leaders and/or staff from prevention and care planning bodies, specify other communications as appropriate, establish links between counseling and testing sites and care services, and detail other areas of cooperation. Expectations for both groups should be clearly stated.

**Planning Body Membership**

Communication between care and prevention planning groups often occurs through overlapping membership. Such shared membership is common. Membership categories likely to bring background in both areas include PLWHA, staff of AIDS service providers, and health department representatives (including epidemiologists).

Planning groups have formally structured overlapping membership by designating membership slots for representatives of the other planning body. Some encourage leaders of each planning body to serve as *ex officio* (non-voting) members of the other body.

Since the Ryan White program enabling legislation requires the planning council membership to include “grantees under other Federal programs, including but not limited to providers of HIV prevention services,” a representative from the CPG might serve this role. HAB/DSHAP encourages planning councils to consider having direct CPG representation on the planning body. In addition, CPG members can join planning council committees or task forces. Similarly, one or two active planning council members might serve on the CPG and/or its committees, particularly those that address areas of common concern such as needs assessment and HIV counseling and testing.

**Joint Meetings**

Joint meetings (regularly scheduled or special sessions) between prevention and care planning representatives can provide a forum for enhanced collaborative planning. They can take several forms:

- **Regular Meetings.** Ongoing leadership dialogue and collaborative thinking can occur through monthly meetings between the co-chairs of the planning council and the co-chairs of the CPG. Agendas for meetings might include issues such as the continuum of care, planning outreach activities, funding and policy issues, and preparation of joint epidemiologic profiles and other needs assessment tasks.
- **Coordinated Meetings.** In some places, the two planning bodies are separate entities but share meeting dates and locations. Monthly meetings might have one group meeting in the morning and the other after lunch. This often works well given overlapping membership and lessened travel time, particularly in geographically large areas.
• **Subcommittees or Task Forces.** A number of planning groups have convened subcommittees, task forces, or ad hoc groups to address specific planning issues or coordinate joint efforts. For example, a planning council might develop an HIV prevention subcommittee to help ensure that its plan adequately addresses coordination between care and prevention services.

• **Special Forums.** Sometimes conference sessions are for care and prevention representatives to meet, present their activities, and share successes/barriers.

### Needs Assessment

Some aspects of needs assessment benefit from joint efforts, like resource inventories and epidemiologic profiles. Others are best done separately (e.g., priority setting). Generally, where the needs assessment’s target audiences and/or methodologies correspond, activities are more readily conducted jointly. If many providers in the community conduct both care and prevention activities, joint needs assessment work is more practical. At a minimum, groups can share data tools and ideas on how to do a needs assessment (e.g., sampling, survey development).

**Epidemiologic Profiles.** Much of the data contained in an epidemiologic profile (e.g., number of AIDS cases, HIV cases, transmission categories and demographics of HIV and AIDS cases, STD and TB data) are equally important to HIV prevention and care planning. Epidemiologic profiles are usually compiled by the same State or local health department staff and thus might be more efficiently prepared at one point in time.

Various States and EMAs/TGAs have worked collaboratively on epidemiologic profiles. Among their insights:

- Certain epidemiologic data items are useful for both care and prevention. For example, STD data can serve as a measure for targeting both HIV counseling and testing and HIV care early intervention activities. Identifying common items is a basis for collaboration.
- Certain epidemiologic data items may be used only in prevention or care planning (e.g., for care, estimates on the number of PLWHA at various CD4 levels serve as a marker for service demand).
- Some State and local health departments take the initiative to develop a regional or local epidemiologic profile that is shared with both care and prevention planning bodies. The usefulness of such a profile can be enhanced by having a State or local epidemiologist provide technical assistance to both care and prevention planning bodies on the development and analysis of the profile.
- Jurisdictions differ in terms of data availability, public health infrastructures, and approaches to planning. This can complicate agreeing on how to develop a single care/prevention epidemiologic profile. This can be addressed by limiting the amount of data compiled and focusing on ensuring that all data are interpreted and presented in user-friendly charts and graphs.
- In regular meetings involving care and prevention planning bodies and health department officials, participants can establish a common language (e.g., defining outreach and secondary prevention) and process, identify data useful to both groups, share data and methods of presentation, and discuss issues of common concern such as data availability.
Resource Inventories. Resource inventories help catalogue existing services in a community. In their basic format, they describe agency services, number and types of clients served, and funding. In such cases, it may be efficient to prepare the inventory jointly, particularly where many providers offer both prevention and care services. This might entail use of a single survey form or compilation from a State HIV/AIDS hotline directory. When the inventory becomes more specific and attempts to include information such as an assessment of service quality (i.e., when it becomes a provider profile of capacity and capability), a joint effort may be harder to achieve. At the least, sharing of mailing lists and contact information can occur.

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<tr>
<th>EPIDEMIOLOGIC PROFILES: COMMON APPROACH FOR CARE AND PREVENTION</th>
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<tr>
<td>In addition, CDC and HRSA work together on many data projects that support both care and prevention planning (see <a href="http://hab.hrsa.gov">http://hab.hrsa.gov</a>). HRSA provides CDC with data on grantee and contractor locations and characteristics. CDC provides HIV/AIDS prevalence data to EMAs/TGAs and States to assist with their grant application processes and to inform Part A and B formula allocations. The two agencies jointly fund efforts to provide estimates of the number of persons with HIV in EMAs/TGAs located in States that do not have HIV reporting. CDC is also working with HRSA to develop methods and technical assistance for estimating unmet need in EMAs/TGAs and States.</td>
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Table 30: Epidemiologic Profiles: Common Approach for Care and Prevention

Merged Planning Bodies

Some areas have merged their prevention and care planning bodies, which has enabled them to share membership recruitment and needs assessment activities and enhance coordination between care and prevention planning. Often, such mergers retain separate committees to address care and prevention planning in greater detail. Committees are typically responsible for priority setting in their care or prevention area, which is harder to merge.

Separate committees have been created when planning body members voiced concerns that prevention planning was not receiving an appropriate level of attention and commitment. Some feared that urgent care and treatment needs were overshadowing the planning body’s focus on prevention planning.

Mergers between Ryan White Part B planning bodies and CPGs have occurred in several States. Facilitating factors include the rural character of the State, the existence of a fairly limited number of AIDS service organizations, and a public health system that is State-coordinated under a regional structure.

Technical Assistance

Since a number of planning activities are similar regardless of whether done for care or prevention planning, technical assistance (TA) can be delivered effectively in a standardized manner. However, some tailoring may still be necessary in responding, for example, to legislative requirements specific to care or prevention.
TA areas that may be addressed similarly include the following:

- Compiling and interpreting epidemiologic profiles
- Conflict resolution
- Grievance procedures, and
- Establishing the planning body.

1. What is care/prevention collaborative planning?

The continuum of collaborative planning ranges from basic information sharing to the establishment of a single, integrated planning process (i.e., merging of care and prevention groups into a joint planning body. Many other joint activities fall between these extremes, such as:

- Development of a single epidemiologic profile
- Preparation of a joint resource inventory
- Cooperation on other components of a needs assessment
- Development of formal linkages between prevention and care providers, and
- Development of plans for specific joint activities, such as collaborative outreach, a referral process linking HIV counseling and testing sites and primary health care facilities, or an initiative focusing on preventing perinatal transmission. The “HIV treatment cascade” including: testing for HIV; engaging in care; CD4 testing; ART treatment; and, finally, full adherence is the framework that best exemplifies the importance of identification, linkage and retention activities that achieve viral suppression and prevent forward transmission of HIV.

2. Why undertake collaborative planning—what are the benefits?

Collaborative planning can create multiple benefits related to savings in time, resources, and effort, and improved plans that contribute to a continuum of prevention and care that better meets community needs. If you are considering collaborative planning, decide what benefits are most important to you. For example, EMAs/TGAs and States have found that collaborative planning can:

- Reduce meeting time for individuals who serve on both care and prevention planning bodies
- Lead to a single epidemiologic profile that is more comprehensive and also reduce the workload of health department staff who would otherwise have to prepare two different profiles
- Reduce time and costs for needs assessment by avoiding duplication of effort by planning body members, staff, and consultants
- Improve linkages between prevention and care so that the continuum of care—from primary prevention through services for PLWHA—is fully developed and referral relationships are improved
- Help infected individuals learn their HIV status earlier and get them into care without delay, thus reducing unmet need for services and improving long-term health outcomes
• Improve secondary prevention efforts, including prevention of HIV perinatal transmission, and
• Encourage providers involved in one aspect of HIV to become involved in the other, thus increasing care and prevention capacity.

3. What are the obstacles to collaborative planning?

Many factors discourage collaborative planning. Some are initial barriers that can be quickly overcome. Some are more serious and may make some kinds of collaboration difficult. Collaboration is most likely to be successful if planning bodies identify and directly address potential barriers rather than ignoring or minimizing them. Among the barriers are:

• **Concerns about the time and effort required.** Planning body members often feel overburdened and unable to expand their work to adequately address both prevention and care issues. This is a particular concern for planning groups considering a merger into a single care/prevention entity.

• **Concern by planning body members that collaboration will be too broad and therefore not successful.** This concern tends to be reduced where initial collaboration addresses specific planning tasks. For example, rather than beginning with a total shared needs assessment, the two bodies might want to collaborate on a shared resource inventory.

• **Fear that prevention will receive reduced attention.** Some members of CPGs are concerned that, in collaborative planning, care might overshadow prevention because there are usually more care dollars to allocate and decision makers might focus more on care.

• **Different perspectives of planning bodies.** The two planning processes require many similar skills but also some different perspectives that may not “cross over” well. For example, primary care personnel typically focus on care, while educators may focus more on prevention issues. Establishing a merged planning body or joint needs assessment committee that provides the whole range of skills and experience can mean a large and unwieldy working group.

4. What factors encourage collaborative planning?

Certain characteristics of communities and planning bodies seem to create an environment that is especially supportive of collaborative planning. For example:

• A shared interest in making the planning process more efficient provides strong motivation for collaborative planning. Where many providers are involved in both prevention and care, the time required to support separate planning bodies and planning efforts seems particularly burdensome. Both prevention and care planning bodies find it difficult to engage members and maintain high levels of consumer participation. The desire to reduce meeting time and prevent member burnout leads to a willingness to make the effort needed for successful collaboration.
Leadership and commitment from key individuals can help move collaboration forward. This includes leaders, care and prevention planning bodies, health department officials, the chief elected official, and providers.

Smaller EMAs, rural areas, and communities with fewer HIV/AIDS cases tend to have fewer agencies and less complicated HIV/AIDS care and prevention systems. With fewer providers to involve in community planning, collaboration is easier to arrange—particularly when the same providers are doing both care and prevention work.

Collaboration is often easier where public health systems are well linked at the State and local levels (e.g., in States where local public health departments are branches of State government). This can create a climate of support for coordinated planning because State and local health department staff may work on both prevention and care, are usually well connected to State as well as local entities, are used to working together, and/or work regularly with community agencies.

Consider what factors within your area are likely to encourage and contribute to the success of collaborative planning.

### 5. What action is needed to begin collaboration?

Following discussion of the above questions, decide whether collaborative planning makes sense and, if so, what you want to do. If you decide to undertake some form of collaborative planning, establish a mechanism—such as a committee or task group—to further develop ideas and set a plan of action. This should include a time frame for carrying out specific agreed-upon planning tasks. If the planning council decides not to proceed at this time, consider establishing a time to revisit the issue. Planning needs may change and the benefits of collaborative planning may become more apparent by the next discussion.

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<tr>
<th>HRSA CARE/PREVENTION ACTIVITIES</th>
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<td>HRSA has engaged in a number of care/prevention collaborative activities. Examples include the above guidelines (developed with both CDC and HRSA input), Special Projects of National Significance (SPNS) projects that are developing models of care, and initiatives (e.g., integrated behavioral and biomedical intervention addressing prevention, access, and adherence to therapeutic regimens; models of prevention and care for HIV-infected individuals).</td>
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| Table 31: HRSA Care/Prevention Activities |

## XII. Ch 5. Partnerships and Collaboration

To enhance access to the continuum of services, the Ryan White HIV/AIDS Program expects grantees to collaborate, partner and coordinate with other Federal and State agencies, including State Medicaid agencies, CHIP, providers of HIV prevention and substance abuse prevention and treatment services, incarceration facilities and all Ryan White Program Parts (A, B, C, D, and F).

Partnerships and collaborations are expected to take place throughout all of the components of the continuum of care to include planning, service delivery and payment of services.

### Planning With Other Programs
Grantees are required to collaborate with other publicly funded programs in the assessment of need, priority setting and resource allocation, and development of their comprehensive plans. Among the most important are Medicaid (by far the largest public payer of HIV care), Medicare (the second largest public payer of HIV care), CHIP, and private health insurance (a source of payment accessible to PLWHA through Ryan White via health insurance continuity payments, which can cover both continuation of existing policies and purchase of new ones). ACA aims to expand access to affordable health coverage and reduce the number of uninsured Americans.

Also important are community health centers and providers of services to the homeless and substance abusers. Planning coordination is evident in the following requirements, each of which is covered in greater detail in other chapters in this manual.

1. Planning Body Membership. Ryan White Part B requirements related to planning bodies are outlined for both States and consortia. The legislation requires States and territories to engage in “a public advisory planning process” in the development and implementation of the comprehensive plan from PLWHA, providers, members of a federally recognized Indian tribe as represented in the State, other Ryan White HIV/AIDS Program grantees, and other agencies, similar to those outlined for Part A planning councils (e.g., PLWHA, health and social service providers, other payers).

   For consortia, the Ryan White HIV/AIDS Program requires the consortium membership to be inclusive in terms of (1) agencies with experience in HIV/AIDS service delivery and (2) populations and subpopulations of PLWHA, who are reflective of the local incidence of HIV. Such consortia are also to be located in areas where such populations reside. The legislation also provides for additional involvement by diverse perspectives by requiring consortia, in establishing their service plans, to demonstrate that they have consulted with PLWHA, the public health agency or other entity(ies) providing HIV-related health care in the area, at least one community-based AIDS service provider, Ryan White Part B grantee, Part D grantees or organizations with a history of serving children, youth, women, and families with HIV, and entities such as those required to be represented on Part A planning councils.

2. Needs Assessment. In order to adequately address priority setting, resource allocation and comprehensive plan requirements, needs assessments must address:
   - Coordination with HIV prevention and substance abuse prevention and treatment programs (including outreach and early intervention)
   - Compatibility with State or local plans for the provision of services to individuals with HIV/AIDS
   - Coordination as appropriate with other community strategies and efforts for identifying individuals with HIV/AIDS who do not know their HIV status

3. Priority Setting and Resource Allocation. States and territories are required to conduct priority setting with consideration to multiple factors, including the availability of other governmental and non-governmental resources, including State Medicaid and CHIP programs, to cover health care costs of eligible individuals and families with HIV diseases.
4. Comprehensive Plan. The comprehensive plan must include strategies to coordinate services with HIV prevention programs (including outreach and early intervention services) and substance abuse prevention and treatment programs. In addition, the comprehensive plan must be compatible with State or local plans for the delivery of HIV services.

5. Statewide Coordinated Statement of Need (SCSN). A collaborative process which must be developed with input from all Ryan White HIV/AIDS Program Parts. The Ryan White Part B grantee is responsible for periodically convening a meeting for the purpose of developing a SCSN. All Ryan White Parts are equally responsible for the development of the process, participation in the process, and the development and approval of a SCSN.

The purpose of the SCSN is to provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of PLWHA, and to maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program Parts. In addition, the SCSN process is expected to result in a document that reflects the input and approval of all Ryan White HIV/AIDS Program Parts.

An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status. The early intervention of individuals living with HIV/AIDS (EIIHA) initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH, and 3) reducing HIV-related health disparities.

The Early Identification of Individuals living with HIV/AIDS (EIIHA) is a legislative requirement that focuses on individuals who are unaware of their HIV status and how best to bring HIV positive individuals into care, and refer HIV negative individuals into services that are going to keep them HIV negative. An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status. The mechanism for developing a SCSN can be a statewide meeting or may be some other locally developed process.

Coordination of Payers

All Ryan White grantees are required to coordinate their services and seek payment from other sources before Ryan White funds are used, making the Ryan White HIV/AIDS Program the “payer of last resort,” meaning that funds are used to fill gaps in care not covered by other resources.

One specific area of payer coordination is services for women, infants, children, and youth (WICY). Each State must allocate funds for each group in an amount no less than the proportion that each is represented in the total number persons living HIV/AIDS cases in the State. A waiver is provided when the State can demonstrate that the needs of these populations are being met through other sources.
Policy 07-07 provides specific guidance that Ryan White HIV/AIDS Program grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White HIV/AIDS Program services. Policy 07-01 states that programs administered by or providing services of the IHS are exempt from the “Payer of Last Resort” restriction for Parts A, B, and C by persons also eligible for benefits under IHS funded programs. In both of these instances, payer coordination on behalf of clients must respect client choice of payer in those cases where VA, IHS and Ryan White are the available payers.

Private health insurance can also be coordinated in various ways with Ryan White funding, such as covering services not paid for by private insurance or paying health insurance premiums, if cost effective. For example, Ryan White Part B grantees may purchase health insurance for clients as part of their AIDS Drug Assistance Programs (ADAPs) under the Health Insurance Continuity Program (HICP). HICP funds may only be used to purchase health insurance that includes the full range of HIV treatments and access to comprehensive primary care services and provides prescription coverage that is equivalent to the ADAP formulary. The total amount spent on insurance premiums cannot be greater than the annual cost of maintaining that same population on ADAP. Clients covered under HICP may continue to qualify for some Part A services that are not covered by their health insurance.

Each State has different insurance laws and regulations. For example, some States and/or territories have existing insurance programs, like risk pools, and Ryan White dollars might be used to pay premiums. If qualified HIV providers are on the preferred provider list for these insurance policies, such pools may offer opportunities for payer coordination.

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010 (Public Law 111-148), aims to expand access to affordable health coverage and reduce the number of uninsured Americans.

**Early Intervention Services and Points of Access**

Early Intervention Services (EIS) and outreach services are intended to increase access to primary care services for PLWHA. In funding EIS, Ryan White Part B grantees must demonstrate that other sources of funds for EIS are insufficient before spending Ryan White funds on EIS and must make this determination in their needs assessment (particularly the resource inventory). For outreach services, Ryan White outreach programs must focus on reaching PLWHA who are not in care.

Ryan White providers are required to maintain appropriate relationships with entities providing “key points of access” to both identify and link PLWHA into care. These include, for example, providers of early intervention services, family planning clinics, substance abuse treatment providers, sexually transmitted disease clinics, community organizations, and correctional institutions.

**XII. Ch 6. Understanding Other HIV/AIDS Payers and Programs**
Federal agencies and programs such as the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Department of Housing and Urban Development’s Housing Opportunities for Persons with AIDS (HOPWA) Program and the Federal Bureau of Prisons, among others are integrally involved in Ryan White planning, priority setting, and service delivery activities at the State, regional and local levels through planning bodies. Additionally, HHS/HRSA is integrally involved at the Federal level in coordination, policy, and planning activities with other Departmental and Administration directives.

A key example of HRSA’s partnership with other Federal agencies is the National HIV/AIDS Strategy (NHAS). In July 2010, the White House released the NHAS. The NHAS has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for PLWH and 3) reducing HIV-related health disparities. The NHAS calls for improved Federal coordination of HIV/AIDS programs. The lead agencies in implementing NHAS are the:

- Department of Health and Human Services
- Department of Justice
- Department of Labor
- Department of Housing and Urban Development
- Department of Veterans Affairs
- Social Security Administration

The ultimate NHAS goal is to inform all HIV positive persons of their status and bring them into care in order to improve their health status, prolong their lives and slow the spread of the epidemic in the U.S. through enhanced prevention efforts. The Ryan White Part B (Early Identification of Individuals with HIV/AIDS) EIIHA legislative requirement calls for grantees to identify HIV positive individuals who are unaware of their HIV status and bring them into care. The NHAS Federal Implementation Plan outlines the specific steps to be taken by various Federal agencies to support the high-level priorities outlined in the Strategy which will require the commitment of Federal agencies, State, tribal and local governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, PLWH, and others. Additional information can be found in the NHAS Section of this manual.

In order to work more effectively with other health programs, particularly Federal programs that provide services for PLWHA, Ryan White grantees should learn more about these programs and payers. Among the most significant Federal programs that provide services for PLWHA are Medicaid, Medicare, CHIP, and private health insurance.

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010 (Public Law 111-148), aims to expand access to affordable health coverage and reduce the number of uninsured Americans.

These programs and several other HHS programs are briefly summarized below.

**Medicaid**
Medicaid, the joint Federal/State health program for low-income and disabled Americans, is the largest public payer of health care services for PLWHA. The Medicaid program is administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). To be eligible for Medicaid, a person must either be very poor, have children, and/or be disabled (based on the Social Security definition). Thus, most PLWHA are not eligible for Medicaid until they become impoverished and disabled. HIV-infected women and children covered by Medicaid are often eligible for reasons other than their HIV/AIDS.

Medicaid programs vary from State to State. While there are basic eligibility rules and a core benefits package (such as hospital, physician, and nursing services), each State may elect to provide optional services (prescription drug benefits, clinic services), modify eligibility rules above the minimum and place beneficiaries in fee-for-services or managed care arrangements. Ryan White funds can be used to fill service and population gaps not covered by Medicaid. When a State’s Medicaid program does not cover a specific service, Ryan White funds can be used for payment.

**Medicaid Managed Care**

In the 1990’s, many States began enrolling Medicaid beneficiaries in managed care. Managed care is designed to reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care. Managed care is characterized by formal enrollment of individuals in a managed care organization, contractual agreements between the provider and a payer, and some gatekeeping and utilization control.

For PLWHA, managed care systems can present some challenges to the receipt of appropriate services. These include:

- Access to primary care providers and specialists experienced in the treatment of HIV/AIDS.
- Adequate coordination between medical and social services.

Additionally, HIV/AIDS and other high-cost conditions present challenges to managed care plans and providers that contract with them where capitation rates do not reflect the real costs of treating HIV/AIDS.

**Medicare**

Medicare is the second largest source of Federal financing of HIV/AIDS care. Most people 65 and older are entitled to Medicare because they are eligible for Social Security payments. Disabled persons who receive Social Security Disability Insurance (SSDI) cash payments (because they have sufficient work history to qualify) become eligible for Medicare after a two-year waiting period. Medicare covers a significant number of PLWHA in care.

Medicare covers such services as inpatient hospitalization, skilled nursing and home health visits, physician and outpatient hospital services, and outpatient prescription drugs. Many beneficiaries purchase supplemental insurance to help with Medicare’s cost-sharing requirements.
and fill gaps in the benefit package. Some opt to enroll in managed care organizations that typically have lower cost-sharing benefits.

A significant number of PLWHA are dually eligible for both Medicare and Medicaid. Despite coverage by both sources of public insurance, gaps in care may exist.

**State Child Health Insurance Program**

CHIP, administered by the CMS Center on Medicaid and State Operations, was enacted in 1997 and allows States to expand health insurance coverage for low-income children. Children cannot be excluded from eligibility due to a disability or pre-existing condition.

States have great discretion in the design of their CHIP programs. For example, States can choose how they will determine family income and have flexibility in determining which groups of low-income children to cover (e.g., based upon age, disability status, where they live in the State). States also have flexibility to revise their child health plans over time.

**Maternal and Child Health Bureau Programs**

HRSA’s Maternal and Child Health Bureau (MCHB) addresses the health of mothers, infants, children and adolescents. A focus is on families with low income levels, those with diverse racial and ethnic heritages, and those living in rural or isolated areas without access to care.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports programs in substance abuse prevention, substance abuse treatment, and mental health services. It oversees State block grants that support HIV early intervention services in substance abuse or mental health treatment settings. In addition, SAMHSA provides HIV/AIDS grants to cities to enhance the effectiveness of outreach in urban areas highly impacted by substance abuse and HIV infection.

**HIV/AIDS Prevention/Counseling and Testing**

Publicly funded HIV counseling and testing services have been provided under grants from CDC through local and State health departments since March of 1985. Both anonymous and confidential voluntary HIV counseling, testing and referral services are available and have evolved to focus on individual, client-centered risk reduction counseling models. CDC Guidelines for HIV Counseling Testing and Referral include many recommendations to ensure that HIV-infected individuals (as well as those at risk) have access to appropriate medical, prevention, and psychosocial support services.

**XII. Ch 7. Making Coordination Work for Parts A and B Planning Bodies**

Although they usually operate fairly independently, Part A and B planning bodies can work together in pursuit of common Ryan White goals to strengthen the service continuum for
PLWHAs and ensure that funds are used to fill gaps in care. More practical benefits can include reduced administrative and planning costs and lessened duplication of effort.

Coordination efforts are driven by grantee initiative and such Ryan White requirements as cross-Part membership in planning groups, consistency across State and local comprehensive plans, and joint work on the Statewide Coordinated Statement of Need (SCSN). Among the more visible areas of coordination is determining use of AIDS Drug Assistance Program (ADAP) dollars in Part A areas. Other areas for coordination with Ryan White Part B include State programs like Medicaid and substance abuse block grants. Tools to streamline planning and enhance services might be jointly developed, thus benefiting providers who are funded under both Parts.

Coordination across Parts A and B can occur on multiple levels, from less formal information sharing to more structured efforts like:

- Cooperation on planning-related tasks (e.g., needs assessment, comprehensive plans).
- Joint service-related tasks (e.g., design of data collection processes, standards of care, quality management, evaluation).
- Consolidation or even merger of planning bodies.

Making such collaboration work requires attention to differing legislative mandates for each Part. In addition, the specific planning task of resource allocation has significant legislative distinctions, with Part A planning council involvement being much more defined in this area.

**Planning Activities**

HRSA/HAB expects and encourages Part A and B coordination on a broad range of activities, even beyond those specifically mandated in law. This is especially true in those geographic areas where planning council and Ryan White Part B planning body service areas overlap. In overlapping service areas, the following types of cooperation should be pursued:

1. Inclusion of a representative of the other Part on each planning body. This might include joint committees. Notably, HRSA/HAB does not specifically promote consolidation of Part A and B planning groups into a single entity. Rather than prescribe a particular model of coordination, HRSA/HAB encourages planning bodies to determine the model that works best in their community.
2. Information-sharing procedures to ensure effective communication between the two planning bodies.
3. Coordinated needs assessment activities, where possible, particularly the epidemiologic profile and other specific needs assessment activities such as development of a joint resource inventory, and perhaps use of the same PLWHA survey instrument.
4. Coordinated comprehensive plans.
5. Consideration of joint priority setting.
6. Collaborative contracts with providers that are funded by both Parts.
7. Coordination of capacity development, outreach, and early intervention services (EIS), expectations for which are outlined in greater detail in both Ryan White and HRSA/HAB policies.

8. Consideration of uniform data collection and reporting systems and collaborative approaches to evaluation and performance measurement.

9. Mutual understanding of both how Ryan White Part B funding is used in the EMA/TGA and what, if any, contribution Part A might make to State-administered programs (e.g., ADAP, health insurance continuity).

10. Collaboration on planning body member training, which might include technical training on topics such as needs assessment, comprehensive planning, resource allocation, and understanding HIV treatments. Joint training for PLWHA members should also be considered.

**Differences in Planning Body Authority and Autonomy**

In exploring ways to work together, Part A and B planning bodies must consider the following differences in their respective authority and autonomy.

1. Planning councils are public bodies established by the EMA’s/TGA’s chief elected official (CEO). Legislation defines their key responsibilities, such as determining service priorities, allocating resources to priority service categories, and assessing the administrative agent’s timeliness in disbursing funds. The procurement process and monitoring of funded service providers are grantee responsibilities. Legislation forbids planning council participation in the procurement process.

2. Since Ryan White Part B planning bodies are not as defined in the legislation, they have a more varied structure and membership than planning councils. Ryan White Part B bodies are shaped primarily by the Ryan White Part B grantee. They may be incorporated bodies with responsibility not only for needs assessment and planning, but—unlike planning councils—also for procurement and contract management. In some areas, a separate local lead agency fulfills those roles or the State may serve as lead agency.

**Benefits of Coordination**

Experience with collaborative and merged planning bodies shows that many types of cooperative activities can be implemented.

1. Joint needs assessments. Variations include use of a single needs assessment to cover both Parts A and B; EMA/TGA and State collaboration in conducting a joint needs assessment, with EMA/TGA responses separated out for use in planning; use of State-developed needs assessment methodologies or tools by Part A planning councils; or coordinated review of past needs assessments. Planning bodies need not merge to make this happen and can remain separate but use a single committee to conduct the needs assessment.

2. Allocation of funds across Parts and funding streams. A coordinated allocations system to disseminate funds can occur through a shared system or a combined planning body.
3. Uniform State and local reporting systems and unified management information systems. Uniform reporting requirements can be developed for use by all Ryan White providers, or the State can support common data collection and management systems that better support use of CAREWare and preparation of the Ryan White Data Report, whose use is required by all Ryan White grantees.

4. Reduced duplication of provider contracts. A single request for proposals (RFP) process can be used for the two Parts so that a provider has just one contract for any type of service.

5. Joint service models or Standards of Care (e.g., case management guidelines) and provider training. Such efforts are especially beneficial for providers funded under both Parts.

6. Equity in access to services across areas. A funding formula can adjust for award of Ryan White Part B funds to counties outside the EMA/TGA, or a parity formula can seek to equalize per capita spending from Part A and B streams. Some EMAs/TGAs contribute Part A funds to the State ADAP, increasing the number of drugs in the formulary and the number of clients served.

7. Coordination of Services. For example, clients in an EMA/TGA might be served by State-supported providers, such as a statewide case management system that also does eligibility determination for both Parts.

**Challenges of Coordination and Lessons Learned**

HRSA/HAB has identified the following challenges faced by planning bodies seeking to enhance collaboration. Many have been successfully addressed.

1. Differences in service boundaries complicate joint planning activities. Mergers often change and sometimes increase the size of the service area. This can complicate planning tasks like needs assessment and priority setting.

2. Multi-State EMAs/TGAs complicate coordination. A merged planning body comprising a Ryan White Part B planning body and multi-state EMAs/TGAs requires Ryan White Part B representatives to become familiar with issues faced by interstate EMAs/TGAs. Procedures may be needed to ensure geographic membership representation, develop intergovernmental agreements, and in some cases arrange for more than one administrative agency as a way to disburse funds efficiently throughout multiple jurisdictions. Specific arrangements may be needed to address such issues as contributions to the State ADAP and differing State licensing and regulatory requirements for services such as home care and ambulatory care. Perhaps the greatest challenge is to ensure that needs assessment and planning consider differences in health care delivery and Medicaid programs. Multi-State EMAs/TGAs may want to collaborate with planning bodies located in each State because they bring valuable expertise in State-specific issues, which can be fed back into a larger planning body effort.

3. Allowable uses of funds may vary. Members of combined planning bodies need to know what services can be funded from which streams. For example, the legislation requires that core medical services be contracted by the State, not by regional Ryan White Part B consortia.
4. A merged planning body might focus on the strictest requirements. This can include such areas as priority setting, resource allocation, and clinical quality management programs. Ryan White Part B consortia are often advisory, while Part A planning councils are decision makers about service priorities and allocations.

5. Financial resources carry influence. The planning body that brings the most money to the merger is likely to expect to exert considerable influence in decision making. Usually, planning councils allocate more funds than Ryan White Part B planning groups, although some control significant State funding for HIV/AIDS services. Planning can ensure that major activities reflect the perspectives of both Parts, such as needs assessments and priority-setting processes that account for both Parts.

6. Mergers may affect planning body membership representativeness and reflectiveness. The membership of a consolidated body must maintain/enhance its diversity and PLWHA involvement. If the bodies are fully merged, then the combined planning body’s membership must be at least 33 percent unaligned PLWHA and include individuals from all the categories specified in the Part A legislation. Ensuring rural representation is also a challenge. The planning body needs to be large enough to represent the membership of both Part A and Ryan White Part B programs but small enough to be manageable. In order to minimize membership issues, different committees within the planning body may need to serve as the official planning council or Ryan White Part B planning body so that the membership is not fully merged.

7. Maintaining provider involvement and minimizing potential conflict of interest. A combined planning body may have a smaller proportion of providers than separate groups. In several sites, provider caucuses have been established, including sub-caucuses of specific providers like case managers. They can meet regularly, provide recommendations to the planning body, and in some locations elect representatives to serve on the consolidated planning body.

8. New protocols may need to define relationships among the planning body, State, and HRSA/HAB. For example, HAB/Division of State HIV/AIDS Programs (DSHAP) generally communicates with Ryan White Part B planning groups only through grantees and would not visit them without first informing the State. However, a merged planning body is also a planning council, and HAB/Division of Metropolitan HIV/AIDS Programs (DMHAP) regularly communicates directly with planning council co-chairs or staff.

XII. Ch 8. References, Links, and Resources

1. Centers for Disease Control and Prevention: http://www.cdc.gov/

For More Information
Please refer to the HAB Target Center at https://careacttarget.org.
Section XIII. Technical Assistance

XIII. Ch 1. Overview

The Ryan White HIV/AIDS Program includes a technical assistance (TA) and training component to support the work of Program constituents, including grantees, providers, planning bodies, and consumers. Activities include provision of TA tools and documents, onsite and distance-based consultations, expert meetings, and specialized TA centers.

XIII. Ch 2. Legislative Background

Ryan White HIV/AIDS Treatment Extension Act of 2009 provisions related to Ryan White Part B training and technical assistance is as follows:

Section 2619 requires the Secretary to “provide technical assistance in administering and coordinating the activities authorized under section 2612 [the Ryan White Part B grant], including technical assistance for the development and implementation of statewide coordinated statements of need.”

XIII. Ch 3. Purpose and TA Topics

TA is provided in areas related to the legislative mandates and programmatic requirements of the Ryan White legislation. Critical topic areas include:

- Access to care
- AIDS Drug Assistance Program
- Clinical care
- Clinical program development
- Consumer development and training
- Cultural competency
- Data collection and programmatic reporting (including client-level data)
- Engagement in care: recruitment and retention
- Fiscal and program management
- Medical case management
- Needs assessment
- Patient-Centered Medical Home TA
- Patient flow evaluation
- Pediatric and Perinatal Guidelines facilitation
- Peer-to-Peer TA or training
- Planning body operations
- Program and capacity development
- Quality
- Stigma
- Strategic planning
- Training peers to serve in health-care teams
- Unit cost analysis
- Unmet needs
- Working with consumers to help address unmet needs by engaging others in care.

XIII. Ch 4. How TA Is Provided

TA and training are provided through the following methods:

- The Technical Assistance Resources, Guidance, Education, and Training (TARGET) Center Web site (http://www.careacttarget.org), which provides centralized, Web-based access to all HAB TA resources and facilitates networking among Ryan White Program Parts. The TARGET Center comprises a telephone help desk, a library of HAB- and grantee-developed TA tools, a TA calendar of upcoming events and trainings, and Web links to all grantees.

- Individualized and onsite peer and expert consultation through a national Technical Assistance Contract (TAC). The TAC also coordinates consultative meetings and conferences, site visits, and conference calls.

- Assisting grantees in replicating successful Special Projects of National Significance (SPNS) to strengthen their capacity to deliver new methods of evidence-based HIV care.

- An array of cooperative agreements with national organizations to deliver TA in specific topics through local and regional workshops, Webcasts, Web-based learning modules, conference calls, onsite trainings, and technical publications and curricula.

- A logistics contract that supports the Ryan White All-Grantee Conferences and Clinical Update, and regional and consultative meetings.

XIII. Ch 5. How to Obtain TA

To obtain more information about TA, contact your HAB project officer. A list of TA products is available on the Technical Assistance Resources, Guidance, Education, and Training (TARGET) Center Web site (http://www.careacttarget.org). Additional sources of TA are discussed in other sections of this Manual.

Cross reference:
See Section VI. Grantee and Sub-Grantee Monitoring in this Manual for more information on the
how TA is provided in areas related to the legislative mandates and programmatic requirements
of the Ryan White legislation.

Cross reference:

See Section III in this manual for more information on how TA is provided in areas related to the
ADAP Data Report (ADR). Section III also includes more information on how TA is provided
by The Office of Pharmacy Affairs (OPA) which funds the Pharmacy Services Support Center
(PSSC) to provide free technical assistance for the 340B Drug Pricing Program. Additional
discounts on some products are negotiated through 340B’s Prime Vendor Program (PVP)
https://www.340bpvp.com/ which leverages public health entities’ collective purchasing power
to negotiate sub-340B discounts.

XIII. Ch 6. References, Links, and Resources

1. Ryan White Technical Assistance Program Fact Sheet, 2012:
3. ADAP Manual 2012: https://careacttarget.org/content/adap-manual

For More Information

Please refer to the HAB Target Center at https://careacttarget.org.