HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Section 2 – Purpose, Structure & Membership

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HIV Health Services Planning Council
Sacramento TGA

HIV Health Services Planning Council Overview

HIV Health Services Planning Council (Council)
The HIV Health Services Planning Council is responsible for planning how Ryan White CARE Act funds will be used in the local Transitional Grant Area (TGA), which consists of Sacramento, El Dorado, and Placer Counties. To properly plan, the Council is responsible for assessing the needs of people living with HIV in the TGA, developing a comprehensive plan that defines short and long term goals for delivering HIV services, setting priorities for which service categories are most needed, allocating resources to prioritized services, coordinating service delivery with other programs and funders, assessing the effectiveness and efficiency in which CARE Act funds are being used, and evaluating how well funded services are meeting community needs. In order to accomplish all of these tasks, the Council has established several working committees that perform specific tasks.

Executive Committee (Exec)
The Executive Committee is the only standing committee specified in the by laws of the HIV Health Services Planning Council (Council). The purpose of the Executive Committee is to "act for the Council between meetings under parameters set by the Council and to provide guidance for the Council in fulfilling its responsibilities and reaching its goals." The chairs of all other standing committees are members of the Executive Committee. Other committee members are Council members appointed to represent specific required categories (such as Placer and El Dorado counties).

Governance Committee (Gov)
The Governance Committee is an ad-hoc committee formed by the Council to address issues of policy, procedure and bylaws modification. Originally formed to recommend a governance structure to the Council, it now addresses questions central to how the Council functions. Some examples include development of conflict of interest policies, committee operation policies and procedures, member absence policies, as well as changes to bylaws as they are needed. Governance Committee work is generally reviewed in various settings forwarded to the full Council for approval and implementation. Members include the Executive Committee and any council members with interest in the topic(s).

Affected Communities Committee (ACC)
The Affected Communities Committee is a standing committee that addresses issues facing the HIV/AIDS community and advises the Planning Council on the affairs of the community. The mission of the committee is to recruit, empower and involve people living with HIV/AIDS in the strategic planning and advocacy of HIV/AIDS care and services. These goals will be accomplished with the assistance of the Council support staff toward the fulfillment of its mission. The committee encourages an environment of trust and safety in achieving its mission.

Priorities and Allocations Committee (PAC)
This standing committee performs some of the most vital work for the Council. The primary responsibilities of the PAC are to review information, data and the updated Needs Assessment, in order to establish funding priorities and service allocations for the upcoming fiscal year. The work of the committee, when accepted by the Council, serves as the directive for issuance of proposal requests and determination of contractors to provide services throughout the TGA, tasks that are competed by the Recipient. Membership on PAC must be balanced to represent consumers, providers, government agencies and other diversity factors specified within PAC and general committee policies.

Needs Assessment Committee (NAC)
This standing committee is charged with re-evaluating and updating Needs Assessment for the TGA. Seeking data, information and opinion from a variety of sources, NAC identifies the service categories that are most needed by people with HIV infection throughout the region. Recommendations are made to the Council and the PAC, which help to focus the development of priorities and allocations for the upcoming funding period. Members are recruited to reflect specific areas of expertise (such as technology and research), as well as consumers and key service category providers.

Administrative Assessment Committee (AdAC)
The Administrative Assessment Committee is a standing committee established to assess the efficiency and effectiveness of the administrative mechanisms for rapidly disbursing CARE Act funds to the areas of greatest need within the transitional grant area (TGA). The AdAC will conduct a bi-annual (twice yearly) assessment of the Fiscal/Administrative mechanisms with the intent of providing feedback and recommendations to the Council and to the Recipient to continually improve such administrative policies and procedures.

Quality Advisory Committee (QAC)
The Quality Advisory Committee is a standing committee that develops service standards to be utilized by providers when delivering services paid for through Ryan White funds. Such standards may include policies, procedures, guidelines, and other information pertinent to the effectiveness and efficiency in which consumers are treated and Ryan White funding is spent. To ensure that standards are appropriate for all stakeholders, members are drawn from providers and consumers of Ryan White services, as well as others interested in health and human services.

Signed: _____ Date: 09/27/2023
Richard Benavidez, Chair

HIV Health Services Planning Council

ADMINISTRATIVE ASSESSMENT COMMITTEE

COMMITTEE OVERVIEW

Purpose Statement:
The Administrative Assessment Committee (AdAC) shall assess and develop recommendations for improving the efficiency and effectiveness of the administrative mechanisms for rapidly disbursing CARE Act funds to the areas of greatest need within the Sacramento Transitional Grant area (TGA).

Committee Responsibilities:
The Administrative Assessment Committee (AdAC) is responsible for conducting the Health Resources and Services Administration (HRSA) mandated function of assessing the variety of processes involved in ensuring that the TGA is able to proficiently disburse funds in the region. In performing this task, AdAC is charged with:

1) Developing an annual assessment tool that consists of standards by which the TGA will evaluate its success in achieving its responsibilities;
2) Reviewing documentation of the TGA's fulfillment of standards on a bi-annual (twice yearly) basis;
3) Recording the findings of the annual assessment, including strengths, weaknesses, and recommendations for improvement to the TGA's efforts;
4) Developing a plan of correction based upon assessment findings;
5) Reporting findings to the Executive Committee, the Council, and HRSA;
6) Monitoring efforts year-round to determine progress towards plan of correction.

Desired Experience of Members:
AdAC is a technical committee requiring a broad skill set from its members. To successfully evaluate the efficiency and effectiveness of administrative mechanisms, AdAC members must have:

- Understanding of the Ryan White CARE Act
- Awareness of Recipient, Planning Council, and Planning Council staff activities;
- Historical understanding of the TGA's development;
- Experience with program evaluation.

Expectations of Members:
For continuity and uniformity in assessment efforts, AdAC requires a consistent membership, with as little change over on an annual basis as possible. In addition to being able to commit to a multiple year membership, members are expected to:

1) Attend and actively participate in all AdAC meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Abide by established assessment process policies and procedures;
4) Provide objective assessments based upon data/information provided;
5) Provide constructive recommendations for improving processes;
6) Continually identify Council Members who may be interested in membership on AdAC;
7) Act as an informal mentor to new Committee members;
8) Sign Oath of Confidentiality at each meeting

Meetings:
The Administrative Assessment Committee meets as determined by the Committee.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630, Angelina.olweny@valleyvision.org

Approved by the HIV Health Services Planning Council on

6/28/2023

Richard Benavidez, Chair

HIV Health Services Planning Council
AFFECTED COMMUNITIES COMMITTEE
www.sacramento-tga.com

COMMITTEE OVERVIEW

Mission Statement:
The Affected Communities Committee addresses issues facing the HIV/AIDS community and advises the Planning Council on the affairs of the community. The mission of the Committee is to recruit, involve, and empower people living with and those affected by HIV/AIDS in the strategic planning and advocacy of HIV/AIDS care and services. The Committee encourages an environment of trust and safety, and will achieve its goals with the support of Planning Council support staff.

Committee Responsibilities:
The Affected Communities Committee (ACC) is the primary route through which the HIV Health Services Planning Council (Council) and its committee(s) access input from individuals living with or affected by HIV/AIDS. To fulfill this role, the ACC will:

1) Be available to review and provide feedback on policy, program, and funding decisions made by the Council to ensure that decisions are acceptable by service consumers and those otherwise affected by HIV/AIDS.
2) Identify and present emerging issues/challenges/barriers relating to service delivery and access to appropriate Council committees.
3) Identify and present challenges and barriers as they relate to involving individuals living with or affected by HIV/AIDS in the planning processes to appropriate Council committees.
4) Educate the HIV/AIDS community and populations most impacted by HIV/AIDS on the purpose and functions of the Council.
5) Recruit people living with HIV/AIDS (PLWH/A) and individuals affected by HIV/AIDS to participate on the Council and its committees.
6) Organize and host consumer forums on topics of interest to people living with or affected by HIV/AIDS.
7) Coordinate HIV Health Services Planning Council Meeting Training Schedule

Desired Experience of Members:
To fulfill its responsibilities, it is necessary for ACC to have a diverse membership that understands and can actively voice the views of a variety of affected communities. Members should be able to use personal networks to disseminate information or mobilize individuals for action. To ensure thorough representation, the ACC seeks people living with or affected by HIV/AIDS from

a number of communities, including but not limited to, race, ethnicity, gender, gender identity, sexual orientation, age, disability, social class, religion, national origin, ancestry, veteran status, and/or political beliefs. ACC values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.

In gathering the above representation, the ACC seeks participation from residents of Sacramento County, El Dorado County, and Placer County.

Expectations of Members:
ACC relies on an active membership to generate ideas and develop strategies for moving ideas forward. For this reason, members must be aware of emerging and existing health and service issues that are impacting people living with HIV/AIDS in the region. To advance the goals of ACC, it is expected that members will:

1) Regularly attend and actively participate in ACC meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Gather information from consumers on how services could be improved.
4) Express ideas on how ACC and the Council might be able to better serve the needs of people living with HIV/AIDS.
5) Report the activities and decisions of the ACC and the Council to your community affiliations;
6) Play an active role in identifying and attracting diverse individuals interested in participating in the service planning processes.

Meetings:
The Affected Communities Committee typically meets on the first Monday of the even months of April, June, August, October, December, and February from 3:00 – 4:00 p.m. Contact Council Staff for the current schedule and location.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630, Angelina.olweny@valleyvision.org, or www.sacramento-tga.com.

Richard Benavidez, Chair Approved: 04/26/2023

HIV Health Services Planning Council
GOVERNANCE COMMITTEE

COMMITTEE OVERVIEW

Purpose Statement:

The Governance Committee will assist Council membership in fulfilling oversight responsibilities with respect to: Council organization, membership composition, standing committee structure, membership and function, and governance policies including the enforcement and any necessary modifications to such policies. In doing so, the Committee will address and track issues of policy, procedure, and bylaws as they relate to Council functions.

Committee Responsibilities:

To ensure effectiveness and efficiency of the Council the Governance Committee will periodically review the Council's policy/procedure and standards related to the conduct and affairs of the Council including but not limited to:

1) Developing, reviewing and monitoring the operating structure of the Council in relation to the ability for administering its mandated tasks;
2) Establishing, reviewing and revising Council bylaws in accordance to changes to the law, regulation or HRSA mandates;
3) Developing, reviewing and modifying policies and procedures for Council and Committee implementation;
4) Reviewing policies, procedures and standards developed in other Council Committees for consistency to form, intent and application to existing governance structure
5) In consultation with the Recipient, monitor Federal/State/Local regulations and guidance to facilitate compliance;

Desired Experience of Members:

Governance Committee membership shall be comprised of members of the Executive Committee and may include Council Members with skill sets addressing the task under review. Desired characteristics include one or more of the following:

- Comprehensive understanding of the Ryan White CARE Act;
- Awareness of responsibilities and activities of the Council and its Committees;
- Historical understanding of the Council's development;

- Stakeholder in Council decisions (consumers, providers, affected communities)
- Experience with organizational/program design and development;
- Familiarity with California and Federal law/regulations related to public boards/councils, HRSA mandated programs and general organization governance
- Policy and/or procedural writing skills.

Expectations of Members:

1) Regularly attend and actively participate in Governance Committee meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Identify issues in need of policy/procedural development;
4) Propose ideas and language for the development of new policies and procedures;
5) Understand existing policies and procedures;
6) Recognize when adopted policies and procedures are ineffective, inconsistent, inadequate or antiquated;
7) Provide constructive recommendations for improving existing policies and procedures;
8) Continually identify individuals who may be interested in membership on Governance.

Meetings:
The Governance Committee is a standing committee.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630 or Angelina.olweny@valleyvision.org

Signed: _____ Date: 04/23/2025
Richard Benavidez, Chair

HIV Health Services Planning Council
NEEDS ASSESSMENT COMMITTEE

COMMITTEE OVERVIEW

Statement of Purpose:
The purpose of the Needs Assessment Committee (NAC) is to support the mission of the HIV Health Services Planning Council. The goal of the NAC is to define and quantify specific needs of the HIV community in the Sacramento Transitional Grant Area (TGA). NAC will provide an updated yearly report on area needs for use by the Planning Council and the Priorities and Allocation Committee in the annual priority setting and allocation processes.

Committee Responsibilities:
NAC is the primary entity through which the Council receives documentation of service needs of people living with HIV in the TGA. To provide this information, NAC is charged with:

1) Developing and implementing methods by which a comprehensive understanding of the service needs of PLWHA can be acquired at least once every three years;
2) Determining capabilities and capacities of service providers at least once every three years;
3) Annually updating needs assessment findings with studies of special populations/populations with special needs;
4) Analyzing and organizing findings for reporting to PAC, Council, and other appropriate entities.

Desired Experience of Members:
NAC membership requires a host of talents, skills, and experiences. Particular needs include:

- Epidemiologists
- Researchers
- Statisticians
- Database designers
- People living with HIV (including Ryan White service consumers)
- HIV service providers (both within and external to the Ryan White service community)
    - Particularly medical, medical case management, outreach and testing providers
- Recipient staff

Expectations of Members:
NAC relies on its members to identify areas in need of investigation and develop strategies for completing studies. To be effective, members are expected to:

1) Regularly attend and actively participate in NAC meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Identify areas that need to be further examined in order for the TGA to gain a better understanding of the service needs and capabilities in the region;
4) Propose strategies for conducting needs and capacity assessment studies;
5) Provide feedback on tools and methodology used for implementation of studies;
6) Facilitate access to communities being studied; and,
7) Continually identify individuals who may be interested in membership on NAC.

Meetings:
Unless otherwise indicated, the Needs Assessment Committee meets quarterly on the first Tuesday of the month, in March, June, September and December, from 3:00 p.m. – 4:30 p.m. at the Sacramento County Health Center, 4600 Broadway, Conference Room 2020, Sacramento, CA 95823.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630 or Angelina.olweny@valleyvision.org

Approved by the HIV Health Services Planning Council on:

Richard Benavidez, Chair Dated: 04/26/2023

HIV Health Services Planning Council
PRIORITIES AND ALLOCATIONS COMMITTEE

COMMITTEE OVERVIEW

Statement of Purpose:
The purpose of the Priorities and Allocations Committee (PAC) is to support the mission of the HIV Health Services Planning Council. To this end, PAC shall review and act on data and information to establish proposals for the annual funding priorities and service allocations for Ryan White CARE Act funds.

Statement of Values:
The PAC is dedicated to considering the following values in recommending service priorities and funding allocations:

- Compassion – Assisting those who cannot support themselves
- Equity – Relatively equal portions with attention paid to severe need
- Fairness – Similar cases treated in a similar fashion
- Utilitarianism – Greatest good for the greatest number
- Nuanced Inclusiveness – Since there are real differences among participants regarding both need and ability, a process for assessing these differences will be developed, thereby allowing for differential distribution.

Committee Responsibilities:
PAC is the body through which the HIV Health Services Planning Council receives recommendations on how best to utilize Ryan White funds throughout the TGA. To provide sensible recommendations, PAC is charged with:

1) Reviewing quantitative and qualitative information on service needs, use, costs, outcomes; and availability (internal and external to Ryan White);
2) Determining which services are most needed by people living with HIV (regardless of funding source) and establishing service category priorities;
3) Projecting annual need for essential services;
4) Calculating reasonable allocation allotments for essential services;
5) Developing annual funding request;
6) Sets directives for service delivery in order to increase access by special populations or otherwise ensure fair distribution of resources.
7) Revising annual allocations based upon actual award/changes in actual service cost or utilization patterns.

Desired Experience of Members:
Because PAC must access and consider a wide range of inputs, desired membership qualities are broad. Desired experience includes:

- Understanding of issues impacting people living with HIV;
    - Service consumers
    - Service providers

- Budgeting expertise, or a willingness to learn the process;
- Familiarity with the health and human service delivery community;
- Recipient staff.

Expectations of Members:
PAC provides critical recommendations to the Council regarding the use of Ryan White funds. It is imperative that members

1) Commit to regularly attend and actively participate in PAC meetings;
2) Thoroughly review meeting materials prior to arriving at the meeting;
3) Abide by approved policies and procedures when discussing priorities and allocations;
4) Provide recommendations on how reviewed material should play into the priority setting and allocation processes;
5) Consider all data prior to making decisions and provide unbiased input;
6) Offer prioritization and allocation proposals justified by reviewed data/information;
7) Identify additional data needs;
8) Identify methods for improving processes;
9) Suggest ideas on how services could best be delivered;
10) Continually identify individuals who may be interested in membership on PAC.

Meetings:
Unless otherwise indicated, the Priorities and Allocations Committee meets on the first Wednesday of the months of March, May, June, September, and January, from 9:00 a.m. – 11:00 a.m., at the Sacramento County Health Center, 4600 Broadway, Conference Room 2020, Sacramento, CA 95817.

Contact Information:
Staff support is provided by Angelina Olweny who can be reached at (916) 325-1630 or Angelina.olweny@valleyvision.org

Signed: _____ Date: 6/28/2023
Richard Benavidez, Chair

HIV Health Services Planning Council

QUALITY ADVISORY COMMITTEE

COMMITTEE OVERVIEW

Mission Statement:
The Quality Advisory Committee (QAC) will seek to ensure the quality, consistency, and cost effectiveness with which Ryan White funded services are delivered to consumers by developing and monitoring standards to be utilized by providers delivering Ryan White services.

Committee Responsibilities:
QAC is responsible for developing service recommendations that impact how providers deliver services to consumers on a daily basis. To accomplish its task, QAC:

1) Provides oversight of the Ryan White Quality Management program
2) Researches methods and practices by which services are delivered in Ryan White funded service categories;
3) Seeks input from service providers on realistic expectations on how services could be provided, with a focus on quality assurance and cost effectiveness;
4) Seeks input from consumers on what is expected or needed when accessing services;
5) Identifies standards by which services should be delivered;
6) Creates category-specific service standards;
7) Periodically reviews service standards for ongoing relevance;
8) Develops and reviews performance indicators to ensure that services are achieving desired quality outcomes.
9) One member of the Quality Advisory Committee will participate in the Ryan White CARE Program's Continuous Quality Improvement Program.

Desired Experience of Members:
QAC must be able to draw on a balance of experiences from both providers and consumers of services. Specific skills include:

- Provider experience (delivery of direct service);
    - Representation from a broad range of services, including medical, dental, psychosocial, and support services
- Consumer experience (accessing direct service);
- Program development and evaluation;
- Quality management;
- Recipient staff.

Expectations of Members:
QAC relies on its regular members to determine the fairness and consistency of service standards in its effort to develop functional service standards. Therefore, members are expected to:

1) Consistently attend and actively participate in QAC meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Identify service categories, or areas of service delivery needing service standards;
4) Propose ideas and language for standards under consideration by the Committee;
5) Facilitate access to stakeholders of service standards;

6) Critique suggestions offered by other Committee members and non-Committee members;
7) Continually identify individuals who may be interested in membership on QAC.
8) As needed, identify individuals with expertise on developing specific service standards.

Meetings:
Unless otherwise indicated, the Quality Advisory Committee meets quarterly on the first Tuesday of the month, in March, June, September, and December from 2:00 p.m. – 3:00 p.m. at the Sacramento County Health Center, 4600 Broadway, Conference Room 2020, Sacramento, CA 95823.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630 or Angelina.olweny@valleyvision.org.

Approved by the HIV Health Services Planning Council on:

Richard Benavidez, Chair Date: 04/26/2023

Sacramento TGA
HIV Health Services Planning Council Roster

9/24/2026

Seat/Category	Name	Gender	Race	Affiliation	Appointed	Expires
1. Affected/Underserved Community	**Vacant**					12/31/26
2. Affected/Underserved Community	Zachary Basler	M	W	Non-Aligned	01/28/20	12/31/27
3. Local Public Health	Nolana Mymka	F	W	County of Sacramento	04/28/26	12/31/26
4. Affected/Underserved Community	Arturo Jackson III	M	Hisp	Non-Aligned	12/12/23	12/31/26
5. Affected/Underserved Community	**Vacant**					12/31/26
6. Health Care Provider	Roxane Gaedeke	F	W	WellSpace Health	05/13/25	12/31/28
7. Substance Abuse Treatment	Aven Armstrong-Sutton	Non-Binary	Mult	One Community Health	08/25/26	12/31/27
8. Affected/Underserved Community	Adrian Lujan	TG	Hisp	Non-Aligned	09/09/25	12/31/28
9. Federal AETC	**Vacant**					12/31/26
10. CBO Serving HIV/AIDS	Kristina Kendricks-Clark	F	AA	Harm Reduction Services	12/06/16	12/31/26
11. Non-Elected Community Leader	**Vacant**					12/31/26
12. Housing & Homeless Service	**Vacant**					12/31/24
13. Affected Community-Parolee	Christopher Kendrick-Stafford	M	W	Non-Aligned	07/11/23	12/31/26
14. Children/Youth/Families	Jake Bradley-Rowe	M	W	Sunburst Projects	07/13/21	12/31/26
15. Alt Affected/Underserved Community	**Vacant**					12/31/11
16. Alt Affected/Underserved Community	**Vacant**					12/31/11
17. Affected/Underserved Community	Troy Stermer	M	W	Sierra Foothills AIDS Foundation	07/11/23	12/31/28
18. Federal Title III (Part C)	Shannon Shaw	F	Mult	One Community Health	09/09/25	12/31/28
19. Affected/Underserved Community	Kane Ortega	M	Hisp	Non-Aligned	01/12/05	12/31/28
20. Affected/Underserved Community	Necati Eris	M	W	Non-Aligned	02/24/26	12/31/28
21. Health Care Provider	Austin Green	M	W	Non-Aligned	09/26/23	12/31/26
22. Affected/Underserved Community	Stephan Thomas	M	AA	One Community Health	12/09/25	12/31/28
23. Fiscal Agent Representative	**Vacant**					12/31/27
24. Affected/Underserved Community	**Vacant**					12/31/03
25. Pediatric Consumer	**Vacant**					12/31/02
26. Affected/Underserved Community	**Vacant**					12/31/28
27. Affected/Underserved Community	Vitor Bastos	M	Hisp	Non-Aligned	06/09/26	12/31/26
28. Non-Elected Community Leader	Clarmundo Sullivan	M	AA	Golden Rule Services	02/27/24	12/31/26
29. State Gov Medi-Cal	Chris Amaral	M	W	CA State Medi-Cal Office	09/09/25	12/31/28
30. Affected/Underserved Community	Richard Benavidez	M	Hisp	Sierra Foothills AIDS Foundation	08/26/14	12/31/27
31. HOPWA	Scott Fong	M	Asian	SHRA	02/27/24	12/31/27
32. Affected/Underserved Community	Frances Henderson	F	W	Non-Aligned	08/25/26	12/31/28
33. Affected/Underserved Community	**Vacant**					12/31/26
34. State Government Title II (Part B)	LeRoy Blea	M	Hisp	CA State Office of AIDS	09/09/25	12/31/28
35. Non-Elected Community Leader	Jose Emmanuel Vega	M	Hisp	Gilead Sciences	09/09/25	12/31/27
36. Non-Elected Community Leader	Lenore Gotelli	F	W	Non-Aligned	08/25/26	12/31/26
37. Social Services	Miriam Aguila	F	Hisp	RX Healthcare	08/26/26	12/31/26
38. HIV Prevention Svcs Professional	Aaron Armer	TG	AA	Sacramento LGBT Center	02/27/24	12/31/28
39. Local Public Health	Melissa Willett	F	W	Sierra Foothills AIDS Foundation	08/24/21	12/31/27
40. Local Public Health	Heather Orchard	F	W	El Dorado County Public Health	12/03/24	12/31/27
41. Affected/Underserved Community	**Vacant**					12/31/26
42. Affected/Underserved Community	Steve Austin	M	W	Non-Aligned	07/28/20	12/31/27
43. Mental Health Service Provider	Michael Gagnon	M	Hisp	Sunburst Projects	08/25/26	12/31/26
44. Affected/Underserved Community (Native American)	**Vacant**					12/31/23

HIV Health Services Planning Council

2026-2027 Council and Committee Chair List

Committee	Name	Phone	Email
HHSPC Chair	Richard Benavidez	916-612-3445	Richardbenavidez70@gmail.com
HHSPC Vice Chair	Stephan Thomas	916-217-8839	Stephan.C.Thomas@gmail.com
ACC Chair	Zach Basler	415-299-7027	zacharybasler@gmail.com
AdAC Chair	Melissa Willett	530-889-2437	melissa@sierrafoothillsaids.org
PAC Chair	Jake Bradley-Rowe	916-440-0889	jake@sunburstprojects.org
Governance Chair	Jake Bradley-Rowe	916-440-0889	jake@sunburstprojects.org
NAC Chair	Lenore Gotelli	916-502-8628	lenore.gotelli@gmail.com
QAC Chair	Lenore Gotelli	916-502-8628	lenore.gotelli@gmail.com

Updated 08/27/2026

FY26		ACC	AdAC	Exec	GOV	NAC	PAC	QAC
Aaron	Armer							
Adrian	Lujan							
Arturo	Jackson	x						
Austin	Green							
Aven	Armstrong-Sutton							
Chris	Amaral							
Christopher	Kendrick-Stafford	x			x			
Clarmundo	Sullivan						x	
Frances	Henderson							
Heather	Orchard							
Jake	Bradley-Rowe			x	x		x	
Jose	Emmanual Vega							
Kane	Ortega	x						
Kristina	Kendricks-Clark						x	
Lenore	Gotelli		x	x	x	x	x	x
LeRoy	Blea							
Melissa	Willett		x	x	x	x	x	x
Michael	Gagnon							
Miriam	Aguila							
Necati	Eris	x						
Nolana	Mymka							
Richard	Benavidez	x	x	x	x	x	x	x
Roxanne	Gaedeke							
Scott	Fong							
Shannon	Shaw						x	
Stephan	Thomas	x		x			x	
Steve	Austin	x						
Troy	Stermer		x					
Vitor	Bastos							

Zach	**Basler**	**x**		**x**	**x**		**x**	

2026-27 Sacramento HIV Health Services Planning Council and Committee Meeting Schedule

Committee meetings are held monthly and are subject to cancellation or change. Please check the Sacramento TGA – HIV Health Services Planning Council Website www.sacramento-tga.com for the most updated meeting schedule.

MEETING	DATE/TIME	LOCATION
HIV Health Services Planning Council	4th Wednesday of each month, 10:00 AM – 12 PM *Except Nov/Dec which will be held 12/9/26	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Administrative Assessment Committee (AdAC) (Must be a Council Member to Participate)	Meets as determined by Committee Generally twice a year.	Online
Affected Communities Committee (ACC)	1st Monday of even months, 3:00-4:00 PM April, June, August, October, December, and February	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Executive Committee (Exec)	2nd Thursday of the months of March, May, June, September, and January, 3:00 PM - 5:00 PM	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Governance Committee (Gov)	1st Wednesday of the months of March, May, June, September, and January, 11:00 AM-12 PM	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Quality Advisory Committee (QAC)	Meets Quarterly, 2:00-3:00 PM 1st Tuesday in March, June, September, and December	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Needs Assessment Committee (NAC)	Meets Quarterly, 3:00-4:30 PM 1st Tuesday in March, June, September, and December	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020
Priorities and Allocations Committee (PAC)	1st Wednesday of the months of March, May, June, September, and January, 9:00-11 AM *Additional meetings may be scheduled	Sacramento County Health Center 4600 Broadway, Sacramento, CA 95820 Community Room 2020

Updated 2.4.26

SACRAMENTO HIV CARE SERVICES PROGRAM
CONTRACTOR LIST – FY26

Golden Rule Services 7171 Bowling Drive, Suite 210 Sacramento, CA 95823 Phone (916) 427-4653 Fax (916) 427-4655	**Sacramento Sexual Health Clinic** 4600 Broadway, Suite 1400 Sacramento, CA 95820 Phone (916) 875-1551 Fax (916) 854-9588
Harm Reduction Services 2800 Stockton Blvd Sacramento, CA 95817 Phone (916) 456-4849 Fax (916) 456-2196	**Sunburst Projects** 2143 Hurley Way, Suite 240 Sacramento, CA 95825 Phone (916) 440-0889 Fax (916) 440-1208
One Community Health 1500 21st Street Sacramento, CA 95811 Phone (916) 443-3299 Fax (916) 325-1980	**UCDMC Pediatric Infectious Disease** 2516 Stockton Blvd, Ticon II Sacramento, CA 95817 Phone (916) 734-3557 Fax (916) 734-7890
WellSpace Health 1820 J Street Sacramento, CA 95811 Phone (916) 737-5555	
YOLO COUNTY PROVIDER: **CommuniCare+OLE** 500-B Jefferson Blvd #195, West Sacramento, CA 95605 or 215 W. Beamer St., Woodland, CA 95695 916-403-2900 x 2904	
El DORADO COUNTY PROVIDER: **Sierra Foothills AIDS Foundation (SFAF)** **El Dorado** **Physical:** 550 Pleasant Valley Road, Suite 1F Diamond Springs, CA 95619 **Mail**: 550 Main Street, Suite 1F, Diamond Springs, CA 95619 Phone (530) 622-1923 Fax (530) 344-0685	PLACER COUNTY PROVIDER: **Sierra Foothills AIDS Foundation (SFAF)** **Placer** 12183 Locksley Lane, Suite 208 Auburn, CA 95602 Phone (530) 889-2437 Fax (530) 889-2443

HIV Care Services Program

FY 2026-2027

CONTRACT PROVIDER PROFILES

Sacramento County

- **Golden Rule Services** – The Agency provides non-medical case management services and emergency financial assistance for people living with HIV/AIDS. Golden Rule Services also provides a variety of free condom distribution, PrEP Navigation, PrEP Enrollment Assistance, HIV, STD, and Hepatitis C education, prevention, and testing services to underserved, high-risk, and vulnerable community members including People of Color, the lesbian, gay, bisexual and transgender community, women, sex industry workers, injection drug users, ex-offenders, and youth.
- **Harm Reduction Services (HRS)** – The Agency provides outreach to under-served populations with a special emphasis targeting People Who Inject Drugs (PWID) and other Substance Using HIV+ individuals who are currently not in medical care as well as individuals engaged in sex work. The agency also provides medical case management services under the Minority AIDS Initiative (MAI) to deliver specialized intensive field-based case management services and provides medical transportation services, food assistance, and emergency financial assistance to their clients.

- **One Community Health** – The Agency provides a wide array of services to persons living with HIV/AIDS including: medical services, oral health care, pharmacy and laboratory services, mental health services, medical case management including Minority AIDS Initiative case management, health insurance premium assistance, non-medical case management, housing, food assistance, transportation, emergency financial assistance, medical nutritional therapy, outreach, and outpatient substance abuse services.

- **Sacramento Sexual Health Clinic** – The Agency provides medical services, medical case management, food, emergency financial assistance, health insurance premium assistance, non-medical case management, health education/risk reduction, linguistic, and transportation services for persons living with HIV/AIDS.

- **Sunburst Projects** – The Agency's mission is to serve the needs of the HIV/AIDS community through compassionate care and services such as medical case management including Minority AIDS Initiative case management. Other programs include behavioral health services such as individual, couples, family, and group mental health therapy, psychiatric care, non-medical case management, transportation, childcare, food, emergency financial assistance, 340b pharmacy services, linguistic services, housing assistance, and other professional services. Sunburst Projects serves men, women, children, and families throughout the Sacramento TGA.

- **University of California – Davis Pediatric Infectious Disease Clinic (UCD)** – The agency provides pediatric primary medical care, pediatric medication adherence services, medical transportation services, and medical case management services to children living with HIV/AIDS.

- **WellSpace Health** – The Agency provides medical services, oral health care, medical case management, food, non-medical case management, mental health, outreach, outpatient substance abuse services, housing assistance, health education/risk reduction, and transportation services for persons living with HIV/AIDS.

El Dorado County

- **Sierra Foothills AIDS Foundation – Diamond Springs, CA** – The Agency's primary mission is to provide comprehensive support services to people living with HIV or AIDS and their families and to provide education and prevention services to the general public, including free HIV testing. Services include medical case management, medical transportation vouchers, health insurance and cost-sharing assistance, mental health services, oral health services, residential substance abuse treatment services, and other critical needs.

Placer County

- **Sierra Foothills AIDS Foundation, Auburn, CA**– The Agency's primary mission is to provide comprehensive support services to people living with HIV or AIDS and their families and to provide education and prevention services to the general public, including free HIV testing. Services include medical case management, medical transportation vouchers, health insurance and cost-sharing assistance, mental health services, oral health services, residential substance abuse treatment services, and other critical needs.

Yolo County

- **CommuniCare+OLE, West Sacramento and Woodland, CA**– Client-focused and community-based, CommuniCare+OLE's HIV/AIDS medical case management services help people living with HIV/AIDS in Yolo County to maintain and enhance their independence and quality of life. The HIV/AIDS medical case management services assist clients in accessing appropriate resources through referrals and provide support for clients dealing with multiple sources of stress including physical illness, emotional well-being, finances, and social relationships. HIV/AIDS medical case management services are comprehensive and long-term in scope.

FY26 HIV Care Services Provider and Service Matrix	One Community Health	Communi-Care+OLE (Yolo)	Sierra Foothills AIDS Foundation (El Dorado)	Golden Rule Services	Harm Reduction Services	Sacramento County Sexual Health Clinic	Sierra Foothills AIDS Foundation (Placer)	Sunburst Projects	UC Davis Pediatrics	WellSpace Health
Ambulatory Care	●					●			●	●
Child Care								●		
Emergency Financial Assistance	●	●	●	●	●	●	●	●		
Food Bank/Home Delivered Meals	●	●			●	●		●		●
Health Education and Risk Reduction						●		●		●
Health Insurance and Cost-Sharing Assistance Program	●		●			●	●			
Housing	●	●						●		●
Linguistic Services						●		●		
Medical Case Management	●	●	●		●	●	●	●	●	●
Medical Case Management - MAI	●				●			●		
Medical Nutritional Therapy	●									
Medical Transportation	●	●	●		●	●	●	●		●
Mental Health	●		●				●	●		●
Non-Medical Case Management	●			●				●		●
Oral Health Care	●	●	●				●			●
Other Professional Services								●		
Outreach Services										●
Substance Abuse - Outpatient	●									●

Updated 9.24.26

FY26 HIV Care Services Provider and Service Matrix	One Community Health	Communi-Care+OLE (Yolo)	Sierra Foothills AIDS Foundation (El Dorado)	Golden Rule Services	Harm Reduction Services	Sacramento County Sexual Health Clinic	Sierra Foothills AIDS Foundation (Placer)	Sunburst Projects	UC Davis Pediatrics	WellSpace Health
Ambulatory Care	A/B					A/EHE			A	A/EHE
Child Care								A		
Emergency Financial Assistance	A	B	A	A	A	A/EHE	A	A		
Food Bank/Home Delivered Meals	A/B	B			A	EHE		A/B		A/EHE
Health Education and Risk Reduction						EHE		A		EHE
Health Insurance and Cost-Sharing Assistance Program	A		A			EHE	A			
Housing	A	B						A		A
Linguistic Services						EHE		A		
Medical Case Management	A	B	A		A	EHE	A	A/B	A	A/EHE
Medical Case Management - MAI	A				A			A		
Medical Nutritional Therapy	A									
Medical Transportation	A	B	A		A/B	EHE	A	A/B		A/EHE
Mental Health	A		A				A	A/B		A
Non-Medical Case Management	A/B			A/B				A/B		A/EHE
Oral Health Care	A/B	B	A				A			A
Other Professional Services								A		
Outreach Services										EHE
Substance Abuse - Outpatient	A									A
HOPWA Services	X	X	X				X	X		

Updated 9/24/26

A = Part A funding
B = Part B Funding
EHE = Ending the HIV Epidemic Funding

RYAN WHITE HIV/AIDS PROGRAM PART A

PLANNING COUNCIL PRIMER

MAY 2018

PLANNING
CHATT
Community HIV/AIDS
Technical Assistance & Training

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Introduction

Uniqueness and Value of Planning Councils

One of the important aspects of the Ryan White HIV/AIDS Program (RWHAP) is its focus on community health planning for HIV care and treatment. Community health planning is a deliberate effort to involve diverse community members in "an open public process designed to improve the availability, accessibility, and quality of healthcare services in their community."[1] The process involves "identifying community needs, assessing capacity to meet those needs, allocating resources, and resolving conflicts." For RWHAP Part A, planning councils/planning bodies play that role.

RWHAP planning councils are unique. No other federal health or human services program has a legislatively required planning body that is the decision maker about how funds will be used, has such defined membership composition, and requires such a high level of consumer participation (at least 33 percent). When more than 100 recipients, planning council leaders, and planning council support staff were asked in a recent national assessment[2] about the greatest value of planning councils, they most often identified the following benefits:

- Community involvement in decision making about HIV services
- A consumer voice in decisions about services
- Collaboration among diverse stakeholders, including consumers and other people living with HIV, providers, the local health department, researchers, and other community members, with everyone sitting at the same table and working together to make the best decisions for the community
- Positive impact on the service system, including improvements in access to and quality of care, and contributions to positive client outcomes including viral suppression.

Individuals who serve as RWHAP planning council members make a vital contribution to their communities by helping to strengthen and improve the service system for people living with HIV.

1 Stern J. Community Planning, American Health Planning Association, 2008. available at http://www.ahpanet.org/files/community_health_planning_09.pdf

2 McKay E., et al. Engaging RWHAP Consumers in Planning and Needs Assessment, 2016 National Ryan White Conference on HIV Care & Treatment. available at https://careacttarget.org/sites/default/files/supporting-files/6746McKay.pdf

Purpose of the Primer

This Primer is designed to help Ryan White HIV/AIDS Program (RWHAP) Part A planning council members better understand the roles and functioning of planning councils.

The Primer explains what RWHAP does, and describes what planning councils do in helping make decisions about what RWHAP services to fund and deliver in their geographic areas. The Primer is intended to be a basic reference to help prepare planning council members to actively engage in planning council activities, and effectively carry out their legislatively defined community health planning duties.

While most RWHAP Part A jurisdictions have planning councils, a few smaller areas have planning bodies, which serve the same purpose but are not subject to the same legislative requirements as planning councils. This Primer describes the expectations for planning councils; there are no specific requirements for other types of planning bodies. However, Health Resources and Services Administration (HRSA) encourages such planning bodies to be as similar as possible to planning councils in their membership, and to carry out the same activities as planning councils[3], as outlined in the legislation. Therefore this Primer should be useful to planning bodies as well as planning councils.

3 HRSA/HAB Letter to RWHAP Part A Grantees, 2013. Available at https://hab.hrsa.gov/sites/default/files/hab/Global/transitionalgrantareasplanningcouncilsmoving-forward.pdf

The Ryan White HIV/AIDS Program

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. The Program reaches over half of all people diagnosed with HIV in the United States.

The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training and the development of innovative models of care. The Program serves as an important source of ongoing access to HIV medications that can enable people living with HIV to live close to normal lifespans.

The RWHAP legislation is known as the Ryan White HIV/AIDS Treatment Extension Act of 2009, and is also Title XXVI of the Public Health Service Act. The legislation was first passed in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The 2009 law is the fourth reauthorization of RWHAP by Congress. The program helps people living with HIV get into care early, stay in care, and remain healthy.

Most RWHAP funds are used for grants to local and state areas to address the needs of people living with HIV. Many decisions about how to use the money are made by local planning councils/planning bodies and state planning groups, which work as partners with their governments.

RWHAP is administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care by strengthening the healthcare workforce, building healthy communities and achieving health equity.

The RWHAP legislation supports grants under the five sections of the Act: Parts A, B, C, D, and F. Below is a short description of each. The majority of the funding that goes to RWHAP Part A and Part B is awarded under a formula based on the number of living HIV and AIDS cases in these areas.

RYAN WHITE HIV/AIDS PROGRAM FUNDING

- **RWHAP Part A:** Grants to metropolitan areas hardest hit by the epidemic for HIV medical care and support services
- **RWHAP Part B:** Grants to states and territories for HIV medical care and support services, including HIV-related medications through the AIDS Drug Assistance Program (ADAP)
- **RWHAP Part C:** Community-based early intervention services grants for HIV medical care and support services
- **RWHAP Part D:** Community-based grants for family-centered primary and specialty medical care and support services for infants, children, youth, and women living with HIV
- **RWHAP Part F:** Support for five programs—Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), HIV Dental Programs, and the Minority AIDS Initiative (MAI)

RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas

RWHAP Part A funds go to local areas that have been hit hardest by the HIV epidemic. The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV to improve their health outcomes.

Almost three quarters of people living with HIV in the U.S. live in RWHAP Part A-funded areas. These areas are called eligible metropolitan areas (EMAs) or transitional grant areas (TGAs):

- EMAs are metropolitan areas with at least 2,000 new cases of AIDS reported in the past five years and at least 3,000 cumulative living cases of AIDS as reported by the Centers for Disease Control and Prevention (CDC) in the most recent calendar year for which data are available. As of early 2018, there were 24 EMAs.
- TGAs are metropolitan areas with between 1,000 and 1,999 new cases of AIDS reported in the past five years and at least 1,500 cumulative living cases of AIDS as reported by the CDC in the most recent calendar year for which data are available. As of early 2018, there were 28 TGAs.

RWHAP Part A funds go to the ***chief elected official (CEO)*** of the major city or county government in the EMA or TGA. The CEO is usually the mayor; however sometimes the CEO is the county executive, chair of the board of supervisors, or county judge. The CEO is legally the recipient of the grant, but usually chooses a lead agency such as a department of health or other entity to manage the grant. That entity is also called the ***recipient***. The recipient manages the grant by making sure RWHAP funds are used according to the RWHAP legislation, program policy guidance, and grants policy. The recipient works with the ***RWHAP Part A planning council/planning body***, which is responsible for making decisions about service priorities and resource allocation of RWHAP Part A funds.

RWHAP Part A funds are used to develop or enhance access to a comprehensive system of high quality, community-based care for low-income people living with HIV. RWHAP Part A recipients must provide comprehensive primary health care and support services throughout the entire geographic service area. RWHAP Part A funds may be used for HIV primary medical care and other medical-related services and for support services (like medical transportation) that are needed by people living with HIV in order to stay in care, and linked to positive medical outcomes.

At least 75 percent of service funds must be used for core medical-related services, and up to 25 percent may be used for approved support services, unless the EMA or TGA successfully

applies for a waiver. A limited amount of the money (up to 10 percent of the total grant) can be used for administrative costs, which include planning, managing, monitoring, and evaluating programs. Administrative funds are also used to support a comprehensive community planning process, through the work of a planning council or other planning body. In addition, some funds (up to 5 percent of the total grant or $3 million, whichever is less) are set aside for clinical quality management, to ensure service quality.

RWHAP Part B: Grants to States and Territories

RWHAP Part B provides funds to improve the quality, availability, and organization of HIV health care and support services in states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the U.S. Pacific Territories and Associated Jurisdictions.

Like RWHAP Part A funds, RWHAP Part B funds are used for medical and support services. A major priority of RWHAP Part B is providing medications for people living with HIV. The RWHAP legislation gives states flexibility to deliver these services under several programs:

- Grants for medical and support services for people living with HIV
- The AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications through the purchase of medications and the purchase of health insurance
- Grants to states with emerging communities that have a growing rate of HIV/AIDS.

States can receive ADAP funds through three types of grants:

- Formula funding that goes to every state and territory based on the number of living HIV/AIDS cases reported by the CDC in the most recent calendar year
- Competitive ADAP supplemental funding, supported through a five percent set aside of the ADAP base award and provided to states and territories that meet RWHAP legislative eligibility criteria and apply for additional funds to address a severe need for medications
- Competitive ADAP Emergency Relief Funding (ERF), available to states and territories that can demonstrate the need for additional resources to prevent, reduce, or eliminate waiting lists, including through cost-containment measures.

ADAP funds are used to provide HIV antiretroviral medications to low-income people living with HIV. Funds may also be used to pay for health coverage, copays, and deductibles* for eligible clients and for services that enhance access and adherence to drug treatments, or monitor drug treatments.

ADAP FORMULARY REQUIREMENTS

Each ADAP must cover at least one drug from each class of HIV antiretroviral medications on its ADAP formulary. RWHAP funds may only be used to purchase FDA-approved medications. Within these requirements, each ADAP decides which medications to include on its formulary and how those medications will be distributed. ADAP eligibility criteria must be consistently applied across the state or territory, and all formulary medications and ADAP-funded services must be equally and consistently available to all eligible enrolled people throughout the state or territory.

As with RWHAP Part A, 75 percent of RWHAP Part B service dollars must be used for core medical-related services unless the state obtains a waiver. RWHAP Part B recipients can use no more than 10 percent of their grants for administration, including indirect costs. They can also use up to 10 percent for planning and evaluation, but the total for both types of activities must be no more than 15 percent of the RWHAP Part B grant. As with RWHAP Part A, recipients may also spend up to 5 percent of their grant or up to $3 million, whichever is less, for the establishment and implementation of a clinical quality management program.

States are required to conduct a needs assessment to determine service needs of people living with HIV. Based upon needs assessment results, states must set priorities and allocate resources to meet these needs. States must also prepare an integrated HIV prevention and care plan, including a ***Statewide Coordinated Statement of Need (SCSN)***, which is a guide on how to meet these needs.

Planning is an essential part of determining how to use limited RWHAP Part B funds in providing a system of HIV/AIDS care. States are required to obtain community input as a component of planning for the use of RWHAP Part B resources, and many states do this through RWHAP Part B advisory groups. A state can choose to oversee planning itself through statewide or regional planning groups, or can assign the responsibility to consortia. Consortia are associations of public and nonprofit healthcare and support service providers and community-based organizations that the state contracts with to provide planning, resource allocation and contracting, program and fiscal monitoring, and required reporting. Some are statewide groups, while others cover specific local areas or regions. Some regional consortia also directly deliver medical and support services.

Some states also receive ***Emerging Communities*** grants to establish and support systems of care in metropolitan areas that are not eligible for RWHAP Part A funding but have a growing rate of HIV. To be eligible for these funds, a metropolitan area must have between 500 and 999 AIDS cases reported in the past five years. To stay eligible, it must have at least 750 cumulative living AIDS cases as of the most recent calendar year. Some Emerging Communities eventually become eligible for RWHAP Part A funding.

RWHAP Part C: Community-Based Early Intervention Services

RWHAP Part C funds local, community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people living with HIV.

RWHAP Part C funding is through ***Early Intervention Services (EIS)*** program grants. RWHAP Part C funds also help organizations more effectively deliver HIV care and services. Unlike RWHAP Part A and Part B, these funds are awarded competitively and go directly to community agencies like community health centers, rural health clinics, health departments, and hospitals. While RWHAP Part C funds many locations around the nation, a funding priority under the legislation is support for HIV-related primary care services in rural areas or for populations facing high barriers to access.

RWHAP Part C recipients must use at least 50 percent of the grant for EIS. They may use no more than 10 percent of their grants for administration, including indirect costs. In addition, RWHAP Part C recipients must use at least 75 percent of their grant funds for core medical services and up to 25 percent for support services. This is the same requirement that applies to Parts A and B.

RWHAP Part C also provides Capacity Development grants. ***Capacity Development*** grants help public and nonprofit entities strengthen their organizational infrastructure and improve their capacity to provide high-quality HIV primary care services.

RWHAP PART C EARLY INTERVENTION REQUIRED SERVICES

EIS programs must include the following components:

- HIV counseling
- High-risk targeted HIV testing
- Referral and linkage of people living with HIV to comprehensive care, including outpatient/ambulatory health services, medical case management, substance abuse treatment, and other services
- Other HIV-related clinical and diagnostic services

RWHAP Part D: Services for Women, Infants, Children, and Youth

RWHAP Part D funds are used to provide family-centered primary medical care and support services to women, infants, children, and youth living with HIV. RWHAP Part D funds are competitive grants that go directly to local public or private healthcare organizations including hospitals, and to public agencies.

RWHAP Part D grants are used for medical services, clinical quality management, and support services, including services designed to engage youth living with HIV and retain them in care. Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth. RWHAP Part D recipients can use no more than 10 percent of their grants for administration, including indirect costs.

RWHAP Part F: SPNS, AETC, Dental Programs, and MAI

RWHAP Part F provides grant funding that supports several research, technical assistance, and access-to-care programs.

- **Special Projects of National Significance (SPNS):** SPNS funds are awarded competitively to organizations that are developing new and better ways of serving people living with HIV and addressing emerging client needs. Projects include a strong evaluation component.
- **AIDS Education and Training Centers (AETCs):** AETC regional and national centers train health care providers treating people living with HIV. AETCs train clinicians and multidisciplinary HIV care team members. They help to increase the number of health care providers prepared and motivated to counsel, diagnose, treat, and medically manage people living with HIV.
- **HIV/AIDS Dental Reimbursement Program:** These funds go to dental schools and other dental programs to help pay for dental care for people living with HIV.
- **Community Based Dental Partnership Program:** These funds are used to deliver community-based dental care services for people living with HIV while providing education and clinical training for dental care providers, especially in community-based settings.
- **Minority AIDS Initiative (MAI):** MAI funds are used to improve access to health care and medical outcomes for racial and ethnic minorities— communities that are disproportionately affected by HIV. RWHAP Part A programs apply for MAI funds as part of their annual applications, and receive funds on a formula basis. They are expected to administer MAI activities as an integral part of their larger programs.

How RWHAP Part A Works

The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV residing in the EMA/TGA, in order to improve their health outcomes. This section of the Primer describes the people and entities that participate in RWHAP Part A and what they do.

Participants

Participants in the RWHAP Part A grant for the EMA or TGA include the following:

- The chief elected official (CEO), who receives the funds on behalf of the EMA or TGA
- The recipient, the entity chosen by the CEO to manage the grant and make sure funds are used appropriately
- The planning council (or planning body), which conducts planning, decides how to allocate resources, and works to ensure a system of care that provides equitable access to care and needed services to all eligible people living with HIV in the EMA or TGA
- The HRSA HIV/AIDS Bureau's Division of Metropolitan HIV/AIDS Programs (HAB/DMHAP), the federal government entity within HRSA that makes sure the RWHAP Part A program is implemented appropriately.

The Chief Elected Official (CEO)

The CEO is the person who officially receives the RWHAP Part A funds from HRSA. The CEO is the chief elected official of the major city or urban county in the EMA or TGA that provides HIV care to the largest number of people living with HIV. The CEO may be a mayor, chair of the county board of supervisors, county executive, or county judge. The CEO is responsible for making sure that all the rules and standards for using RWHAP Part A funds are followed. The CEO usually designates an agency to manage the RWHAP Part A grant—generally the county or city health department. The CEO establishes the planning council/planning body and appoints its members.

The Recipient

As the person who receives RWHAP Part A funds, the CEO is the recipient. However, in most EMAs and TGAs, the CEO delegates responsibility for administering the grant to a local government agency (such as a health department) that reports to the CEO. This agency is called the recipient. The word "recipient" means the person or organization that actually carries out RWHAP Part A tasks, whether that is the CEO, the public health department, or another agency that reports to the CEO.

THE RWHAP PART A AWARDS PROCESS

Each year Congress appropriates funds for the Ryan White HIV/AIDS Program, including RWHAP Part A. The money for RWHAP Part A is divided into formula and supplemental funds and Minority AIDS Initiative (MAI) funds.

- **Formula funds** are awarded to EMA or TGAs based on the number of persons living with HIV and AIDS in the EMA or TGA.
- **Supplemental funds** are awarded to the EMA or TGA based on increasing prevalence rates, documented demonstrated need and service gaps, and a demonstrated disproportionate impact on vulnerable populations.
- **RWHAP Part A MAI funds** are allocated based on each EMA's or TGA's percentage of all living HIV disease cases among racial and ethnic minorities.

EMAs or TGAs must submit a grant application to HRSA to receive RWHAP Part A formula, supplemental, and MAI funds.

The recipient should prepare the application with planning council/planning body input. The funding year begins on March 1.

The Planning Council

Before an EMA/TGA can receive RWHAP Part A funds, the CEO must appoint a planning council. The planning council must carry out many complex planning tasks to assess the service needs of people living with HIV living in the area, and specify the kinds and amounts of services required to meet those needs. The planning council is assisted in fulfilling these complex tasks by ***planning council support (PCS) staff*** whose salaries are paid by the grant.

The RWHAP legislation requires planning councils to have members from various types of groups and organizations, including people living with HIV who live in the EMA/TGA. A key function of the planning council is to provide the consumer and community voice in decision-making about medical and support services to be funded with the EMA/TGA's RWHAP Part A dollars.

TGAs do not have to follow the legislative requirements related to planning councils, but must provide a process for obtaining consumer and community input. TGAs that have currently operating planning councils are strongly encouraged by the HIV/AIDS Bureau to maintain that structure.

HRSA/HAB

The HRSA HIV/AIDS Bureau (HAB) is the office in the federal government that is responsible for administering RWHAP Part A throughout the country. The HRSA/HAB office is located in Rockville, Maryland. HRSA develops policies to help implement the legislation, and provides guidance to help recipients understand and implement legislative requirements. These include Policy Clarification Notices (PCNs), related Frequently Asked Questions (FAQs), and Program Letters.

Each EMA or TGA is assigned a ***Project Officer*** who works in HRSA/HAB. Project Officers help the recipient and planning council do their jobs and make sure that they are running the local RWHAP Part A program as the RWHAP legislation, National Monitoring Standards, and other federal regulations say they should. Project Officers make periodic site visits and hold monthly monitoring calls with the recipient. The planning council Chair is sometimes included on a part of these calls.

Planning Council and Recipient: Separate Roles and Mutual Goals

The RWHAP Part A planning council and the recipient have separate roles that are stated in the RWHAP legislation, but they also share some duties.

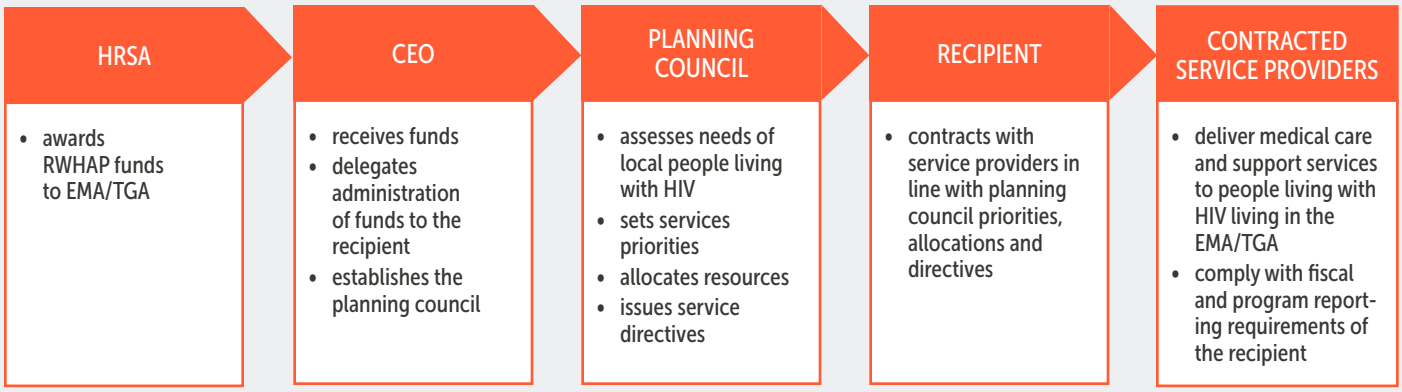
The planning council and the recipient work together on identifying the needs of people living with HIV (by conducting a needs assessment) and preparing a ***CDC and HRSA Integrated HIV Prevention and Care Plan***, formerly known as a comprehensive plan (which is a long-term guide on how to meet those needs).

Both also work together to make sure that other sources of funding work well with RWHAP funds and that RWHAP is the "payor of last resort." This means that other available funding should be used for services before RWHAP dollars are used to pay for them.

The planning council decides what services are priorities for funding and how much funding should be provided for each service category, based upon the needs of people living with HIV in the EMA/TGA. The recipient is accountable for managing RWHAP Part A funds and awarding funds to agencies to provide services that are identified by the planning council as priorities, usually through a competitive "Request for Proposals" (RFP) process.

The planning council cannot do its job without the help of the recipient, and the recipient cannot do its job without the help of the planning council. Some of the responsibilities are identified clearly in the RWHAP legislation. Others must be decided locally. It is important that the planning council and the recipient work together and come to an agreement about their duties. This agreement should be written in planning council bylaws and in a memorandum of understanding (MOU) between the recipient and the planning council.

How RWHAP Part A Improves Access and Services for People Living with HIV



The table below shows which RWHAP Part A participant has responsibility for specific roles and duties. Each of these roles/duties is described in detail in the following sections of the Primer.

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Service Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

Planning Council Duties

The planning council (and its staff) must carry out many complex tasks, summarized in the box and described below.

The first step is to set up rules and structures to help the planning council to operate smoothly and fairly (***planning council operations***). This includes bylaws, grievance procedures, conflict of interest policies and procedures, procedures that ensure open meetings, and an open nominations process to identify nominees for the planning council. It also includes a committee structure. Planning councils must be trained in planning, and new members must receive orientation to their roles and responsibilities and those of the recipient.

The planning council must find out about what services are needed and by which populations, as well as the barriers faced by people living with HIV in the EMA or TGA (***needs assessment***). Next—based on needs assessment, utilization, and epidemiologic data—it decides what services are most needed by people living with HIV in the EMA or TGA (***priority setting***) and decides how much RWHAP Part A money should be used for each of these service categories (***resource allocations***).

The planning council may also provide guidance to the recipient on service models, targeting of populations or service areas, and other ways to best meet the identified priorities (***directives***). The planning council works with the recipient to develop a long-term plan on how to provide these services (***integrated/comprehensive planning,*** formerly called comprehensive planning). The planning council reviews service needs and ways that RWHAP Part A services work to fill gaps in care with other RWHAP Parts through the Statewide Coordinated Statement of Need (SCSN) as well as with other programs like Medicaid and Medicare (***coordination***).

The planning council also evaluates how providers are selected and paid, so that funds are made available efficiently where they are most needed (***assessment of the efficiency of the administrative mechanism***). All of these roles are described below.

PLANNING COUNCIL ROLES AND RESPONSIBILITIES

- Planning council operations: structure, policies, and procedures, and membership tasks
- Needs assessment
- Integrated/comprehensive planning
- Priority setting and resource allocations
- Directives: guidance to the recipient on how best to meet priorities
- Coordination with other RWHAP Parts and other HIV-related services
- Assessment of the efficiency of the administrative mechanism
- Development of service standards
- Evaluation of program effectiveness (optional)

Planning Council Operations

Planning councils must have procedures to guide their activities. Planning council operations are usually outlined in their bylaws and described in greater detail in policies and procedures covering the following areas:

MEMBERSHIP

The planning council needs a membership committee and a clear and open nominations process to choose new planning council

members and to replace members when a member's term ends or the person resigns. This includes making sure that the planning council membership overall and the consumer membership meet the requirements of ***reflectiveness***—having characteristics that reflect the local epidemic in such areas as race, ethnicity, gender, and age, and ***representation***—filling the required membership categories as stated in the legislation (See page 17). Particular attention should be paid to including people from disproportionately affected and "historically underserved"[4] groups and subpopulations. At least 33 percent of voting members must be consumers of RWHAP Part A services who are *"unaffiliated"* or *"unaligned."* This means they do not have a conflict of interest, meaning they are not staff, paid consultants, or Board members of RWHAP Part A-funded agencies.

Open nominations require member vacancies and nomination criteria to be widely advertised. The announcement of an opening on the planning council should include the qualifications and other factors that are considered when choosing members. Nomination criteria must include a conflict of interest standard so that planning council members make decisions that are best for people living with HIV in the EMA or TGA, without considering personal or professional benefits for themselves or their families. The planning council reviews nominations against vacancies and recommends members to the CEO for appointment.

LEADERSHIP

Every planning council has a leader, usually called the Chair. This responsibility may be shared by two or more persons, called Co-Chairs, or there may be a Chair and Vice Chair(s). HRSA suggests that the Chair of the planning council be elected by its members. Sometimes a Chair or one Co-Chair is appointed by the recipient from the list of members recommended by the planning council. A person who works for the recipient may not be the only Chair of the council—in this case, there must be Co-Chairs.

COMMITTEES

Planning councils do much of their work in committees. Most planning councils require each member to participate actively on one committee and to attend full planning council meetings. Bylaws usually specify several permanent "standing committees," and may permit special ad hoc temporary or time-limited committees or caucuses as well. Committee structures vary, but most planning councils have an executive or steering committee, a membership committee (sometimes also responsible for operations such as policies and procedures), and a people living with HIV or consumer committee or caucus. In addition, they usually have one or several committees responsible for carrying out major legislative responsibilities related

4 Ryan White HIV/AIDS Treatment Extension Act of 2009 www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf

Required Planning Council Membership Categories

PEOPLE LIVING WITH HIV & COMMUNITY

- Members of affected communities*
- Non-elected community leaders
- Representatives of recently incarcerated people living with HIV
- Unaffiliated consumers

PUBLIC HEALTH & HEALTH PLANNING

- Public health agencies
- Healthcare planning agencies
- State agencies**

HEALTH & SOCIAL SERVICE PROVIDERS

- Healthcare providers, including FQHCs
- Community-based organizations and AIDS service organizations
- Social service providers
- Mental health and substance abuse treatment providers

FEDERAL HIV PROGRAMS

- RWHAP Part B recipients
- RWHAP Part C recipients
- RWHAP Part D recipients†
- Recipients under other federal HIV programs‡

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* Including people living with HIV, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and "historically underserved[4] groups and subpopulations

** Including state Medicaid agency and agency administering the RWHAP Part B program

† If there is no RWHAP Part D recipient in the EMA or TGA, representatives of organizations with a history of serving children, youth, and families living with HIV

‡ Including HIV prevention services

PLANNING COUNCIL BYLAWS

Each planning council must have written rules, called bylaws, which explain how the planning council operates. Bylaws must be clear and exact. They should include at least the following:

- Mission of the planning council
- Member terms and how members are selected (open nominations process)
- Duties of members
- Officers and their duties
- How meetings are announced and run, including how decisions are made
- What committees the planning council has and how they operate
- Conflict of interest policy
- Grievance procedures
- Code of Conduct for members
- How the bylaws can be amended

to needs assessment, integrated/comprehensive planning, priority setting and resource allocations, and maintaining and improving the system of care. Committees typically discuss issues, develop plans or recommendations, and bring them to the executive/steering committee for review and possible revision. Then the recommendations go to the full planning council for final discussion and action.

TRAINING

Members need to learn how to participate in the many tasks involved in RWHAP planning. Planning councils must provide orientation for new members, covering topics such as the legislation and their roles and responsibilities in planning, as well as those of the recipient. All planning council members should receive periodic training to help them carry out their roles. HRSA requires planning councils to confirm in the annual RWHAP Part A application that training for all members occurred at least once during the year.[5]

GROUP PROCESS

This includes a Code of Conduct, as well as rules for committee and full planning council operations, meeting times, and locations. These decisions are usually summarized in the bylaws and detailed in official policies and procedures.

DECISION MAKING

The planning council needs to agree on how decisions will be made —for example, by voting or consensus—and how grievances related to funding decisions and conflict of interest will be managed (see Planning Council Bylaws). For example, the planning council needs to decide whether its meetings will follow *Robert's Rules of Order.* These rules and procedures are usually included in the bylaws and further described in separate policies and procedures.

CONFLICT OF INTEREST

The planning council must define ***conflict of interest*** and determine how it will be handled as the planning council carries out its duties. The planning council must develop procedures to assure that decisions concerning service priorities and funding allocations are based upon community and client needs and not on the financial interests of individual service providers or the personal or professional interests of individual planning council members. Conflict of interest procedures generally include a disclosure form completed by all members that states in writing any affiliations that could create a conflict of interest.

5 The FY 2018 Notice of Funding Opportunity (NOFO) for RWHAP Part A requires that the letter of assurance from the planning council or the letter of concurrence from the planning body leadership provide evidence that "ongoing, annual membership training occurred, including the date(s)" [p 15].

Usually, conflict of interest policies also apply to specified family members. Thus, planning councils must decide how planning council members may or may not participate in making decisions about specific services if they or close family members are staff, consultants, or Board members of agencies that are receiving RWHAP Part A funds for these specific services, or are competing for such funds. For example, if a planning council member works for a substance abuse treatment provider receiving RWHAP Part A funds, the member may not participate in decision making about priorities, allocations, or directives related to substance abuse treatment. However, members may freely share their insights and expertise at appropriate times in a non-voting context, such as during data presentations or community input sessions, since all members can benefit from hearing a variety of perspectives and expertise.

GRIEVANCE PROCEDURES

The planning council must develop ***grievance procedures*** to handle complaints about how it makes decisions about funding. The grievance procedures must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled. The recipient must also have its own grievance procedures, which focus on handling of complaints about the process used for funding of ***subrecipients*** who provide services. The two sets of grievance procedures should be written to be in alignment with each other so that they do not conflict.

PLANNING COUNCIL SUPPORT

Planning councils need personnel to assist them in their work, and money to pay for things like a needs assessment and meeting costs. This is called ***planning council support***. Planning council support should cover reasonable and necessary costs associated with carrying out legislatively mandated functions. The planning council's budget is a part of the recipient's administrative budget, so the planning council and recipient decide together what funds are needed. The planning council then works with its support staff to develop its own budget and monitor expenses, but must meet RWHAP and recipient rules regarding use of funds. In deciding how much planning council support to pay for, planning councils and recipients should balance the need for support in order to meet planning requirements with the need for other administrative activities and for direct services for people living with HIV.

HRSA encourages planning councils to use some planning council support funds to reimburse unaffiliated consumer members for their actual expenses related to participation in the planning council, such as travel or child/dependent care. However, RWHAP funds may not be used to provide stipends to members.

Needs Assessment

The planning council works with the recipient to identify service needs by conducting a needs assessment. This involves first finding out how many persons living with HIV (both HIV/non-AIDS and AIDS) are in the area through an ***epidemiologic profile***. Usually, an epidemiologist from the local or state health department provides this information. Next the council determines the needs of populations living with HIV and the capacity of the service system to meet those needs. This assessment of needs is done through surveys, interviews, key informant sessions, focus groups, or other methods.

The needs assessment seeks to determine:

- Service needs and barriers for people living with HIV who are in care
- The number, characteristics, and service needs and barriers of people living with HIV who know their HIV status and are not in care
- The estimated number, probable characteristics, and barriers to testing for individuals who are HIV-infected but unaware of their status
- The number and location of agencies providing HIV-related services in the EMA or TGA—a resource inventory of the local "system of care"
- Local agencies' capacity and capability to serve people living with HIV, including capacity development needs
- Service gaps for all people living with HIV and how they might be filled, including how RWHAP service providers need to work with other providers, like substance abuse treatment services and HIV prevention agencies.

The needs assessment must include direct input from people living with HIV. Needs assessment is usually a multi-year task, with different components updated each year.

The needs assessment should be a joint effort of the planning council and recipient, with the planning council having lead responsibility. It is sometimes implemented by an outside contractor under the supervision of the planning council. Usually the costs for needs assessment are part of the planning council support budget. Regardless of who does this work, it is important to obtain many perspectives, especially those of diverse groups of people living with HIV, and to consider the needs of people living with HIV in and out of care, including the need to identify those who do not know their status. Results should be carefully analyzed and compared with other data, such as information from the recipient on client characteristics and utilization of funded services. (See Appendix I for a description of the multiple data sources the planning council reviews in making its decisions.)

Priority Setting and Resource Allocations

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

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

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

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

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

ELIGIBLE RWHAP PART A & PART B SERVICES

Core medical-related services, including:

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

Support services, including:

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

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

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

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

Integrated/Comprehensive Planning

The planning council works with the recipient in developing a written plan that defines short- and long-term goals and objectives for delivering HIV services and strengthening the system of care in the EMA or TGA. This is called a comprehensive plan in the legislation, but is now called the CDC and HRSA Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN).

The legislation gives the planning council a lead role in the planning process, which must be carried out in close coordination with the recipient. The EMA or TGA may submit a joint plan with the state RWHAP Part B program. The plan is based, in part, on the results of the needs assessment and other information such as client utilization data. It is used to guide decisions about how to deliver HIV services for people living with HIV. The plan should be consistent with other existing local or state plans and with national goals to end the HIV epidemic.

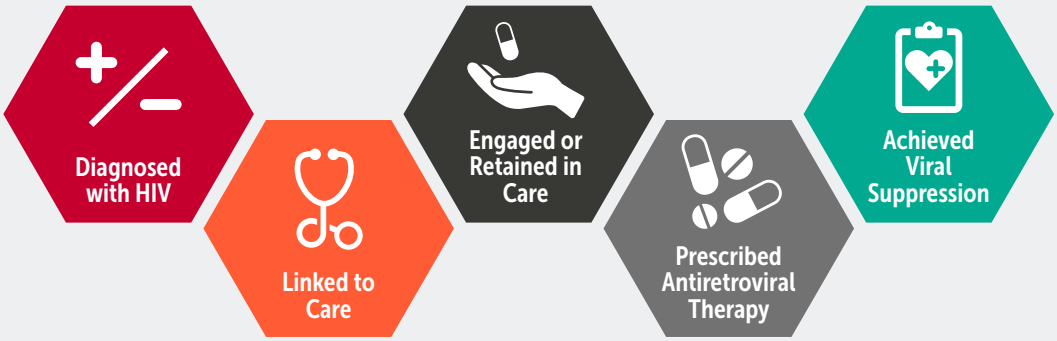
The plan should ensure attention to each stage of the ***HIV care continuum***, which measures the steps or stages of HIV medical care from diagnosis to linkage to care, retention in care and treatment, prescribing of HIV medications, and achieving the goal of viral suppression (a very low level of HIV in the body).

CDC and HRSA/HAB provide joint guidance on what the integrated HIV Prevention and Care Plan should include and when it needs to be completed. The first Integrated Prevention and Care Plan was submitted to CDC and HRSA on September 30, 2016 as a five-year plan covering the years 2017–2021. The plan should be reviewed, and where necessary updated, annually, and should be used as a roadmap for implementation of the jurisdiction's RWHAP Part A programs.

NATIONAL GOALS TO END THE HIV EPIDEMIC

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

HIV Care Continuum



Coordination with Other RWHAP Parts and Other Services

The planning council is responsible for ensuring that RWHAP Part A resource allocation decisions account for and are coordinated with other funds and services. The planning tasks described earlier (needs assessment, priority setting and resource allocation, integrated/comprehensive planning) require getting lots of input, including finding out what other sources of funding exist. This information helps avoid duplication in spending and reduce gaps in care. For example, the needs assessment should find out what HIV prevention and substance abuse treatment services already exist. Integrated/comprehensive planning helps the planning council consider the changing healthcare landscape and the implications for HIV services.

The ***Statewide Coordinated Statement of Need***, called the SCSN, is a way for all RWHAP activities in a state to work together to identify and address significant HIV care issues related to the needs of people living with HIV, and to use that information to maximize coordination, integration, and effective linkages across programs. Representatives of the planning council—and the recipient—must participate with other RWHAP Parts (Parts B, C, D and F) in the state to develop a written SCSN. The SCSN is a part of each state's Integrated HIV Prevention and Care Plan.

Assessment of the Efficiency of the Administrative Mechanism

The planning council is responsible for evaluating how rapidly RWHAP Part A funds are allocated and made available for care. This involves ensuring that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether the amounts contracted for each service category are the same as the planning council's allocations. The results of this ***assessment of the efficiency of the administrative mechanism*** are shared with the recipient, who develops a response including corrective actions if needed. Both the results of the assessment and the recipient response are summarized in the RWHAP Part A funding application for the following year.

Development of Service Standards

The planning council usually takes the lead in developing service standards for funded service categories. ***Service standards*** guide providers in implementing funded services. They typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities. The service standards set the minimum requirements of a service and serve as a base on which the recipient's clinical quality management (CQM) program is built. Developing service standards is usually a joint activity; the planning council works with the recipient, providers, consumers, and experts on particular service categories. These service standards must be consistent with HHS guidelines on HIV care and treatment as well as HRSA/HAB standards and performance measures, including the National Monitoring Standards.

Evaluation of Services

The planning council may choose to evaluate how well services funded by RWHAP Part A are meeting identified community needs, or it can pay someone else to do such an evaluation. The Part A recipient's CQM program can provide information on clinical outcomes that informs the planning council about the impact of services. The recipient may include planning council members on its CQM committee. In addition, most planning councils regularly review EMA/TGA performance along the HIV care continuum. The planning council uses evaluation findings in considering ways to improve the system of care, including changing service priorities and allocations and developing directives.

To carry out the array of planning tasks described above the planning council meets regularly throughout the year, as a whole and in committees. See Appendix II for a sample calendar describing the approximate timing of various planning council activities by months of the year.

CEO and Recipient Duties

CEO Duties Related to the Planning Council

The CEO has three important duties related to the planning council:

- **Establish the Planning Council:** The CEO must establish and maintain the planning council—or, in the case of a TGA, some other process to obtain community input, particularly from people living with HIV. This includes making sure that the planning council membership meets requirements related to representation, reflectiveness, and participation of unaffiliated consumers. The CEO should ensure that these requirements are specified in planning council bylaws.
- **Choose Planning Council Members:** The CEO establishes the first planning council. After that, the council itself is responsible for identifying and screening candidates and forwarding their names, the membership categories they will fill, and other requested information to the CEO so they can be considered for appointment. The CEO retains sole responsibility for appointment and removal of planning council members. If some nominees submitted by the planning council are not appointed, the CEO informs the planning council, and it provides additional nominees.
- **Review and Approve Bylaws and Other Processes:** The CEO establishes the planning council and thus has the authority to review and approve planning council bylaws and other policies. Often, the planning council is considered an official board or commission of the city or county. Its bylaws and procedures must fit the policies established for these bodies as well as meeting RWHAP legislative requirements.

Recipient Duties

The recipient has several planning duties that are shared with the planning council. These include assisting the planning council with needs assessment and integrated/comprehensive planning and providing information the planning council needs to carry out its priority setting and resource allocation responsibilities. It also shares responsibility for coordination with other RWHAP activities and services. In addition, the recipient has administrative duties, which means that it is responsible for making sure that RWHAP Part A funds are fairly and correctly managed and used. The main duties of the recipient are described below.

ADDITIONAL RECIPIENT ADMINISTRATIVE DUTIES

- ☐ Establish intergovernmental agreements (IGAs) with other cities/counties in the EMA or TGA
- ☐ Establish grievance procedures to address funding-related decision making
- ☐ Ensure delivery of services to women, infants, children, and youth with HIV
- ☐ Ensure that RWHAP funds are used to fill gaps and do not pay for care that can be supported with other existing funds
- ☐ Ensure that services are available and accessible to eligible clients
- ☐ Control recipient and provider administrative costs
- ☐ Prepare and submit the annual RWHAP Part A funding application
- ☐ Meet HRSA/HAB reporting requirements

Appendix III briefly describes these duties.

RECIPIENT ADMINISTRATIVE DUTIES

Below are the major RWHAP Part A recipient duties designed to make sure that funds are used fairly and appropriately, in a way that maximizes linkage of people living with HIV to care, retention in care, and positive medical outcomes. Additional duties are listed in the box and described in Appendix III.

Procurement of Services

The recipient is responsible for identifying and selecting qualified service providers for delivering RWHAP Part A services. The recipient must award service funds to eligible providers (***subrecipients***) based on a fair and equitable system, usually through a competitive Request for Proposals (RFP) process.

In contracting for services, the recipient must distribute RWHAP Part A funds according to the priority setting and resource allocation decisions of the planning council. The recipient can only spend the amount of money that the planning council decides should be used for each funded service category. In addition, the recipient must follow planning council directives about "how best to meet" priority needs.

The planning council has no say about how the recipient uses funds for its own administrative expenses.

Contract Monitoring

Once subrecipient contracts have been awarded, the recipient must manage them and regularly monitor subrecipients. The recipient must make sure that the providers who receive RWHAP Part A funds use the money according to the terms of the subrecipient contract they signed with the recipient and meet RWHAP Part A National Monitoring Standards and other federal requirements established by HRSA/HAB. The recipient monitors subrecipients to determine how quickly they spend RWHAP Part A funds, and if they are providing the contracted services, providing services only to eligible clients, using funds only as approved, and meeting reporting and other requirements. Contract monitoring is solely a recipient responsibility.

The planning council receives monitoring results only by service category, not by subrecipient.

The recipient must keep track of how rapidly RWHAP Part A money is, or isn't, being spent. If funds are not being spent in a timely fashion, there are two options:

1. The recipient may reallocate the funds to another provider within the same service category, or
2. The planning council may agree to reallocate funds to a different prioritized service category.

The recipient and the planning council must share information and work together to ensure that any changes are in agreement with the priorities and allocations established by the planning council.

Clinical Quality Management Activities and Evaluation of Performance and Outcomes

The recipient must establish a ***clinical quality management (CQM)*** program, designed to improve patient care, health outcomes, and patient satisfaction. Components include infrastructure, performance measurement, and quality improvement.

- An ideal ***infrastructure*** includes leadership, dedicated staffing and resources, a quality management plan that covers all funded medical and support services, a CQM committee, consumer and stakeholder involvement, and assessment of the CQM program.
- ***Performance measurement*** is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, and patient satisfaction with the services they receive. Recipients select a portfolio of performance measures based on funded services, local HIV epidemiology, the identified needs of PLWH, and the national goals to end the epidemic.
- Based on performance measurement results, recipients work with subrecipients in the development and implementation of ***quality improvement*** activities to make changes to the program to improve services.

Subrecipients must be actively involved in CQM activities. Recipients are expected to ensure that subrecipients have the capacity to contribute to the CQM program, have the resources to conduct CQM activities, and implement a CQM program in their organization.

Recipients can use up to 5 percent of the award or $3 million (whichever is less) to conduct CQM programs. The recipient shares with the planning council the results of its CQM activities. The planning council receives information by service category, but not about individual providers/subrecipients. These CQM data help the planning council in future cycles of priority setting and resource allocation.

QUALITY MANAGEMENT, QUALITY ASSURANCE, AND QUALITY IMPROVEMENT

Clinical Quality Management is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction, as described in this section.

Quality Assurance refers to activities aimed at ensuring compliance with minimum quality standards. Quality assurance activities include the process of looking back to measure compliance with standards (e.g., HHS guidelines, professional guidelines, service standards). Site visits and chart reviews are examples of commonly used quality assurance activities.

Quality Improvement is a part of CQM. It uses CQM performance data as well as data collected as part of quality assurance processes to strengthen patient care, health outcomes, and patient satisfaction.

As part of, or along with, CQM, the recipient often evaluates clinical outcomes. These outcomes are often measured using the HIV care continuum, with its focus on linkage to care, retention in care, use of antiretroviral therapy, and viral suppression. These results may be reviewed for all people living with HIV in the service area, for all RWHAP clients, and for key client subpopulations. Subpopulations may be defined by characteristics such as race/ethnicity, gender, age, place of residence, and/or risk factor. This helps the planning council in future decision making.

RECIPIENT DUTIES SHARED WITH THE PLANNING COUNCIL

Support for Planning Council Operations

The recipient must cooperate with the planning council by negotiating and managing its budget, providing staff expertise to support committees, and providing information the planning council needs to carry out its responsibilities. This includes data on client characteristics, service utilization, and service costs, as well as information for assessing the efficiency of the administrative mechanism.

Both the planning council and the recipient have the responsibility to support participation of people living with HIV on the planning council, although primary responsibility lies with the planning council. Examples include reimbursing expenses of consumer members such as travel and child care costs. The planning council establishes reimbursement policies; the recipient helps to ensure timely payment of reimbursements. The recipient assists in training planning council members by explaining recipient roles and helping planning council members understand information provided by the recipient such as data on service costs and client utilization of funded services.

Needs Assessment

The recipient works with the planning council to assess the needs of communities affected by HIV. It usually arranges for an epidemiologic profile to be provided by its surveillance unit or by the state's surveillance unit, and it ensures that funded providers cooperate with needs assessment efforts such as surveys and focus groups of people living with HIV and providers.

Integrated/Comprehensive Planning

The recipient and planning council work together to develop, review, and periodically update the CDC and HRSA Integrated HIV Prevention and Care Plan for the organization and delivery of HIV services. The recipient helps develop goals and objectives, and works with the planning council to ensure a workable joint plan for implementing them. Usually the recipient plays a key role in arranging to collect performance and outcomes data to evaluate progress towards the goals and objectives of the plan. Both recipient and planning council participate in reviewing and updating the plan.

Coordination with Other RWHAP Parts and Other Services

The recipient and planning council work together to make sure that RWHAP Part A funds are coordinated with other services and funders. This coordination occurs partly through planning, including needs assessment and the Statewide Coordinated Statement of Need. Throughout the year, the recipient helps keep the planning council informed about changes in HIV-related prevention and care services and funding, as well as the evolving healthcare landscape.

RECIPIENT PLANNING DUTIES SHARED WITH THE PLANNING COUNCIL

- ☐ Needs assessment
- ☐ Integrated/comprehensive planning
- ☐ Development of service standards
- ☐ Coordination with other RWHAP activities and other services, including:
  - – Participation in the Statewide Coordinated Statement of Need (SCSN)
  - – Ensuring that use of RWHAP funds is coordinated with other funding sources and with other healthcare systems and services

Technical Assistance

The RWHAP Part A recipient and the planning council/planning body may request technical assistance from HRSA to help them develop the knowledge and skills needed to meet the responsibilities outlined in this Primer. Examples of the kinds of technical assistance that HRSA can provide include: supporting participation of people living with HIV in RWHAP planning, training the planning council on using data for decision making, helping in the design of a needs assessment, assisting the planning council to refine committee structures and operations, and providing training to help the planning council and recipient understand their roles and work well together. HRSA can provide information describing what other EMAs or TGAs have done, offer model training materials, or provide experts to work with the planning council and recipient either long distance or on-site.

RWHAP Part A recipients and planning councils may seek and request technical assistance through the following channels:

- **HRSA/HAB Project Officer:** HRSA federal Project Officers are the first point-of-contact for RWHAP recipients in accessing technical assistance. Requests for technical assistance for the recipient or the planning council must be made in writing by the recipient to the HRSA/HAB Project Officer. For more information, visit the HAB Web Site at www.hab.hrsa.gov

- **TargetHIV.org** The TargetHIV website is the central source and "one-stop shop" for finding technical assistance and training resources for the Ryan White HIV/AIDS Program. Among the website's key features are a resource library, a calendar of technical assistance and training events, contact information for RWHAP recipients, a Help Desk, and information about specific programs and services including tools and tips. Users can search for information on a particular topic or directed at a particular audience. Visit the TargetHIV website at www.targetHIV.org

- **Planning CHATT:** The *Community HIV/AIDS TA and Training for Planning* project (*Planning CHATT*) builds the capacity of RWHAP Part A planning councils and planning bodies across the U.S. to meet their legislative requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning. The Planning CHATT project provides training and technical assistance to support the work of planning council/planning body members, staff, and RWHAP Part A recipients. Find Planning CHATT on the TargetHIV website: www.targetHIV.org/planning-chatt

References and Resources for Further Information

Descriptions of Ryan White HIV/AIDS Treatment Extension Act of 2009

Materials available on the HRSA/HAB website describing the Ryan White HIV/AIDS program (RWHAP), including each of its Parts:

Overview

- About the Ryan White HIV/AIDS Program
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program

RWHAP Fact Sheets

Fact sheets on all RWHAP Parts

www.hab.hrsa.gov/publications/hivaids-bureau-fact-sheets

- Part A: Eligible Metropolitan Areas and Transitional Grant Areas
- Part B: States and U.S. Territories
- Part B: AIDS Drug Assistance Program
- Part C: Early Intervention Services and Capacity Development
- Part D: Women, Infants, Children, and Youth
- Part F: Special Projects of National Significance
- Part F: AIDS Education and Training Centers Program
- Part F: Dental Programs

RWHAP Part A

- RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas, including list of current Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-a-grants-emerging-metro-transitional-areas

RWHAP Part B

- RWHAP Part B: Grants to States & Territories
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-grants-states-territories
- RWHAP Part B: AIDS Drug Assistance Program
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-aids-drug-assistance-program

RWHAP Part C

- RWHAP Part C: Early Intervention Services and Capacity Development Program Grants
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-c-early-intervention-services-and-capacity-development-program-grants

RWHAP Part D

- RWHAP Part D: Services for Women, Infants, Children, and Youth
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-d-services-women-infants-children-and-youth

RWHAP Part F

- Special Projects of National Significance
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program
- AIDS Education and Training Centers
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-aids-education-and-training-centers-aetc-program
- Dental Programs
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-dental-programs
- Minority AIDS Initiative
  www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-minority-aids-initiative

RWHAP Recipients

- Recipient lists and addresses by RWHAP Part, and list of RWHAP Part A planning councils/planning bodies
  www.targethiv.org/content/grantees-part

Planning Council Legislative Requirements

Current legislation, which is a part of the Public Health Service Act

- Ryan White HIV/AIDS Treatment Extension Act of 2009
  www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf
- Title XXVI, HIV Health Care Services Program, of the Public Health Service Act
  www.legcounsel.house.gov/Comps/PHSA-merged.pdf

Service Standards

- Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/Planning Bodies. December 2, 2014
  www.targetHIV.org/ServiceStandards

The Planning Process

Strengthening the Healthcare Delivery System through Planning: a three-part planning institute at the 2016 National Ryan White Conference on HIV Care and Treatment

www.targetHIV.org/planning-CHATT/planning-institute-2016

- Planning Bodies 101
- Planning Infrastructures 201
- Data-Driven Decision Making 301

Planning Council Roles, Responsibilities, and Operations

RYAN WHITE HIV/AIDS PROGRAM PART A MANUAL, REVISED 2013

A primary source of information about requirements, expectations, and suggested practices for planning council operations and for implementation of legislative responsibilities. Chapters identified below address legislative duties and some key aspects of planning council operations.

www.hab.hrsa.gov/sites/default/files/hab/Global/happartamanual2013.pdf

Implementing Legislative Responsibilities

- Planning Council Responsibilities: Section X. Chapter 3
- Needs Assessment: Section XI. Chapter 3
- Priority Setting and Resource Allocations: Section XI. Chapter 4
- Integrated/Comprehensive Plan: Section XI. Chapter 5
- Effectiveness of Funded Services to Meet Identified Need: Section X. Chapter 9
- Outcomes Evaluation: Section X. Chapter 10

Planning Council Operations

Membership

- Planning Council Membership: Section X. Chapter 4
- Planning Council Nominations: Section X. Chapter 5
- Member Involvement and Retention: Section XI. Chapter 8

People living with HIV/Consumer Participation

- Section X. Chapter 6
- Section XI. Chapter 9

Policies and Procedures

- Grievance Procedures: Section X. Chapter 7
- Conflict of Interest: Section X. Chapter 8

Federal Regulations and Guidelines

National Monitoring Standards (NMS)

See Monitoring Standards Guidance under www.hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-recipient-resources

- Frequently Asked Questions www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringfaq.pdf
- Universal Monitoring Standards www.hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf
- RWHAP Part A Fiscal Monitoring Standards www.hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringparta.pdf
- RWHAP Part A Program Monitoring Standards www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf

Policy Clarification Notices (PCNs) and Program Letters

www.hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

Among the PCNs and program letters most important to Planning Councils are the following:

- *Transitional Grant Areas and Planning Councils Moving Forward, Program Letter,* December 4, 2013. Clarifies expectations and recommendations around the continued maintenance of planning councils by Transitional Grant Areas (TGAs) that were formerly Eligible Metropolitan Areas (EMAs) after Fiscal Year 2013.
- *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds* Policy Clarification Notice (PCN) #16-02, Revised December 5, 2016 and effective for awards made after October 1, 2016. Identifies eligible individuals, describes allowable service categories for RWHAP, and provides program guidance for implementation.
- *Clinical Quality Management,* Policy Clarification Notice (PCN) #15-02, undated. Clarifies HRSA RWHAP expectations for clinical quality management (CQM) programs.

Uniform Guidance

- For all federal awards, *OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Guidance), 2 CFR [Code of Federal Regulations] Part 200.* The Guidance will supersede and streamline requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up.
  www.bit.ly/2EJqWwt
- For HHS Programs: *45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards*
  www.bit.ly/2GX2Cc9

RWHAP Part A Application Requirements

Ryan White HIV/AIDS Program Part A, HIV Emergency Relief Grant Program, Notice of Funding Opportunity (NOFO) No. HRSA-18-066

www.targetHIV.org/library/funding-opportunity-rwhap-fy18-part-hrsa-18-066

Program Use and Impact

- *Annual Client-Level Data Report: Ryan White HIV/AIDS Program Services Report (RSR) 2015.* Health Resources and Services Administration, December 2016.
  www.hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf

Appendix I: Types of Data Reviewed by Planning Councils for Priority Setting and Resource Allocation

Epidemiologic profile: A description of the HIV epidemic in the EMA or TGA, usually prepared annually by local or state HIV surveillance staff, for use in both HIV prevention and HIV care planning. It usually describes characteristics of the general population, persons newly diagnosed with HIV infection, persons living with HIV disease, and persons at risk for HIV. Data help planning councils identify trends in the epidemic that will affect service needs.

Needs assessment data: Information about the number, characteristics, and service needs and barriers of people living with HIV, both in and out of care; current provider resources available to meet those needs; and service gaps. These data help the planning council improve service access and quality, overall and for specific subpopulations.

Service expenditure and cost data: Information provided by the recipient showing how much money is spent for each funded service category and what it costs to provide one "unit" of service or to serve one client for a year. Planning councils use this information in funding decisions and estimating the costs of serving additional clients.

Client characteristics and service utilization data: Data on the total number and characteristics of local RWHAP clients, including the number and characteristics of RWHAP Part A clients served in each service category. Data usually come from the annual Ryan White Services Report (RSR). Data help planning councils understand the demand for specific services and identify subpopulations facing barriers to access.

HRSA performance measures and clinical outcomes data: Data used to monitor and improve the quality of care across the EMA/TGA and in individual provider organizations, usually based on the percent of clients that meet the goal or service standard. Measures may relate to a process (such as frequency of medical visits or development of a case management care plan) or clinical outcome (such as viral suppression). Data help planning councils make funding decisions and agree on changes in service standards or models of care.

Clinical Quality Management (CQM) data: Information on patient care, health outcomes, and patient satisfaction. Performance measures are gathered through CQM processes. Then subrecipients work together on structured quality improvement projects that make changes to address identified weaknesses. CQM data help planning councils decide whether program or funding changes are needed to improve service quality and outcomes.

Testing/EIIHA data: Data on the number of people who receive HIV tests, the number and percent testing positive and their characteristics, and the number referred to needed services. HRSA/HAB requires RWHAP Part A programs to implement a strategy for the Early Identification of Individuals with HIV/AIDS (EIIHA). This includes identifying key target populations, locating individuals with HIV who do not know their HIV status, informing them of their status through testing, and helping link them to medical care and support services.

Unmet Need data: An estimate of the number of people living with HIV in the service area who know they are HIV-positive but are not receiving HIV-related medical care. May also include an assessment of the characteristics of individuals with unmet need and their service barriers and gaps. Planning councils use this information to make decisions about use of funds to find people with unmet need and link or relink them to care.

HIV care continuum data: Data that outline the steps or stages of HIV care that people living with HIV go through, and the number and proportion of individuals at each stage in the EMA or TGA. The continuum may begin with the estimated total number of people living with HIV (including those unaware of their status) or with the number diagnosed and living with HIV. Typical steps include diagnosis, linkage to care, retention in care (based on doctor visits and/or laboratory tests), treatment with antiretroviral therapy, and viral suppression (a very low level of HIV in the body). Planning councils use this information to improve services all along the continuum, often based on HIV care continuum data for specific RWHAP Part A subpopulations (for example, young gay men of color or African American women).

Appendix II: Sample Planning Council/ RWHAP Part A Program Calendar

Most planning councils operate on a RWHAP Part A program year, which runs from March through February. The chart below provides a "typical" annual calendar, though of course planning councils vary in their timing of key activities. Recipient activity is included in the chart, since some tasks, especially priority setting and resource allocations (PSRA), need to link to recipient deadlines, especially submission of the RWHAP Part A application. The application is usually due in September. The chart does not include regular committee meetings, but most planning councils have them monthly except in December. Most planning councils also have a retreat and/or some training during the year, but there is no set time for them.

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
January	• Beginning of member terms [most frequent date] • Orientation for new members • Needs assessment	• Final reallocations • Review of RWHAP Part A competitive applications and selection of subrecipients for program year beginning March 1
February	• Election of officers [date varies] • Needs assessment (continued) • Committee development/approval of work plans for coming year	• Receipt of Notice of Award (NOA) for program year starting March 1—often a partial award
March	• Final allocations based on actual award amount [if full award is received; happens later if a partial award is received because there is not yet a final federal HHS budget] • Needs assessment (continued) • Review of progress on Integrated Plan	• Initial closeout of prior program year • Submission of Ryan White Services Report (RSR) • Review/preparation of response to conditions of award • Contracting with providers
April	• Town halls for input to PSRA • Obtain and review/integration of data from various sources • Directives development • Updating of Integrated Plan work plan as needed, with assignments to committees [process more complicated if joint plan was developed with state]	• Review of performance and outcome measures for prior year • Input to Integrated Plan update • Completion or obtaining of epi profile/ trends report
May	• Identification of any data problems or gaps • Assessment of the efficiency of the administrative mechan ism (AAM) begins • Data presentation	• Final closeout of prior year • Submission of Annual Progress Report for prior year • Submission of Program Expenditure Report for prior year
June	• Directives development (continued) • Priority setting and resource allocation (PRSA) begins	• Review of first quarter expenditures • Subrecipient monitoring [ongoing]

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
July	• PSRA work sessions and final approval • Presentation/adoption of directives • Submission of PSRA results to recipient	• Submission of Annual Federal Financial Report • Planning for submission of RWHAP Part A application
August	• Presentation/discussion of AAM report • PC sections of RWHAP Part A application • Negotiation of PC budget amount with recipient • Development of PC budget • Reallocation of funds if needed based on expenditures	• Preparation of RWHAP Part A application • Negotiation of PC budget amount • Recommendations for reallocation of funds if needed based on expenditures • Response to AAM report
September	• Review of draft application • Preparation of PC letter to accompany application, signed by Chair/Co-Chairs	• Completion and submission of RWHAP Part A application
October	• Review of service standards	• Issuance of RFP for RWHAP Part A services (selected services each year; often a 3-year cycle)
November	• Rapid reallocations • Planning for needs assessment	• Rapid reallocations • Receipt of provider applications in response to RFP for RWHAP Part A services
December	• Planning for new program year, including committee work plans	• Estimated Unobligated Balance (UOB) and estimated carryover request

Appendix III: Additional Recipient Administrative Duties

Establish Intergovernmental Agreements (IGAs): The recipient must make sure that RWHAP Part A funds reach all communities in the EMA or TGA where need exists. Thus, it must establish formal, written agreements with cities and counties within the EMA or TGA that provide HIV-related services and also account for at least 10 percent of the EMA's or TGA's reported AIDS cases. This agreement is called an Intergovernmental Agreement (IGA.) An IGA should describe how RWHAP Part A funds will be distributed and managed.

Establish Grievance Procedures: The recipient must develop grievance procedures to handle complaints about funding, such as the process by which contractors (subrecipients) are chosen. Like the planning council's grievance procedures, they must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled.

Ensure Services to Women, Infants, Children, and Youth with HIV/AIDS: The recipient must assure that the percentage of money spent on serving women, infants, children, and youth with HIV is at least in proportion to each group's percent of the total number of cases of HIV disease in the EMA or TGA. An exception is allowed when the recipient can show that their needs are met through other programs like Medicaid, Medicare, or RWHAP Part D. The planning council must consider this requirement when setting priorities and allocating resources.

Ensure that RWHAP Funds are Used to Fill Gaps: RWHAP Part A recipients must ensure that RWHAP Part A funds do not pay for services that are funded by other sources and are not used to replace local spending on HIV care. The legislation requires that RWHAP be the "payor of last resort." This means, for example, that the recipient must require subrecipients such as clinics to make sure clients are not eligible for Medicaid or some other source of funding before they use RWHAP Part A funds to pay for their care. This requirement makes sure that RWHAP funds are used to assist people living with HIV who do not have any other source of payment for the services they need.

Ensure Availability and Accessibility of Services to Eligible Clients: Recipients must ensure that RWHAP Part A services are available regardless of an individual's health condition or ability to pay and in settings that are accessible to low-income people living with HIV.

Outreach must be provided to inform people of the availability of services and to link them to care. One of the most important

priorities of the RWHAP legislation is to identify people who are unaware of their HIV status and need to be tested, help them determine their status, and refer and link people newly diagnosed with HIV to care. (This process is called Early Identification of Individuals with HIV and AIDS, or EIIHA.) Another priority is to find people who know their HIV status but are not receiving regular HIV-related medical care (people with "unmet need") and help them to enter and stay in care.

Subrecipients receiving RWHAP Part A funds must be required to work with other providers so that people living with HIV have access to services. This network of providers is called a "continuum of care" or "system of care." As part of this, providers should prioritize getting people into care as soon after diagnosis as possible by maintaining what the legislation calls "appropriate relationships with entities that constitute key points of access to the health care system." Key points of access include, for example, testing sites, emergency rooms, substance abuse treatment programs, and sexually transmitted disease clinics. Processes must be in place to ensure that people newly diagnosed with HIV are immediately referred and linked to care and helped to remain in care.

Control Administrative and Quality Management Costs: The recipient may use up to 10 percent of the RWHAP Part A grant for managing the RWHAP Part A program and for other administrative activities, including planning council support, and up to 5 percent of the grant for Clinical Quality Management. Examples of administrative duties include writing applications, preparing reports, and activities related to procurement and contract monitoring (including reviewing provider applications, negotiating and monitoring contracts, and paying subrecipients). The recipient must control those costs, and also ensure that local subrecipients, contractors, and other entities, collectively, spend no more than 10 percent of total RWHAP Part A service funds for administrative expenses.

Prepare and Submit the RWHAP Part A Application: The recipient is responsible for preparing and submitting a RWHAP Part A application to the federal government each year. Although this is the recipient's responsibility, the planning council should participate in the preparation of this application because the application requires information about the planning council and how it works, as well as the planning council's priorities and proposed resource allocations for the coming year. The Chair or Co-Chairs of the planning council must certify in writing to HRSA that the priorities in the application are the ones developed by the planning council. They must also verify that the recipient spent funds in the past year according to the planning council's allocation decisions and indicate how the planning council established priorities for the upcoming program year.

Meet HRSA/HAB Reporting Requirements: As a federal grantee, the recipient is required to meet a variety of HRSA/HAB requirements, including submission of data, programmatic, and fiscal reports. Some reports include input from the planning council/planning body or reflect its decisions. For example, the Program Terms Report and the Program Submission are due 90 days after the final Notice of Award. The Program Terms Report includes information such as a consolidated list of contractors (subrecipients). Among the information required for the Program Submission are a signed endorsement letter from the planning council Chair or Co-Chairs endorsing the priorities and allocations submitted by the recipient, and a planning council membership roster and information on member reflectiveness. The recipient also submits an Estimated Unobligated Balance (UOB) and an estimate of anticipated carryover funding to HRSA by December 31, a RWHAP Part A and Minority AIDS Initiative Final Expenditure Report and an Annual Progress Report 90 days after the end of the program period, and a Carryover Request for any unspent funds within 30 days after the Final Expenditure Report.

All recipients under RWHAP Parts A-D, along with their contracted subrecipients, must also submit an annual client-level data report called the Ryan White Program Services Report (RSR) that covers the calendar year. The RSR provides data on the characteristics of RWHAP recipients, providers, and clients served. RSR data document program performance and accountability. RSR data on client characteristics and service utilization are used by the planning council and recipient in decision making about use of funds and the system of care. Because it provides data from all recipients, the RSR provides information used by HRSA/HAB for monitoring client health outcomes, assessing organizational capacity and service utilization, monitoring the use of RWHAP to address HIV in the U.S., and tracking progress toward the national goals to end the epidemic.

PLANNING
CHATT
Community HIV/AIDS
Technical Assistance & Training

BOARD ORIENTATION TO SACRAMENTO COUNTY PUBLIC HEALTH

01/29/24

SACRAMENTO COUNTY PUBLIC HEALTH

SACRAMENTO COUNTY
PUBLIC HEALTH
Promote • Prevent • Protect

Updates to the Board Orientation to Sacramento County Public Health:

Revision Date	Update	Page #s	Approved by

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PURPOSE

The purpose of this document is to give its reader an overall understanding of Sacramento County governance, and the laws, legislation, responsibilities, and health priorities that guide Sacramento County Public Health (SCPH). This document can be used in conjunction with other formal orientation guides for the Sacramento County Board of Supervisors (BOS) provided by the Sacramento County Clerk of the board, as well as any other orientations provided to members of associated Advisory Boards, Coalitions or Committees.

Every attempt will be made to keep this document current with any changes in laws, code, and health data; but it cannot be guaranteed. If there are questions or concerns about information or links within this document please contact: Dr. Olivia Kasirye @ kasiryeo@saccounty.gov.

SACRAMENTO COUNTY AUTHORITY

Sacramento County is one of 58 California counties. It serves as an agent of the State of California to provide mandated health, welfare, and other social services programs. It also serves as a unit of local government responsible for providing a wide array of local services, including libraries, parks, public protection, election services, agricultural inspection services, local use planning, construction inspection, public health, primary medical care, inpatient and outpatient mental health services, social services and much more. Sacramento County has more than 30 departments, offices and agencies that provide services to Sacramento County residents.

Sacramento County Board of Supervisors

The BOS is the governing body of the County of Sacramento and is responsible for both legislative and executive functions of County government. (Gov. Code, § 25000). The BOS is empowered to make and enforce rules and regulations necessary for the government of the board, the preservation of order, and the transaction of business. (Gov. Code, § 25003.) The BOS' primary legislative duties include adopting County ordinances and resolutions for the purpose of setting policy and providing for its administration, adopting an annual County budget, and holding public hearings on a variety of matters of public concern. The BOS' primary executive function is to maintain the effective administration of County government.

Delegated Authorities

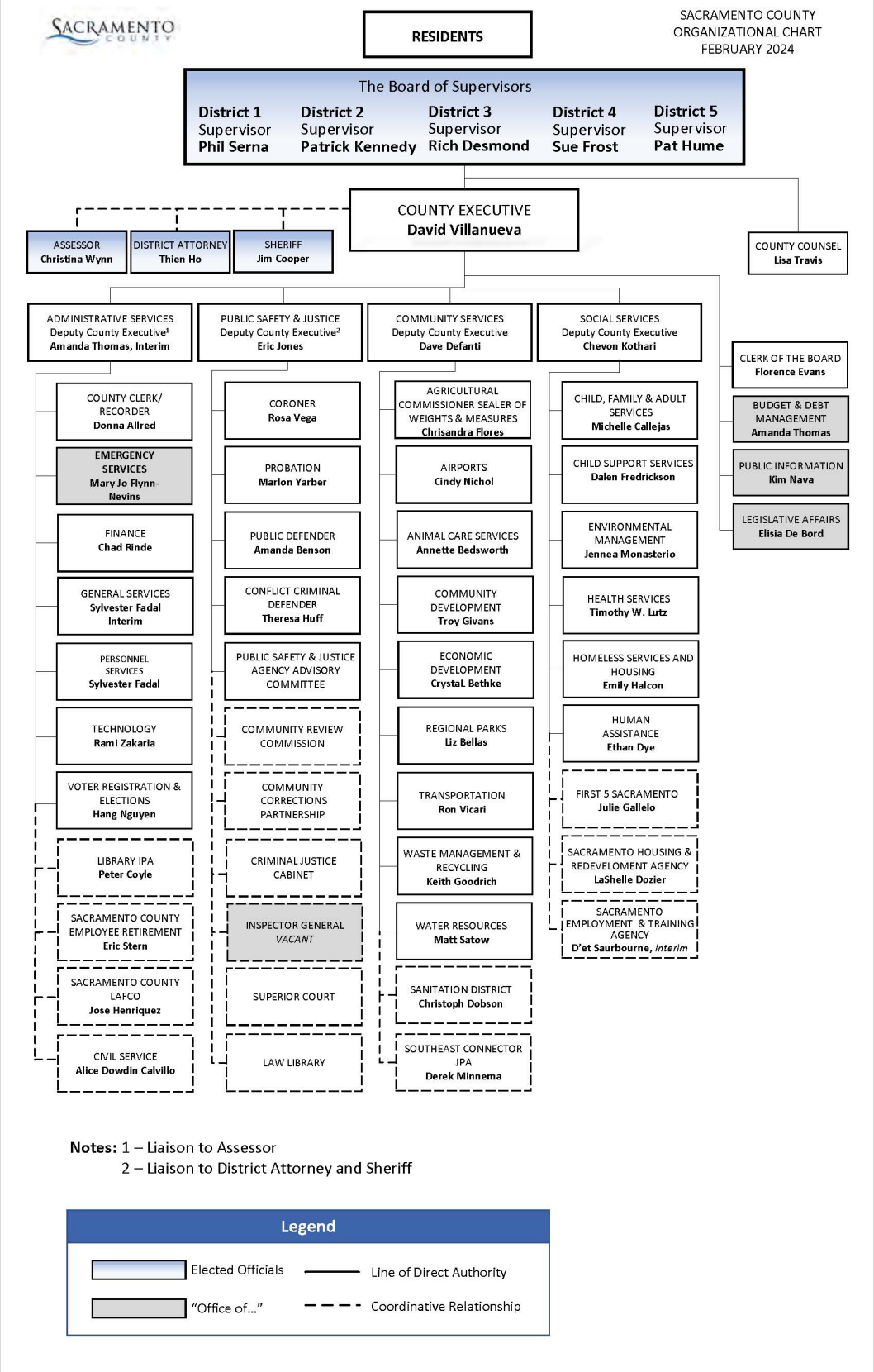
In Sacramento, the BOS had delegated certain authority to the County Executive for administrative responsibilities. The County Executive is authorized and empowered to plan, organize, direct, control, and coordinate County activities. The County Executive also serves in an advisory capacity to the BOS with respect to the functions of officials and boards not under the direct jurisdiction or control of the County Executive. The functions and activities of the County Executive are mandated by the County Charter. (Sac. County Code, Article VII.)

Whereas the BOS and County Executive's office provide County oversight, the Department of Health Services (DHS) is designated as responsible for health-related issues in Sacramento County. (Sac. County Code, ch. 2.21, § 2.21.040).

Administration of Sacramento County Public Health (SCPH)

Pursuant to local ordinance, the BOS appoints a Public Health Officer, who is a physician, and who serves as the chief medical officer for the county on public health issues, and enforcement of public health laws and regulations. (Sac. County Code, ch. 2.21, § 2.21.070). The Health Officer is accountable to the

Director of DHS. (See organizational chart). The BOS is responsible for approving the annual budget for DHS and SCPH.



LAWS AND REGULATIONS GOVERNING PUBLIC HEALTH

The California Code is the body of law arranged by subject. California Law consists of 29 codes. The bodies of law that mandate public health operations, programs, and services are California Health and Safety Code (Health & Saf. Code), California Code of Regulations (Cal. Code. Regs.), Water Code (Wat. Code), Penal Code, (Pen. Code), Business and Professions Code, (Bus. & Prof. Code), and Food and Agriculture Code (Food & Agr. Code).

BOARD AUTHORITY

The BOS has two main authorities. First, Health and Safety Code states that a County BOS must appoint a health officer (Health & Saf. Code, § 101000). The County Health Officer shall be a graduate of a medical college of good standing and repute, and their compensation shall be determined by the BOS. (Health & Saf. Code, § 101005).

Second, the BOS approves an annual budget which includes SCPH annual budget and any requested growth requests. In addition, the BOS approves for SCPH through board letter:

1. Applying for a grant or other outside funding.
2. Receiving a grant award.
3. Contracting with a new provider/subcontractor.
4. Asking for authority to amend a contract.
5. Making a substantial change to one or more programs.
6. Creating a new program.
7. Contracting with continuing providers for the upcoming fiscal year/MOU.
8. Adding or deleting staff positions (department level).

HEALTH OFFICER AUTHORITY

The County Health Officer shall enforce and observe in the unincorporated territory of the county, all of the following (Health & Saf. Code, § 101030):

- Orders and ordinances of the BOS pertaining to the public health and sanitary matters.
- Orders, including quarantine and other regulations, prescribed by the department.
- Statues relating to public health.

Every governing body of a city shall appoint a health officer, except when the city has made other arrangements, as specified in this code, for the county to exercise the same powers and duties within the city, as are conferred upon city health officers by law (Health & Saf. Code, § 101465).

The local health officer may take any preventative measures that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency", "state of emergency", or "local emergency" within his or her jurisdiction (Health & Saf. Code, § 101040)

HEALTH DEPARTMENT AUTHORITY

A Local Health Department is defined by the Health and Safety code (Health & Saf. Code, § 101175-101185) as:

1. A local health department serving one or more counties that shall provide services to all cities whose population is less than 50,000 in addition to the unincorporated territory of the county or counties.

2. A county health department that does not serve all of the cities of less than 50,000 population, but that has the provisional approval of the department, in accordance with Section 101225.
3. The health department of a city of 50,000 or greater population, except that the governing body of the city by resolution may declare its intention to be included under the jurisdiction of the county health department, as provided by existing statutes.
4. The local health department of any county that had under its jurisdiction on September 19, 1947, a population in excess of 1,000,000, or the local health department of any city and county.

The Health and Safety code governs the organization, powers, and duties of the Local Health Department. (California Health & Safety Code)

Public Health departments are required by law to provide certain "Basic Services." (17 Cal. Code. Regs., § 1276).

These services include:

(a) Collection, tabulation and analysis of all public health statistics
(b) Health education programs
(c) Communicable disease control
(d) Services to promote maternal and child health
(e) Environmental health and sanitation services, including surveillance of occupational health hazards
(f) Laboratory services
(g) Nutrition services
(h) Chronic disease services
(i) Services directed to the social factors affecting health
(j) Occupational health services
(k) Family planning services, and
(l) Public health nursing services to provide for the preventive and therapeutic care of the population served

PROGRAM AUTHORITY

Information about Sacramento County Public Health and its programs can be found beginning on Page 16 of this document. For reference, below is a listing of each health department program, along with a description of the mandated service and reference to the legal citation.

Mandated Program	Service Description (Legal Citation)
Administrative Support Services	1. Maintain and operate a central office and headquarters (17 Cal. Code. Regs., § 1251) 2. Provide and process applications for a medical marijuana identification cards, collect fees, and issue cards (Health & Saf. Code, §§ 11362.71-11362.755)

Health Officer	1. Health Officer (17 Cal. Code. Regs., § 1250) 2. Prevent the spread of disease (Health & Saf. Code, § 120175) 3. Receive and investigate complaints concerning dispensing or furnishing of drugs requiring a prescription, without a license (Health & Saf. Code, § 101070) 4. Determine exemptions from the mandatory vaccination requirements established in the Regulation and Control of Dogs statutes (Health & Saf. Code, § 121690) 5. Receive permits for the importation of wild animals (Health & Saf. Code, § 121840) 6. Organize and operate a program for the topical application of fluoride to the teeth for students in public and private elementary and secondary schools (Health & Saf. Code, § 104840) 7. Establish, maintain, and enforce quarantine and isolation measures (Health & Saf. Code, §§ 120195, 120200, 120215, 120220, 120275, 120280, 120295) 8. Ensure availability of adequate isolation facilities, provision of diagnostic consultative services, epidemiologic investigation, and appropriate preventive measures for the particular communicable disease hazards in the community (17 Cal. Code. Regs., § 1276) 9. Provide HIV testing in criminal cases involving the transfer of bodily fluids (Pen. Code, § 1524.1)
Infectious	
Communicable Disease Prevention & Control	1. Report individuals to DMV when doctors submit a lapse in consciousness report (Health & Saf. Code, § 103900) 2. Inspect local jails annually, in collaboration with Environmental Health Services (Health & Saf. Code, § 101045) 3. Take measures to prevent the spread of disease (Health & Saf. Code, § 120175) 4. Report local epidemics and communicable diseases to the California Department of Public Health (Health & Saf. Code, §§ 120185, 120190) 5. Receive and investigate reports of food-borne illnesses (Health & Saf. Code, § 113949)

	6. Notify the County Agricultural Commissioner and the Director of Environmental Health Hazard Assessment of a spill or accidental release of pesticide (Health & Saf. Code, § 105215) 7. Receive and process reports of pesticide poisoning or exposure (Health & Saf. Code, § 105200) 8. Complete Local Rabies Control Activity Annual Report (Health & Saf. Code, § 121690) 9. Receive and investigate reportable illnesses; Restrict and clear cases of specific illnesses (17 Cal. Code. Regs., § 2500)
STD & HIV Prevention & Control	1. Inspect each clinical laboratory CD4+ T-Cell test report to determine if the test is related to a case of HIV infection and, if related, report it to the state. If not related, destroy it (Health & Saf. Code, § 121023) 2. [Optional] Needle Exchange Program (Health & Saf. Code, §§ 120780.1, 121349-121349.3) 3. Fulfill contract requirements for prevention, education, needs assessments, evaluation (Health & Saf. Code, § 120805) 4. Fulfill contract requirements for test site services (Health & Saf. Code, § 120846) 5. Provide anonymous HIV testing, counseling, referral (Health & Saf. Code, § 120890 & 120895) 6. Fulfill contract requirements for early intervention projects (Health & Saf. Code, § 120900) 7. Fulfill requirements to integrate HIV primary prevention, health education, testing, and counseling, specifically designed for women and children into STD and other programming (Health & Saf. Code, § 120860) 8. Fulfill contract requirements for early intervention education (Health & Saf. Code, § 120920) 9. Comply with standards and requirements of the AIDS Drug Assistance Program (ADAP) (Health & Saf. Code, § 120960) 10. Alert sexual and needle sharing partners of potential exposure to HIV (Health & Saf. Code, § 121015) 11. Comply with test/counselor training requirements (Health & Saf. Code, § 120871) 12. Provide for HIV education and testing ordered by the court (Pen. Code, § 1202.1)

	13. Receive reports of transfusion-associated AIDS cases, HIV infections, and viral hepatitis infections; and contact all persons who have confirmed cases of AIDS (Health & Saf. Code, § 1603.1) 14. Report HIV cases to State using confidential reporting. Ensure access to anonymous testing, report breaches of confidentiality (Health & Saf. Code, § 121022) 15. [Optional] Disease Prevention Demonstration Project (Health & Saf. Code, §121285) 16. Investigate infectious venereal diseases and take measures to prevent transmission (Health & Saf. Code, § 120575) 17. Inspect and quarantine STDs as needed (Health & Saf. Code, § 120585) 18. Receive reports, investigate, and report cases of ophthalmia neonatorum (Bus. & Prof. Code, § 554) à reported as gonorrhea or chlamydia from mother
Tuberculosis Prevention & Control	1. Investigate and control TB cases and outbreaks; prepare and send TB case and outbreak reports; maintain records (17 Cal. Code. Regs., § 2501, 2502, 2509) 2. Make expenditures necessary for the preservation of the public health (Health & Saf. Code, § 121360) 3. [Optional] Certify TB testers annually in participating local Skilled Nursing Facilities and Hospitals. Reports adverse events resulting from improper training or performance (Health & Saf. Code, § 121360.5) 4. Receive TB case reports from local health providers. Attempt to locate and refer contacts to treatment (Health & Saf. Code, § 121361- 121363) 5. Order TB exams, where indicated (Health & Saf. Code, § 121364) 6. Investigate all reported or suspected active TB disease and protect public health, up to isolation and detainment (Health & Saf. Code, § 121365-121370) 7. Advise state medical, correctional, and educational institutions regarding the control of tuberculosis (Health & Saf. Code, § 121380) 8. Follow State policies and standards for operating local TB program. Maintain records and prepare

	expenditure reports semiannually (Health & Saf. Code, § 121455) 9. Order TB test for suspected TB cases among students (Health & Saf. Code, § 121485) 10. Ensure compliance with TB testing for private, parochial, and nursery school employees (Health & Saf. Code, § 121540)
Non-Infectious	
California Children's Services	1. Operate a CCS Program, including diagnosis, treatment, care, therapy, and maintenance for handicapped children under age 21 (Health & Saf. Code, § 123800-123995)
Chronic Disease & Injury Prevention	1. Provide services in nutrition, including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease (17 Cal. Code. Regs., § 1276) 2. Provide services in chronic disease, which may include case finding, community education, consultation, or rehabilitation, for the prevention or mitigation of any chronic disease (17 Cal. Code. Regs., § 1276)
Emergency Medical Services (EMS) Agency	1. Authorize the County to designate a local emergency medical services agency (LEMSA) to perform functions required by the Emergency Medical Services Act (Health & Saf. Code, § 1797 et seq.)
Epidemiology & Data Management	1. Collect, tabulate and analyze of all public health statistics, including population data, natality, mortality and morbidity records, as well as evaluation of service records (17 Cal. Code. Regs., § 1276)
Immunization Program	1. Organize and maintain a program to make immunizations available to all persons (Health & Saf. Code, § 120350). Program offers information to the public and partners on where immunizations can be obtained. 2. Determine immunization deficiencies (Health & Saf. Code, § 120375)

	3. Operate immunization information systems jointly among more than one jurisdiction (Health & Saf. Code, § 120440)
Maternal Child and Adolescent Health	1. Operate of a MCAH Program (Health & Saf. Code, § 123255) 2. Provide parents of SIDS death with information, support, and referral services/follow-up with child care provider, if applicable (Health & Saf. Code, § 123740) 3. Provide services to promote maternal and child health (Cal. Code Regs., Title 17, § 1276) 4. Appropriate services in the field of family planning (Cal. Code Regs., Title 17, §1276) 5. Prepare a list of family planning and birth control clinics located in the county for distribution to all local hospitals (Health & Saf. Code, § 101050) 6. Interpret family planning materials into other languages that are 10% of population or higher (Health & Saf. Code, § 124300) 7. Assess needed services for mother, child, family for substance-exposed infant (Health & Saf. Code, § 123605) 8. Establish a CHDP Program and provide early and periodic assessment of health status of children and other services (Health & Saf. Code, § 124040) 9. Provide anti-tobacco education by CHDP (Health & Saf. Code, § 104395) to end July 1, 2024. 10. Operate an Oral Health Stakeholder Advisory Committee in Sacramento California AB 1467 (2012)
Public Health Laboratory	1. Examine of specimens from suspected cases of infectious and environmental diseases (Health & Saf. Code, §101150) 2. Lab must be CLIA-approved (Health & Saf. Code, §101160) 3. Public Health Laboratory Director (17 Cal. Code. Regs., § 1255) 4. Any person may perform analysis of SARS-CoV-2 if they meet the requirements (Health & Saf. Code, §101161) to end July 1, 2028

	5. Operate County's Nondiagnostic General Health Assessment (NGHA) Registration and Enforcement Program (Bus. & Prof. Code, § 1244)
Public Health Nursing	1. Director of Public Health Nursing, public health nursing staff, and supervisory personnel (17 Cal. Code. Regs., § 1253) 2. Nursing services to provide for the preventive and therapeutic care of the population served (17 Cal. Code. Regs., § 1276)
Tobacco Prevention and Control	1. Provide tobacco prevention and smoking cessation services (Health & Saf. Code, § 104375, Health & Saf. Code, §§ 104400-104415)
Vital Records & Registration	1. Perform all duties of local registrar of births and deaths (Health & Saf. Code, § 102275). See below for details: o Review, number, and register births, deaths, fetal deaths/stillbirths, and foundlings (Health & Saf. Code, §§ 102305, 102310, 102400-102415, 102500, 102775-102780, 102950-102955, 103040.1) a. Send copies to state registrar and county recorder weekly (Health & Saf. Code, §§ 102335, 102345) b. Issue burial permits (Health & Saf. Code, §§ 103050-103105). c. Assist with amending records (Health & Saf. Code, § 103225). d. Send copies of deaths to Registrar of Voters, Social Services, and Social Security monthly (Health & Saf. Code, § 102360) e. Send copies of work-related deaths to Department of Industrial Relations monthly (Health & Saf. Code, § 102346) f. Receive reports of contagious disease from funeral directors (Health & Saf. Code, § 7302)
Women Infants & Children (WIC) Program	1. Distribute nutrition coupons for certified farmers' markets (Health & Saf. Code, § 123279) 2. Operation of WIC Program (Health & Saf. Code, § 123280-123290) 3. Expansion of the breastfeeding program for WIC (Health & Saf. Code, § 123361)

Other Related Departments	
Sacramento County Environmental Management Department (EMD) Environmental Health Department (or other agency, as noted)	1. Conduct inspections and enforce standards for body art facilities & tattoo parlors (Health & Saf. Code, §§ 119301, 119304, 119319) 2. Control, contain, and remediate sites identified by law enforcement personnel as having been potential methamphetamine laboratories (Health & Saf. Code, § 25400.17) 3. Develop a written plan for remediation of the methamphetamine laboratory sites (Health & Saf. Code, § 25400.35) 4. On notification by law enforcement, determine whether laboratories producing analogs of fentanyl, phencyclidine, and methamphetamine pose an immediate threat to public health and safety and, if so, take corrective action (Health & Saf. Code, § 11642) 5. Regulate the use of equipment for cleaning septic tanks, chemical toilets, cesspools or sewage seepage pits (Health & Saf. Code, § 117400) 6. Enforce legal requirements for small water systems and report on compliance (Health & Saf. Code, § 116340) 7. Issue orders to owners of property where hazardous substance spills have occurred (Health & Saf. Code, § 25359.5) 8. Receive reports of the improper disposal of hazardous waste (Health & Saf. Code, § 25180.5) 9. Receive copies of plans for construction of public swimming pools (Health & Saf. Code, § 116038) 10. Enforce building standards and other regulations pertaining to swimming pools (Health & Saf. Code, § 116053) 11. Order abatement of contamination of water (Health & Saf. Code, § 5412) 12. Receive evidence that legal requirements are met by persons intending to use a previously inactive water well (Health & Saf. Code, § 115700) 13. Receive reports of recalled meat products (Health & Saf. Code, § 110806) 14. Enforce building standards related to organized camps (Health & Saf. Code, § 18897.4)

	15. Regulate materials that require special handling that, when removed from a major appliance, constitute a hazardous waste (Health & Saf. Code, § 25212) 16. Receive reports of rises in bacterial count of water in public water systems (Health & Saf. Code, § 116450) 17. Approve establishment of garbage dumps (Health & Saf. Code, § 6512) 18. Environmental Health Services including: food, housing and institutions, radiological health, milk and dairy products, water oriented recreation, safety, vector control, wastes management, water supply, air sanitation, land development and use (17 Cal. Code. Regs., § 1371) 19. Order the abatement of contamination caused by use of recycled water (Wat. Code, § 13522) 20. Notify the public of sewage discharge into water (Wat. Code, § 13271) 21. Conduct inspections and enforce standards for food facilities (Health & Saf. Code, §§ 113713, 113709)
First 5 Program	First 5 Program (Health & Saf. Code, § 130140)
County Sheriff	The sheriff of each county, or city and county, may enforce within the county, or the city and county, all orders of the local health officer issued for the purpose of preventing the spread of any contagious, infectious, or communicable disease. Every peace officer of every political subdivision of the county, or city and county, may enforce within the area subject to his or her jurisdiction all orders of the local health officer issued for the purpose of preventing the spread of any contagious, infectious, or communicable disease. This section is not a limitation on the authority of peace officers or public officers to enforce orders of the local health officer. When deciding whether to request this assistance in enforcement of its orders, the local health officer may consider whether it would be necessary to advise the enforcement agency of any measures that should be taken to prevent infection of the enforcement officers (Health & Saf. Code, § 101029).

ABOUT SACRAMENTO COUNTY PUBLIC HEALTH (SCPH)

MISSION

The mission of SCPH is to promote, protect, and assure conditions for optimal health and public safety for residents and communities of Sacramento County through leadership, collaboration, prevention and response.

VISION

Optimal health and well-being for Sacramento County communities!

VALUES

DEDICATION We are dedicated to meet the public health needs of Sacramento County residents and communities.

QUALITY We provide high quality and effective services based on best practices and the most current information and resources.

COMPETENCE We hire staff with essential skills, education, experience, and certification to accomplish program goals.

RESPONSIVENESS We listen to community needs, monitor community health, and develop responses to match needs.

ACCOUNTABILITY We accept responsibility and accountability for providing efficient and quality service. We conduct ourselves with integrity in delivering services.

DIVERSITY We respect and value diversity within the community and strive to deliver services that are respectful and relevant to the needs, values, and beliefs of the community. We seek to recruit and hire diverse staffs that enhance our level of understanding of various populations and to promote cultural competence.

EFFICIENCY We look for the most efficient way to get the job done.

STRATEGIC PRIORITIES

1. Enhance Community Access, Engagement, and Partnerships
2. Strengthen Infrastructure
3. Champion Health Equity
4. Improve Health and Community Well-Being
5. Emphasize a Culture of Continuous Quality Improvement and Excellence

CULTURE

Sacramento County Public Health strives to achieve excellence and envisions optimal health and well-being for all communities in Sacramento County. We accomplish this by utilizing a trauma informed approach that embraces a culture of safety, inclusivity, and transparency; ALL rooted in health & racial equity. We are committed to reducing inequities in the community and within our organization by intentionally building trusted relationships, improving communication, leaning into innovation and fostering inclusive and sustainable collaborations.

SCPH Organizational Chart

SCPH AFFILIATED COUNTY BOARDS AND COMMISSIONS

There are over 95 Sacramento County Boards, Commissions and Affiliated Organizations that assist the BOS with policy related to County programs. A current list can be found on the BOS Clerk of the Board webpage.

Several of these boards are specifically associated with work done in and by SCPH programs. SCPH has one mandated advisory board: the HIV Health Services Planning Council. All other boards, while not legally mandated, serve important roles in advising and informing the BOS about public health work.

MANDATED ADVISORY BOARD

HIV HEALTH SERVICES PLANNING COUNCIL

The federal Ryan White HIV/AIDs program (RWHAP) provides care and treatment services to people living with HIV. The RWHAP provides a comprehensive system of HIV primary medical care, medication assistance, and essential support services to more than 50 percent of people diagnosed with HIV in the United States. The RWHAP makes grants for the purpose of assisting in the provision of services on a local level. To be eligible for grant assistance, Sacramento County is required to "establish or designate an HIV health services planning council that shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations." (42 U.S.C. § 300ff-12 (LexisNexis, Lexis Advance through Public Law 118-34, approved December 26, 2023, with a gap of Public Law 118-31).) The HIV Health Services Planning Council (HHSPC) meets this requirement for Sacramento County.

The HHSPC is responsible for planning how Ryan White CARE Act funds will be used in the local Transitional Grant Area (TGA), which consists of Sacramento, El Dorado, and Placer Counties. To properly plan, the Council is responsible for assessing the needs of people living with HIV in the TGA, developing a comprehensive plan that defines short and long term goals for delivering HIV services, setting priorities for which service categories are most needed, allocating resources to prioritized services, coordinating service delivery with other programs and funders, assessing the effectiveness and efficiency in which CARE Act funds are being used, and evaluating how well funded services are meeting community needs.

Information about HHSCP meetings and membership can be found: https://www.sacramento-tga.com/

DISCRETIONARY ADVISORY BOARDS

PUBLIC HEALTH ADVISORY BOARD

The primary role of the Sacramento County Public Health Advisory Board (PHAB) is to advise the BOS and DHS on policy issues related to public health and primary care.

The objectives of the PHAB Board are to:

1. Identify local public health and primary care needs and priorities;
2. Encourage the development of public health and primary care services;
3. Coordinate various forums on public health and primary care issues;

4. Advise the BOS, First 5, and/or Human Services Coordinating Council on the nature, scope and impact of all major policy issues regarding public health and primary care; and
5. Perform other responsibilities as requested by the BOS, DHS, the County Health Officer, the Human Services Coordinating Council, or First 5.

Membership of PHAB consists of a minimum of 12, and a maximum of 15, voting members appointed by the BOS.

Information about PHAB meetings and membership can be found at: https://dhs.saccounty.gov/PUB/Pages/Public-Health-Advisory-Board/BC-Public-Health-Advisory-Board.aspx

MATERNAL, CHILD & ADOLESCENT HEALTH ADVISORY BOARD

The purpose of the Maternal, Child & Adolescent Health Advisory Board (MCAH AB) is to advise the BOS, DHS, and Sacramento County Public Health on local programs and services affecting the health of mothers, children, and adolescents, to improve coordination of services and to promote an integrated health system serving mothers and children.

The Advisory Board Staff and the MCAH AB are responsible for reviewing the community's maternal, child, and adolescent health needs and the adequacy of health care services, programs, providers, and facilities to meet those needs. The MCAH AB reviews and comments during the development and adoption of the required annual local maternal and child health services plan. The MCAH AB will provide guidance and serve in a consultative capacity in the planning and implementation of the Nurse Family Partnership activities.

MCAH AB is made up of 19 regular voting members appointed by the BOS.

Information about MCAH Advisory Board meetings and membership can be found at: https://dhs.saccounty.gov/PUB/Pages/Maternal-Adolescent-Health/GI-Maternal-Child-and-Adolescent-Health-Advisory-Board.aspx

MEDI-CAL DENTAL ADVISORY COMMITTEE

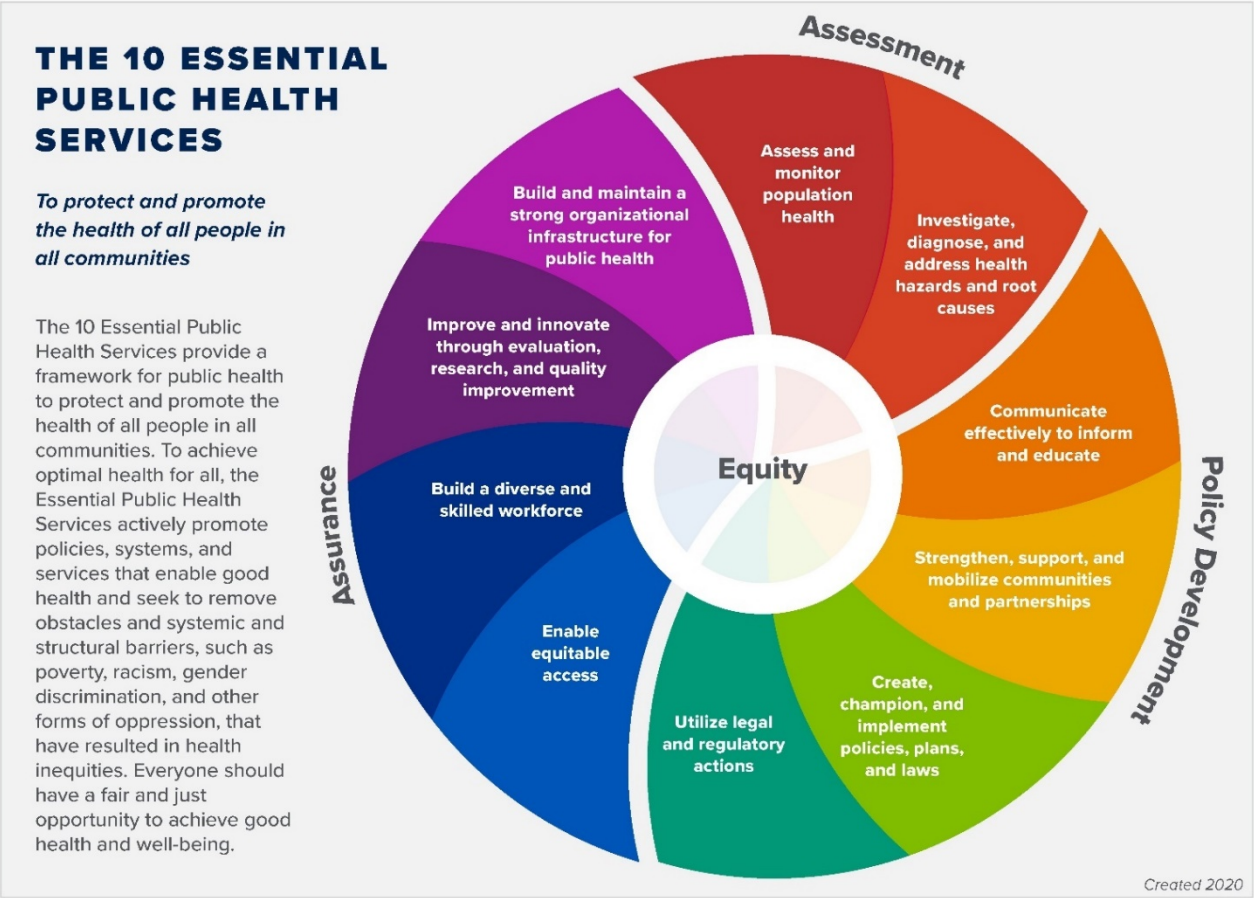
The purpose of the Medi-Cal Dental Advisory Committee (MCDAC) is to provide oversight and guidance to improve dental utilization rates, the delivery of oral health and dental care services, including prevention and education services, under Medi-Cal Dental managed care and fee-for-service delivery systems in Sacramento County.

The MCDAC consists of up to 18 members, plus one representative from each of the three Department of Health Care Services (DHCS) contracted dental plans (Access, Health Net, and Liberty) for a total of 21 members. Each member serves a two-year term, although there is no limit to how many consecutive terms a member may serve. Consistent with the statute, the advisory committee includes representatives from local nonprofit organizations, including the First 5 Sacramento Commission, the local dental society, and local health services.

MCDAC reports annually to DHCS, the California Legislature, the BOS and other leadership, as requested.

Information about MCDAC meetings and membership can be found: https://dhs.saccounty.gov/PUB/Pages/Medi-Cal%20Dental%20Advisory%20Committee/GI-Medi-Cal-Dental-Advisory-Committee.aspx

10 ESSENTIAL PUBLIC HEALTH SERVICES



Sacramento County Public Health delivers all 10 essentials of public health services displayed in the graphic above.

HEALTH STATUS OF THE COMMUNITY & SCPH PRIORITIES

SCPH recently evaluated overall community health and published its findings through the Sacramento County Public Health Community Health Assessment 2023 (CHA).[1]

Using this information, SCPH then works to prioritize the top health issues of those identified through the CHA and create a long-term, systematic, community-led plan for improvement, also known as the Community Health Improvement Plan (CHIP). SCPH created a CHIP Implementation Team to determine the top community health priorities in Sacramento County.

[1] SCPH used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework for the CHA process. There are three main assessments in the MAPP 2.0 framework that combine to create the CHA.

The CHIP Implementation Team identified the following three priorities:

1. Housing Insecurity & the Built Environment
2. Food Insecurity
3. Mental Health

The Community Health Improvement Plan including goals and objectives for 2024-2029 can be found on the Public Health website.

SACRAMENTO COUNTY PUBLIC HEALTH
Promote • Prevent • Protect

Sacramento County Public Health

PROGRAMS AND SERVICES

Disease Control, Surveillance, & Preparedness

Chest Clinic/Tuberculosis Control
(916) 874-9823
Surveillance of & clinical care for tuberculosis cases & contacts. Located at the Primary Care Center at 4600 Broadway in Sacramento.

Disease Control & Epidemiology
(916) 875-5881
Disease surveillance, disease & outbreak investigations, contact tracing & follow-up, prevention of disease transmission, & education.

Emergency Medical Services (EMS)
(916) 875-9753
Regulatory entity integrating elements of emergency care from 911 dispatch to emergency departments in one system. Licensing, training, & quality assurance for emergency services.

Immunization Assistance
(916) 875-7468
Consultation & resources for parents, CBOs, medical & child care providers, & schools regarding immunizations & immunization laws. Resources & childhood immunizations, COVID-19, & flu vaccines.

Public Health Emergency Preparedness
(916) 875-5881
Pivotal in the coordination of preparedness & response efforts through plan development, resource management, & training in Sacramento County related to public health & medical emergencies.

Public Health Laboratory
(916) 874-9231
Routine & specialized testing services for detection, control & prevention of communicable diseases in Sacramento & many surrounding counties.

Sexual Health
(916) 875-6022
HIV & STI education, counseling/testing, clinical sexual health services, surveillance, & partner notification. Provider education, training, & technical assistance. Coordination of care & support for people with HIV, STIs, & HCV.

Vital Records
(916) 875-5345
Registers all births, deaths, & fetal deaths; issues birth certificates, death certificates, & disposition permits; issues medical marijuana identification cards.

Maternal, Child, & Family Services

African American Perinatal Health (AAPH)
(916) 875-2229
Public health nurse home visitation program to improve birth outcomes for pregnant African American women.

Black Infant Health (BIH)
(916) 875-2229
Support group intervention encouraging empowerment & social support. Case management for access to community & health-related services.

California Children's Services (CCS)
(916) 875-9900
Diagnostic & treatment services, medical case management, & physical & occupational therapy services for children & young adults under age 21 with CCS-eligible medical conditions.

Child Health & Disability Prevention (CHDP)
(916) 875-7151
Coordinates free health exam for low to moderate income children by participating CHDP providers. Care coordination services for families accessing diagnostic & treatment services.

Community Nursing
(916) 875-0900
Public Health nurse home visitation for families with children 0-18 to improve child/adolescent health, development, & safety. Focused nurse case management for unhoused individuals & families.

Comprehensive Perinatal Services
(916) 876-7750
Coordinates prenatal care, health education, nutritional & psychosocial assessment, & referrals support for up to 60 days after delivery.

DCFAS Nursing (CPS, APS, IHSS)
(916) 875-4728
Provides nursing assessment, consultation, collaboration, & care coordination regarding preventative health & specialty services.

Nurse Family Partnership (NFP)
(916) 875-0900
Public health nurse home visitation for 1st-time pregnant women during pregnancy & the 1st 2 years of the child's life to improve pregnancy outcomes, child health, & development.

Women, Infants & Children (WIC)
(916) 876-5000
Support for pregnant women, new moms, & children 0-5 years to eat well, stay healthy, & be active.

Community Health Promotion

Child Passenger Safety
(916) 875-5869
Child Passenger Safety education & resources for parents & guardians to increase awareness & proper use of car/booster seats & seatbelts.

Childhood Lead Poisoning Prevention
(916) 875-7151
Staff & parent education, educational materials & resources, & public health awareness campaigns. Case management services & environmental investigations for children exposed to lead.

Obesity Prevention
(916) 875-5869
Training, technical assistance, & education addressing nutrition & physical activity behaviors through policy, system, & environmental changes. Referrals & resources for CBOs, child care providers, & FQHCs.

Older Adult Health
(916) 875-5869
Fall prevention, Alzheimer's, & brain health initiatives to provide resources and support for older adults and caregivers.

Oral Health
(916) 875-5869
Oral health education, dental care service resource & referral assistance for parents, school staff, & public health professionals.

Stop Stigma Sacramento Speakers Bureau
(916) 875-7908
Part of Behavioral Health's *Mental Illness: It's Not Always What You Think* stigma & discrimination reduction project. Speakers with lived experience share their stories of hope & recovery.

Suicide Prevention
(916) 875-5869
Partner with Behavioral Health to coordinate & implement prevention, rapid reporting systems, & crisis response to monitor and reduce suicide and suicide attempts in individuals 25 & under.

Tobacco Education
(916) 875-5869
Address tobacco & vape related health disparities through policy, system, & environmental changes. Educate, reduce youth tobacco access, promote cessation, & support the Greater Sacramento Smoke & Tobacco Free Coalition.

Accreditation:	Demonstrate SCPH's ability to carry out the 10 Essential Public Health Services & meet national public health standards, with the ultimate goal of achieving public health accreditation.
Budget & Administration:	Budget & administrative support to all SCPH programs; coordination with funders, DHS & County Fiscal, contracts, & facilities.
Health & Racial Equity:	Work across all SCPH programs & in the community to address the impacts of racism & ensure equitable & positive health outcomes for everyone in Sacramento County.
Workforce Development	Strengthen infrastructure to improve gaps in employee engagement, retention, communication, training, development, and technology modernization.

To learn more about Sacramento County Public Health, visit www.scph.com.

01/29/2024