Palm Beach County HIV Care Council Membership Manual

Palm Beach County HIV Care Council

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Introduction

Palm Beach County CARE Council Mission Statement:

Establish a collaborative and balanced body of HIV infected and affected individuals, service providers, and community leaders and interested individuals whose responsibilities shall be to plan, develop, monitor, evaluate, and advocate for a medical and support service system for individuals and families affected by HIV Spectrum Disease.

Membership Roles and Responsibilities

Orientation to the Palm Beach County HIV CARE Council

THE PALM BEACH COUNTY HIV CARE COUNCIL

The Palm Beach County HIV Services Planning Council was created through an ordinance of the Board of County Commissioners in November 1993. In August of 1997, the Planning Council and the Palm Beach County AIDS Consortium officially merged and became the Palm Beach County HIV Comprehensive AIDS Resources Emergency (CARE) Council. On August 19, 1997, the Board of County Commissioners approved the Bylaws for this new organization. The present CARE Council is made up of a maximum of 27 members who represent legislatively mandated membership categories; including individuals, both infected and affected by HIV/AIDS, and reflects the diverse population of Palm Beach County.

DUTIES OF THE COUNCIL:

1. To annually update HIV/AIDS service needs in Palm Beach County by conducting a needs assessment.
2. To develop and maintain Comprehensive HIV/AIDS Service Plan
3. To prioritize and allocate Ryan White Title I and Title II funds within Palm Beach County
4. Assure community participation in needs assessment and priority setting
5. To prioritize and allocate Housing Opportunities for People with AIDS (HOPWA) funds within Palm Beach County
6. To prioritize and allocate Florida State General Revenue Patient Care and AIDS Network funds within Palm Beach County
7. To assess the efficiency of administrative mechanisms in rapidly allocating funds to the areas of greatest need
8. To work with community members and other planning bodies to ensure a coordinated system of care
9. To maintain diversity and inclusion reflective of the epidemic in Palm Beach County in the Council membership
10. Assure services to women, infants, children and youth with the HIV disease
11. Work with other CARE Act representatives to develop the Statewide Coordinated Statement of Need (SCSN)

LEGISLATIVE REQUIREMENTS OF PLANNING COUNCIL

Planning Council Operations

Open meetings Meeting minutes

Establish operating procedures to make planning tasks function smoothly Meeting attendance records

Planning Council Membership Requirements

At least 33% of the members must be PLWH/As.

Planning Council Membership Categories:

1. Health Care Providers including federally qualified health centers
2. Community-Based Organizations serving affected populations
3. Social Service Providers
4. Mental Health Providers
5. Substance abuse providers
6. Local Public Health Agencies
7. Hospital or Health Care Planning Agencies
8. Affected Communities including PLWH/As and historically underserved groups
9. Hospital Planning Agencies or other Health Care Planning Agencies
10. Non-elected Community Leaders
11. State government, including the State Medicaid Agency and State Part B Program
12. Part C Grantees (does not exist at this time in Palm Beach County)
13. Part D Programs, or organizations with a history of serving children, youth and families with HIV/AIDS.
14. Other Federal HIV Programs, including HIV Prevention Programs
15. Representative of/or formerly incarcerated PLWHAs
16. Federally Recognized Indian Tribe
17. Co-infection with Hepatitis B or C from an underserved population

Planning Council Nomination Process

The planning council nominations process must be open, with criteria for membership delineated and publicized. Nominations criteria must include a conflict of interest standard.

Conflict of Interest

Planning councils are strictly prohibited from involvement in the selection of particular entities to receive Title I funding. If individual members of planning councils have a financial interest in, are a member of, or are employed by an organization seeking funds, they cannot participate (directly or in an advisory capacity) in the process of selecting entities seeking such funds.

Grievance Procedures

Planning councils and grantees must develop procedures for addressing grievances with respect to funding. Health Resources and Services Administration (HRSA) has developed model grievance procedures describing the elements that must be addressed in the local procedures, and must review and approve grievance procedures developed by grantees and planning councils.

Severe Need

The legislation defines severe need for Eligible Metropolitan Areas (EMAs) applying for supplemental grant funds. Priority consideration is to be given to EMAs based on such factors as sexually transmitted diseases (STDs), substance abuse, tuberculosis, severe mental illness, new or growing populations of PLWH/As, and homelessness, to the extent that such national incidence data is available.

Training

Members must develop/maintain nine competencies determined by HRSA, which include the following:

- o Know Ryan White HIV/AIDS Treatment Modernization Act
- o Understanding roles and responsibilities
- o Be comfortable with meeting procedures
- o Understand conflict of interest
- o Be sensitive to views of others
- o Understand budgets
- o Be sensitive to needs of underserved communities
- o Understand technical issues, such as use of data in decision-making
- o Understand treatment requirements, guidelines, and their impact on cost of care.

Attendance records must be maintained. Each new member is given a membership manual.

Coaching Program

Each new member of the CARE Council is assigned a mentor. The role of the mentor is to help the new member of the CARE Council feel welcome, become comfortable with the CARE Council process and to update them on the latest CARE Council issues.

The mentor and the person newly appointed to the CARE Council meet on an as needed basis." All meetings between 2 or more members of the CARE Council to discuss CARE Council business MUST take place at a public meeting that is noticed as a public meeting, with an agenda, recording, minutes, and opportunity for public comment.

The purpose of the scheduled sessions is so that CARE Council members may remain compliant with the Sunshine Amendment. In Florida, public officials (including CARE Council members) must abide by the Sunshine Amendment, and therefore cannot meet privately to discuss CARE Council matters. The Mentor Sessions are where CARE Council members can meet and discuss CARE Council issues.

Membership Roles and Responsibilities

Organizational Chart

PALM BEACH COUNTY HIV CARE COUNCIL

ORGANIZATIONAL CHART 2022

Us Health Resources Service Administration (HRSA) ↔ State of Florida Department of Health HIV/AIDS Bureau Administrator for Ryan White Part B ↔ Palm Beach County Department of Health As Administrator for AIDS Network Funds, General Revenue and Ryan White Part B Program

Us Health Resources Service Administration (HRSA) ↔ Palm Beach County Board of County Commissioners as Grantee for Ryan White Part A → Palm Beach County HIV CARE Council

US Department of Housing and Urban Development (HUD) ↔ City of West Palm Beach Board of City Commissioners Integrated with Palm Beach County HOPWA Program

Palm Beach County HIV CARE Council

CARE Council Coordinator

CARE Council Temporary Part Time Staff

Executive Committee

- Priorities and Allocation Committee
- Planning Committee
- Quality Management and Evaluation Committee
- Local Pharmaceutical Assistance Program Committee
- Community Awareness Committee
- Membership Committee
- LGBTQ Health Equity Committee
- AD Hoc Committees: Bylaws Grievance
- AD Hoc Housing Committee

**** For additional information contact Neeta Mahani, Coordinator (561) 355-4820 ****

File: PBC HIV CARE Council Org Chart 050222

Neeta Mahani/DMR 050222

Membership Roles and Responsibilities

Palm Beach County HIV CARE Council Committees

CARE Council Committees

Purpose of Committees:

Committees are appointed or elected for specific purposes. They should have defined assignments to complete within a specified time.

Committees work in various ways: as a full body, in smaller groups or sub-committees, or through individuals. During committee meetings, the members work and plan collectively. Specific tasks, however, may be assigned to individuals or teams, during or between meetings.

Types of Committees:

Standing Committees and Program Support Committees have permanent or ongoing functions.

The CARE Council Standing Committees include:

A. Community Awareness Committee
B. Executive Committee
C. LGBTQ Health Equity Committee
D. Local Pharmaceutical Assistance Program
E. Membership Committee
F. Quality Management & Evaluation Committee
G. Planning Committee
H. Priorities and Allocations Committee

The CARE Council's Ad hoc Committees may include, but are not limited to:

A. Bylaws Ad hoc Committee
B. Grievance Ad hoc Committee
C. Ad hoc Housing Committee

Community Awareness Committee:

The Community Awareness Committee is responsible for the following activities:

1. Conducting outreach to HIV/AIDS service consumers;
2. Acting as an informal caucus to bring consumer issues to the CARE Council, or CARE Council committees as appropriate. (this would be especially true if there was a general consumer; concern regarding a specific service or service provider);
3. Helping identify ways to reach People Living with HIV/AIDS (PLWHA) communities served, including minority and other special populations;
4. Providing an ongoing link with the community. Bringing community issues to the CARE Council, as well as information about available treatment, research, and care information to the community.

Executive Committee:

1. The Executive Committee shall consist of the Chair, Vice Chair, Treasurer, and Secretary of the CARE Council.
2. The Executive Committee shall also consist of the Chair of each Standing Committee of the CARE Council. At least one committee member with HIV must be present to constitute a quorum for decisions.
3. The Executive Committee will meet on a regularly scheduled basis. It may also be convened by the Chair of the CARE Council and/or at the request of a Grantee or Lead Agency, to take action on time-sensitive issues relating to prioritization or allocation of funds which make it impractical to convene the CARE Council.
4. The duties and responsibilities of the Executive Committee shall include, but are not limited to, oversight of the grant application process, contracting processes implemented by Grantees or Lead Agencies on behalf of the CARE Council, and implementation of policy or actions established by the CARE Council. Emergency actions taken by the Executive Committee shall be subject to ratification of the CARE Council.

LGBTQ Health Equity Committee:

1. Creating a platform where individuals are able to lend a significant voice to the issues, barriers and gaps in prevention, medical care and treatment, and biomedical intervention.
2. Conducting community outreach and improved engagement in the LGBTQ community.
3. Identifying barriers to linkages to care, treatment, and other social services to LGBTQ individuals infected/affected by HIV/AIDS.
4. Working with the Planning Committee on development of the CARE Council's Integrated Plan

Local Pharmaceutical Assistance Program Committee:

The Local Pharmaceutical Assistance Program Committee is responsible for the following activities:

1. Compiling a written formulary, as well as the process and procedures to add or remove medications. The LPAP Committee shall develop a procedure for clinical review for prior authorization approval;
2. Ensure the system of care meets the LPAP requirements as outlined in the HRSA/HAB Division of Metropolitan HIV/AIDS Program Monitoring Standards and local Standards of Care (SOC) as approved;
3. Provide input on a statement of need, submitted with the annual Ryan White grant application. The statement of need shall include an assessment of the need for an LPAP including the financial feasibility and evaluation of all available resources for medications, and the reasons these resources do not meet the needs of the clients;
4. Include LPAP stakeholders, including affected community, prescribing providers, pharmacy professionals, and AIDS Drug Assistance Program (ADAP) representative, to the extent possible.

Membership Committee:

Charged with identifying and recruiting members for the CARE Council and its Committees who are reflective of the HIV/AIDS epidemic in Palm Beach County.

The Membership Committee is responsible for the following activities:

1. Developing and implementing recruitment plan;
2. Recruiting new members;
3. Training new and existing members of the CARE Council in CARE Council responsibilities, policies and procedures the CARE Council uses to address its responsibilities;
4. Ensuring the CARE Council membership list complies with necessary grant requirements;
5. Monitoring membership attendance as required by Policies and Procedures.

Planning

1. Develops major planning activities of the CARE Council
2. Works with other planning/funding entities in PBC to ensure inclusion of all needed and available resources
3. Develops a county-wide Needs Assessment
4. Contributes to the Integrated Planning process for PBC
5. Develops and implements evaluation tools and programs
6. The Planning Committee is also responsible for the development and implementation of evaluation tools and programs to ensure quality services are provided to persons utilizing HIV/AIDS services in Palm Beach County.

Priorities and Allocation

1. Uses data to establish a list of services to enhance the medical condition and improve quality of life for people living with HIV/AIDS
2. Prioritizes services and appropriately allocates funding

Quality Management and Evaluation Committee:

The Quality Management and Evaluation Committee (QMEC) is responsible for ensuring that HIV funded agencies participating in the Coordinated Services Network (CSN) comply with standards of care established by the CARE Council in the delivery of services to their clients with HIV/AIDS. The QMEC is responsible for detailed planning and oversight of all services relating to the general health of persons living with HIV/AIDS who receive services funded through the collaborative funding sources of the CARE Council.

The QMEC is responsible for the following activities:

1. Overseeing the CARE Council's Quality Management Program;
2. Developing written Quality Management and Evaluation Plans;
3. Establishing quality management and evaluation activities including cost effectiveness analyses, monitoring medical and support services standards of care, outcome indicators (specific information that tracks a program's success), and client-level outcomes (benefits or changes for clients during or after receiving services);
4. Assisting HIV funded agencies participating in the CSN in implementing continuous quality improvement activities that are consistent with the CARE Council's Standards of Care;
5. Working collaboratively with other quality management and evaluation entities in Palm Beach County including persons living with HIV/AIDS;
6. Working with the Planning Committee to develop services definitions relating to each of the funded services;
7. Working with the Planning Committee on development of the CARE Council's Integrated Plan.

Ad hoc committees

Are formed when a specific need arises, and disbanded when the work is completed.

The CARE Councils Ad hoc Committees include, but are not limited to:

A. Bylaws Ad hoc Committee
B. Grievance Ad hoc Committee
C. Ad hoc Housing Committee

2021-2022 PBC HIV CC Committees Roster

CARE Council Members	Executive Committee	Community Awareness
Ashnika Ali ‘Ashaki Sypher Miguel Velasquez **Chris Dowden- Chair** **Kim Rommel-Enright-** **Vice Chair** **Kenny Talbot- Treasurer** **‘Richardo Jackson-Secretary** Felisha Douglas-Bowman Dale Smith Damion Baker Hector Bernardino Kristen Harrington Lilia Perez Lysette Perez Eileen Perry	**Chris Dowden – CC Chair & QMEC Chair** **Kenny Talbot – CC Treasurer, P&A Chair** **Felisha Douglas Bowman – LPAP & AD HOC Housing Chair** **Kim Enright CC Vice Chair & LGBTQ Chair** **Felisha Douglas –Vice Chair** **Felisha Douglas-Community Awareness - Vice Chair** **‘Richardo Jackson-Membership Chair** **Neeta Mahani**	Arlene Griffiths **Cecil Smith- Chair** Denise Brown **Felisha Douglas – Vice Chair** Hector Bernardino Peggy King Sandra Stewart Wanda Dhoray Taylor Velasquez Medford Carney Beatrice Manning Cassandra Felton Dale Smith Henriette Johnson Keisha Jackson Linda Warren

Thomas McKissack Tyrina Pinkney Medford Carney Angelie Diya Alejandro Velez Lisa Kemp Angelie Diya Mark Axelrod **Neeta Mahani**		Yasmin Perez Kenny Talbot 'Richardo Jackson **Neeta Mahani** **Felisha Douglas**

Membership Committee	Planning Committee	P & A Committee
Richardo Jackson – Chair	Ashnika Ali	**Kenny Talbot – Chair**
Kim Enright – Vice Chair	**Cecil Smith – Vice Chair**	**Medford Carney – Vice Chair**
Cecil Smith	**Chris Dowden -Chair**	Cecil Smith
Damion Baker	Kristina Rowe	Eileen Perry
Kenny Talbot	Linda Cledanord	Glenn Krabec
Dale Smith	Denise Brown	Dale Smith
Thomas McKissack	Nancy Aubourg	Felisha Douglas
Felisha Douglas	Rosaline Jocurin	
Eileen Perry	Kenny Talbot	
Rosaline Jocurin	Eileen Perry	
Lilie Resco	Lysette Perez	**Neeta Mahani**
		Thomas Eaton
Neeta Mahani	**Neeta Mahani**	
	Dr Casey Messer	
LGBTQ Health Equity Committee	**Q M & Evaluation Committee**	**LPAP Committee**
Denise Brown	**Hector Bernardino- chair**	Marie Presmy
Kim Enright – Chair	Cecil Smith	Mary Kennel
Vacant– Vice Chair	**Neka MacKay – Vice Chair**	Glenn Krabec
Richardo Jackson	Kristen Harrington	Eileen Perry

Kenny Talbot Quinton Dames Richard Montuori **Neeta Mahani** **Sean Conklin**	Linda Cledanord Nancy Aubourg Kristina Rowe Lilia Perez Tyrina Pinkney Katy Anderson Katie Mathieu **Shoshana Ringer &** **Dr Daisy Wiebe**	**Felisha Douglas – Chair** Donna Sabatino Lilia Perez **Scott Rice – Vice Chair** **Neeta Mahani** **Shoshana Ringer**

AD HOC Housing Committee		
Felisha Douglas - Chair Ashnika Ali Thomas Mckissack Cecil Smith Dale Smith Kristina Rowe ‘Ashaki Sypher Tyrina Pinkney **Lisa Kemp – City of W.P.B (Vice Chair)** Denise Brown Neka MacKay Linda Clenardo Miguel Velasquez Lilie Resco Chris Dowden **Neeta Mahani** **Dr. Casey Messer**		

Application for Membership 2022-2026 (Volunteer)

Part 1: Contact Information

To help us process your membership application, please provide all of the information requested and type or print clearly.

Name:

Home Address:

City/State: Zip Code:

Home Phone: Cellular/Mobile Phone:

Personal E-mail: Employer (if applicable): Employer Address:

Employer City/State: Employer Zip Code:

Title/Position:

Work Phone: Work Fax:

Work E-mail:

Planning Council Support staff will be contacting you via mail, e-mail, and/or telephone about meeting activities. Please tell us how you prefer to be contacted:

I prefer to receive calls and messages at	☐ Home	☐ Work
I prefer to receive mail at	☐ Home	☐ Work
I prefer to receive e-mail messages at	☐ Home	☐ Work

How did you hear about the PBC HIV CARE Council?

Part 2: Applicant Demographics

Please check the box for each category with which you most closely identify. Feel free to include any additional information that you use to describe yourself on the 'other' lines. Your response will be kept CONFIDENTIAL and available only to CARE Council Support staff and the members of the Nominating Committee.

I am ☐ Mal e ☐ Female ☐ Transgen der

My age range is ☐ 19 and under ☐ 20-29 ▯ 30-39 ▯ 40-44

☐ 45-49 ▯ 50-59 ▯ 60-69 ▯ 70+ No [OPTIONAL]

☐ Yes ▯ No [OPTIONAL]

I am a person living with HIV (PLWH) I am a person living with Hepatitis B ☐ Yes ▯ No

I am a person living with Hepatitis C ▯ No [OPTIONAL]
Yes ▯

1

If you are a person living with HIV, are you willing to self-identify as such for legal documents and CARE Council activities?* ☐ Yes ☐ No

Do you receive services at any of the agencies funded through Part A? ☐ Yes ☐ No

Compass Found care Legal Aid Society of Palm Beach County Florida Dept of Health AHF Health Council of South East Florida

**Disclosure of HIV status is encouraged, but <u>not required</u> for membership.*

Race/Ethnicity

*You **MUST** choose one*	*Choose as many as applicable, but you **MUST** choose at least one*	*You may choose one or more from the following Racial/Ethnic Groups*
☐ Hispanic or Latino/a	☐ White	☐ African
☐ Not Hispanic or Latino/a	☐ Black or African-American	☐ Haitian
☐ Unknown/Unreported	☐ Asian	☐ Brazilian
	☐ Native Hawaiian/Pacific Islander	☐ Portuguese
	☐ American Indian/Alaskan Native	☐ Puerto Rican
	☐ Other: _	☐ Other: _____

What languages do you speak? ____

What languages do you read and write? ______

Do you have any special needs (e.g. accessibility)? ______

Part 3: CARE Council Membership

Why do you want to be a CARE Council member?

____

____

____

The CARE Council meets once a month (currently on the Last Monday of each month) for a two-hour meeting (from 2pm to 4pm) in Palm Beach County. The CARE Council's committees will require an additional two-hour commitment. Can you commit to spending four (4) hours a month on CARE Council activities?

____

____

I am a former CARE Council member re-applying: ☐ Yes ☐ No

If yes, what years did you serve? ____

What committee(s) are you interested in joining?

☐ Planning/Needs Assessment	☐ LGBTQ Health Equity ☐ Membership	☐ Local Pharmaceutical Assistance Program

☐ Priorities and Allocation

☐ Quality Managem ent

☐ Community Awareness

Part 4: Special Skills and Program Involvement

What special skills or areas of expertise would you bring to the CARE Council?

☐ Advocacy/Awareness ☐ Community Organizing

☐ Health Planning ☐ Evaluation of HIV or Health Services

☐ Public Health Administration ☐ Provider Perspective

☐ Dental Services and Needs ☐ Homelessness/Housing Services and Needs

☐ Substance Use/Abuse Services and Needs ☐ Mental Health Services and Needs

☐ PLWH Nutritional Services and Needs ☐ PLWH Legal and Financial Services and Needs

☐ Primary Medical Care: Ambulatory/Outpatient ☐ Primary Medical Care: Antiretroviral Therapies

☐ White MSM HIV Issues and Needs

☐ Women's HIV Issues and Needs

☐ Transgender HIV Issues and Needs

☐ Immigrant/Migrant HIV Issues and Needs

☐ MSM of Color HIV Issues and Needs

☐ Children/Youth HIV Issues and Needs

☐ Ex-offender HIV Issues and Needs

☐ Other: ____

Please respond briefly to the questions below. If you need more space than provided, feel free to continue on a separate sheet of paper and attach it to this application. ***You may attach a current resume.***

What special skills, educational background, perspectives, or life experiences do you think you will bring to the Planning Council? If you are a previous CARE Council member, what **new** experiences would you bring to the new CARE Council term?

____
____
____
____

What experiences (personal, volunteer, or professional) have you had, if any, with the HIV community?

____
____
____
____
____
____

Please check all that apply.

I am affiliated as an **<u>employee</u>**, **<u>consultant,</u>** or **<u>board member</u>** with the following types of organizations, agencies, or programs:

☐ **I am not affiliated as an employee, consultant, or board member with any of the types of agencies listed**

☐ Health Care Providers (including federally qualified health centers)

☐ Community-Based Organizations (CBOs) serving affected populations/AIDS service organizations (ASOs)

☐ Social Service Providers (including housing and homeless service providers)

☐ Mental Health Providers

☐ Substance Abuse Providers

☐ Local Public Health Agencies

☐ Hospital Planning Agencies or Other Health Care Planning Agencies

☐ Affected communities, including PLWA and Historically Underserved Subpopulations

☐ Non-elected Community Leaders

☐ State Medicaid Agency

☐ Ryan White Act Part A Funded Agencies

☐ Ryan White Act Part B Funded Agencies

☐ Ryan White Act Part C Funded Agencies

☐ Ryan White Act Part D Funded Agencies

☐ Ryan White Act Part F Funded Dental Reimbursement Programs

☐ Ryan White Act Part F Funded Special Projects of National Significance (SPNS)

☐ Ryan White Act Part F Funded AIDS Education and Training Centers (AETC)

☐ CDC-Funded Prevention Providers

☐ Representatives of or Formerly Incarcerated PLWH

The name(s) of the organization(s) that I've referred to above and my role(s) in those organizations are:

Part 5: Statement of Member Commitment

As a member of the Palm Beach County HIV CARE Council, you are subject to Florida's Government-In-The-Sunshine requirements. Certain personal requirements are placed upon you and your conduct with other members, the public at large and the Department of Community Services. Upon notification of appointment, all new members will undergo a new member orientation which will include complete discussion of Government-In-The- Sunshine.

Certain assurances pertaining to potential conflicts-of-interest must be executed by all members of the Palm Beach County HIV CARE Council. Disclosure of business and personal relationships with agencies or individuals benefitting from award of Ryan White Funding must be given each time an issue is raised which could present a conflict of interest. Council members must indicate prior to discussion any potential conflicts, and must abstain from voting on issues presenting a potential conflict.

Signature of applicant:______Date:__

Part 6: Application Checklist

Please verify that you have completed each part of this application. Check all boxes.

☐ Part 1: Contact Information

☐ Part 2: Applicant Demographics

☐ Part 3: Planning Council Membership

☐ Part 4: Special Skills and Program Involvement

☐ Part 5: Statement of Member Commitment

☐ Code of Ethics Form

Memorandum of Understanding (MOU)

Between the PBC Ryan White Part A Recipient and PBC HIV CARE Council

I. Purpose Statement

This Memorandum of Understanding (MOU) is designed to:

- □ Create a shared understanding of the relationship between the PBC Ryan White HIV/AIDS Program (RWHAP) Part A Recipient and the PBCHIV CARE Council
- □ Delineate the roles and responsibilities of each entity; and
- □ Encourage a mutually beneficial relationship between these important partners.

The MOU describes the legislated responsibilities and roles of each party, the locally defined roles, and expectations for how these roles and responsibilities will be carried out. The MOU will establish positive and appropriate communication, information sharing, and cooperation that will help ensure the effective and efficient delivery of medical and support services to persons affected and living with HIV in the PBC Eligible Metropolitan Area (EMA)

II. Roles and Responsibilities

A. Roles and Responsibilities of the CARE Council

The CARE Council is solely responsible for the following tasks, as specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009:

1. Priority setting and resource allocation: Set priorities among service categories, allocate funds to those service categories, and provide directives to the Recipient on how best to meet these priorities. This includes reallocation of funds as required during the program year and allocation of carryover funds.

2. Assessment of the administrative mechanism: Assess the Recipient's process for procuring services and disbursing funds to the areas of greatest need within the EMA.

B. Roles and Responsibilities of the Recipient

The Recipient is solely responsible for meeting the following legislatively mandated responsibilities:

1. Procurement: Manage the process for awarding contracts to specific service providers.
2. Contracting: Distribute funds according to the priorities, allocations, and directives of the Planning Council.
3. Contract monitoring: Monitor contracts to be sure that sub recipients are meeting their contracted responsibilities in compliance with established standards of care. Recommend re-allocations during the grant year based on service category performance.
4. Technical Assistance to Service Providers: Provide technical assistance to sub recipients on an as- needed basis to build capacity and to improve contract compliance and service delivery.

C. Shared Responsibilities

The Recipient and CARE Council share the following legislative responsibilities, with one entity having the lead role for each, as stated below:

1. Needs Assessment: Determine the size and demographics of the population of individuals with HIV in the EMA, and their service needs. The PBC HIV CARE Council Planning committee has primary responsibility for needs assessment, with the Recipient staff assisting with the process and providing the CARE Council information such as service utilization data and expenditures by service category.
2. Clinical Quality Management (CQM): Establish a clinical quality management program to assess the extent to which HIV-related primary health care services are consistent with Public Health Service guidelines and to enhance health and supportive service access and delivery and continuously improve systems of care. Includes identifying quality improvement projects. Except for service standards (see below), the Recipient has primary responsibility for other CQM activities. CARE Council members sit on the Quality Management and Evaluation Committee and People Living with HIV may be part of CQM field teams visiting Part A providers/sub recipients.
3. Service Standards: develop and maintain service standards and outcomes measures. The Quality Management & Evaluation Committee of CARE Council takes the lead in this effort, with extensive Recipient involvement.

4. Integrated Plan: The CARE Council works with the recipient to develop a written integrated plan for HIV service delivery and improving the system of care within the EMA. The CARE Council should take a lead role in plan development while coordinating closely with the Recipient. The plan should include long-term and shortterm goals and should address each stage of the HIV care continuum.

D. Administrative Responsibilities

In addition to these legislative roles, the Recipient and CARE Council share the following responsibilities related to Part A CARE Council and management:

1. **Fiscal management of CARE Council support funds**: The Recipient provides fiscal management of CARE Council support funds. The annual CARE Council support budget is funded as a part of the allocation of up to 10% of the total grant that may be used for administrative costs. The amount to be used for CARE Council support must be negotiated between the Recipient and CARE Council. The CARE Council support staff works with the P&A Committee to develop the CARE Council budget, which is reviewed by the Recipient to ensure proposed use of funds meets federal and municipal requirements. CARE Council Support staff works with the P&A Committee to monitor CARE Council expenditures, based on reports provided by the Recipient through CARE Council support staff. The Recipient is responsible for ensuring that all expenditures meet RWHAP guidelines as well as local financial management regulations.
2. **Office Space**: The Recipient and CARE Council support staff will maintain separate and distinct office space within the same building where feasible. Office space for the CARE Council must meet all Americans with Disabilities Act (ADA) requirements.
3. **Triennial application process**: The Recipient has primary responsibility for preparation and submission of the Part A grant application. CARE Council support staff provides information for the application sections related to CARE Council membership and responsibilities (such as priority setting and resource allocations), and assists with preparation and review of the application. To the maximum extent possible given time constraints, the CARE Council Chair or Vice-Chairs [and the Executive Committee] have an opportunity to review the application before submission and make suggestions for its improvement. The CARE Council Chair signs a letter of assurance accompanying the application that indicates whether the Recipient has expended funds in accordance with CARE Council priorities, allocations, and directives, and other information as specified in the annual Part A Notice of Funding Opportunity Announcement (NOFO) from HRSA/HAB.
4. **Sub recipient NOFO**: Procurement is the Recipient's responsibility. However, because contracting is required to ensure that the CARE Council's directives are being addressed, and the CARE Council develops service standards that become a part of sub recipient requirements. The Recipient therefore allows up to [two] representatives of the CARE

Council who have no actual or perceived conflict of interest to review in draft the portions of the NOFO that address service standards and CARE Council directives. Any CARE Council member who reviews the NOFO sections is required to sign a statement of confidentiality and non-disclosure. No part of the NOFO is reviewed by any CARE Council member affiliated with a current or potential Part A service provider.

III. Communications

A. Principles for Effective Communications

Both the Recipient and the CARE Council recognize the importance of regular & open Communication and of sharing information on a timely basis. Information needs to be received regularly. There should be clarity regarding what will be communicated, when, and to whom. When problems or issues arise, there should be a joint commitment to resolving them through established procedures. The parties commit themselves to the following principles:

1. All parties will take responsibility for establishing and maintaining open communications. This includes both sharing information on a timely basis and reviewing shared information once it has been received. If issues or problems arise, it means communicating with the other parties to clarify the situation and decide how best to address it.
2. CARE Council standing committees except the Membership Committee will have a Recipient staff member who is assigned to it and attends meetings regularly. That staff member will serve as liaison to the Recipient for that committee and will be responsible for responding to communications and information requests from the committee.
3. The Recipient and CARE Council will each have a designated liaison responsible for sharing and receiving information for all other communication requests, and for disseminating information within their entity. When questions or concerns arise, the designated liaison will ensure that they are addressed in a timely manner. For the CARE Council, the designated liaison will be the CARE Council coordinator. For the Recipient, it will be the Ryan White Program Manager.
4. Both entities will use designated liaisons and channels of communication. When someone needs information or materials beyond those that are regularly shared, they will request it through the designated liaison, and the request will be made in writing (via e-mail or letter). This means, for example, that a Committee Chair who needs information from the Recipient will request it either through the assigned Recipient staff member during the meetings or through CARE Council support staff. For information beyond normal reports and information, it is the responsibility of the CARE Council coordinator and Ryan White Program Manager to determine whether the

Recipient is the appropriate source for this information and whether the information is available and can be provided within the
Recipient's resources. Where the Recipient feels it cannot meet the request, the Ryan White Program Manager will consult with the CARE council support staff member and with the Chair or Committees chair as necessary

5. Staff of both entities and CARE Council members will avoid inappropriate communication requests or channels. This means not asking for information from individuals other than the designated individuals, using and not bypassing established communication channels, and maintaining the confidentiality of information that should not be shared outside the Part A program.
6. When policies or procedures appear problematic, the parties will work together to clarify and, if appropriate, refine them – while adhering to legislative requirements, HRSA/HAB guidance and expectations as stated in Part A-related manuals, policy statements, and guidance, and state and local statutes and policies.
7. Communications and problem solving will protect the separation of roles between the CARE Council and Recipient. For example, the CARE Council is not supposed to have access to information about the performance or expenditures of individual providers; it should receive such information only by service category. In cases where there is only one service provider for a service category, the CARE Council will have access to this information but without identifying information.
8. If either Recipient staff or CARE Council support staff or members receive complaints about the other party, they will inform the other party, with appropriate protection of confidentiality.
9. The CARE Council will not become involved in consumer complaints about services. If the CARE Council or its support staff receives consumer or provider concerns or complaints about a specific provider, it will refer the individual expressing the concern to the individual provider for resolution through its own complaints process. If the CARE Council or support staff receives broader, systemic complaints or concerns about services, it will refer them to the Part "A" Program Manager.

B. Implementing these Principles

To facilitate communications and implement these principles, all parties agree to the following actions:

1. **The signatories to this agreement will participate in a face-to-face Executive meeting including both entities and all parties following the elections of CARE Council Leadership annually.** The first meeting, held just before the Part A program begins on March 1, will be used to lay out specific mutual expectations for the year, ensure a mutual understanding of the Part A program's status and directions, clarify a calendar for the year

including dates when materials and information will be shared, and address potential issues or problems. This includes identifying additional or different reports or information needed. Subsequent meetings will be used to monitor progress and refine the calendar as needed, further define information sharing needs, and address any issues that may arise in the relationship between the Recipient and CARE Council.

2. **When making special requests for information or materials, both parties will provide as much lead time as possible; when sharing information, both parties will do so as quickly as possible**. Requests for information will generally be met within five business days. If requests will take longer to meet, the party responding will contact the other party within three business days to discuss and agree on a time frame for meeting the request. Both parties commit themselves to responding rapidly to any requests that involve meeting Conditions of Award, satisfying other HRSA/HAB requirements or requests, and addressing other matters that may affect the funding or reputation of the EMA/TGA's RWHAP Part A program.

IV. Information/Document Sharing and Reports/Deliverables

A. Overview

It is the intent of this MOU to encourage regular sharing of information and materials throughout the year. This section specifies a set of materials to be provided and information to be shared through meetings. Parties to the MOU may request and receive additional materials or information, except for those that should not be shared for reasons of sensitivity or confidentiality.

B. Information to be Provided by the CARE Council to the Recipient

The CARE Council will provide the Recipient Part A Program Manager with the following information and materials:

1. A dated list of CARE Council members and their terms of office, with primary affiliations as appropriate, to be provided annually and updated as needed throughout the year, in accordance with current HRSA/HAB requirements.
2. Notification of the CARE Council's monthly meetings, retreats, orientation and training sessions, and other CARE Council events, at the same time notification goes to CARE Council members.
3. The meeting notice, agenda, and information package for each CARE Council meeting, to be provided at the same time they are provided to CARE Council members.
4. The annual list of service priorities and resource allocations, along with the process used to establish them and directives to the Recipient or edits to existing directives on how best to meet these priorities – the same information that is submitted to HRSA/HAB as part of

the annual Part A application. This information will be provided within two weeks after the CARE Council has approved the priorities, allocations, and directives.

5. Copies of final planning documents prepared by the Recipient staff Health Planner, such as needs assessment reports and the integrated Plan, within ten days after their completion and approval by the CARE Council.
6. Information or documents needed by the Part A Program Manager to complete the sections of the annual application related to the CARE Council and its functions, to be provided on a mutually agreed-upon schedule.

C. Information to be Provided by the Recipient to the CARE Council

The Part A Program Manager will provide the CARE Council Support Coordinator the following reports and information. These will be the minimum requirements. Additional or different information needs will be discussed and agreed upon at the beginning of each year. Use list or chart specifying data or document to be provided, frequency, and timing for providing the information to the CARE Council.

1. A copy of the annual Notice of Award (NOA) including Conditions of Award, a copy of any approved carryover request, and a copy of other official communications from HRSA/HAB that directly involve the CARE Council, within three business days after they are received from the funding agency and more quickly where time-sensitive responses are required.
2. A written monthly expenditures report by service category, provided in writing at least THREE business days before the meeting of the appropriate committee. The Recipient will also provide an oral presentation to the Priorities & Allocation & Executive Committee, highlighting any unexpected expense levels.
3. A report to the CARE Council regarding over- and under-expenditures and any unobligated balances, by service category and jurisdiction, and any suggested reallocations, to be provided monthly at least [THREE]business days before the meeting of the Priorities &Allocations, Executive & CARE Council Committee. This report is to be submitted monthly due to the importance of avoiding unobligated funds at the end of the program year, given the provisions of the legislation.
4. Utilization data by service category, including client numbers and demographics for each service category and for mutually determined special populations requiring additional analysis (e.g., young MMSC {Male to male sexual Contact} of color; women over 55), to be provided [Semi Annually], including end-of-year data consistent with the Ryan White Services Report (RSR). Basic data will be provided within 30 days after the RSR is submitted; due dates for more complex analyses will be mutually determined annually.
5. HIV Care Continuum data for all PLWH in the jurisdiction and for Ryan White clients, as well as mutually agreed upon breakdowns by subgroups, to be provided annually in [May

&June]. If data are obtained from the State, the Recipient will be responsible for arranging timely provision of these data.

6. Other performance and clinical outcomes data including HRSA/HAB-specific measures, collected by the Recipient, to be provided quarterly.
7. Information and recommendations requested as needed by the CARE Council to carry out its responsibility in setting priorities among service categories, allocating funds to those service categories, and providing directives to the Recipient on how best to meet these priorities. The content and format for this information will be mutually agreed upon each year, but will typically include epidemiologic data, additional cost and utilization data, and an estimate of unmet need for primary Health care among people who know their status but are not in care. In addition to providing the information in written form, the Recipient will participate in data presentations to the CARE Council at a mutually agreed upon date and time.
8. Information requested as needed by the CARE Council to meet its responsibility for assessing the efficiency of the administrative mechanism. The content and format for this information will be mutually agreed upon each year, but will typically include information from the Recipient on the procurement and grants award process; statistics (such as number of applications received, number of awards made, number of applications from minority providers, number of new providers funded, and number of minority providers funded), and reimbursement procedures and timelines.
9. Carryover information as it becomes available. This includes the estimated carryover as submitted to HRSA/HAB at the end of the calendar year, the actual carryover from the Financial Status Report, the carryover plan submitted to HRSA/HAB, and the approved carryover plan. Each document will be provided to the CARE Council within five business days after it is submitted or received.
10. The Federal Financial Report (FFR) and other end-of-year reports including the Final Implementation Plan and Final Allocations Report, as submitted to HRSA/HAB in the final progress report each year, providing information on the number of individuals served and costs per client for each service category. CARE Council will receive this information within ten business days after the Recipient submits the final progress report to HRSA/HAB, based on the Conditions of Award, in time for use in priority setting and resource allocation.

When the CARE Council or a Committee requests special or additional information from the Recipient, the request will always be listed in the summary minutes of the meeting. In addition, CARE Council support staff will provide a list of requests in a follow-up e-mail to the Recipient, within two business days, with a copy to the Committee Chair or CARE Council Chair. The request will always specify the date by which the information is needed, and for what legislatively defined task, and Recipient will respond within five business days, indicating whether it can meet the request and by what date. The two parties will negotiate content and timing where required.

D. Documents and Information that will not be shared

In order to maintain the confidentiality of sensitive information, the following information will not be shared, subject to the requirements of Florida's Public Records Law, Chapter 119, Florida Statutes:

1. The CARE Council will not share information on the HIV status of members of the CARE Council who are not publicly disclosed as people living with HIV/AIDS. Except for individuals who choose to disclose their status, the HIV status of CARE Council members will not be shared with the Recipient or with other CARE Council members except those involved in the Membership Process.
2. CARE Council support staff will not inquire, interfere, or otherwise discuss needs of, or actual HIV services provided to, CARE Council members by the Recipient or Subrecipients. CARE Council support staff will instruct members to communicate directly with their service provider or the Recipient staff to address individual medical care and support service needs.
3. The Recipient will not share information about individual applicants for service sub recipient contracts or about the performance of individual contractors –

   Information will be shared by service category only. If there is only one sub recipient in a service category, the information will be shared, but without identifying information.

4. Information about the individual salaries of Recipient and CARE Council staff will not be shared beyond those with a direct need to know. The CARE Council will not have access to the Recipient's detailed budget other than the summary version submitted in the Part A Application. The Part A Program Manager will have access to the CARE Council's detailed budget as needed for the Part A application, Conditions of Award, and other HRSA/HAB requirements.

V. Settling Disputes or Conflicts

If conflicts or disputes arise with regard to the roles and responsibilities specified in Section II of this Memorandum of Understanding, the parties will use the following procedures to resolve them:

1. Begin with a face-to-face meeting between the parties to attempt to resolve the situation, within five working days after the issue or dispute arises.
2. If the situation cannot be resolved by these parties, hold a meeting of representatives of both parties, along with the Recipient staff supervisor and the Chair of the CARE Council, to discuss the issue and reach resolution if possible, within ten working days after the initial meeting.

3. If the situation still cannot be resolved, the two parties will be removed from the discussion and the mutual decision of the Recipient staff supervisor and Chair of the CARE Council will be final.

VI. Responsible Parties and Contact Information

The following are the parties to this MOU and the parties' representatives at the time this MOU is adopted. Any notice or communications required to be sent by this MOU shall be sent to the parties' representative at the email provided.

The MOU will continue in effect regardless of changes in the individuals who hold these positions. Their successors will be expected to follow the MOU.

For the Recipient:

- Part A Program Manager, Dr Casey Messer, cmesser@pbcgov.org

For the CARE Council:

- CARE Council Chair, Chris Dowden, cdowden@midwaycare.org

VII. MOU Duration and Review

A. Effective Date

The MOU will become effective once all the authorized individuals representing the Recipient and CARE Council sign it.

B. Duration

The MOU will remain in effect for 5 years unless or until the parties take action to end it or The Recipient no longer receives Part A funding for the EMA/TGA.

C. Process for Reviewing and Revising the MOU

The MOU will be reviewed and revised annually, with the involvement and approval of all parties. Reviews will occur:

1. Following each reauthorization or legislative revision of the Ryan White legislation by the U.S. Congress, to ensure that the MOU remains fully appropriate, updated, and reflective of the Act.
2. At least once every year at the first meeting of the parties to this MOU.

VIII. Signatures

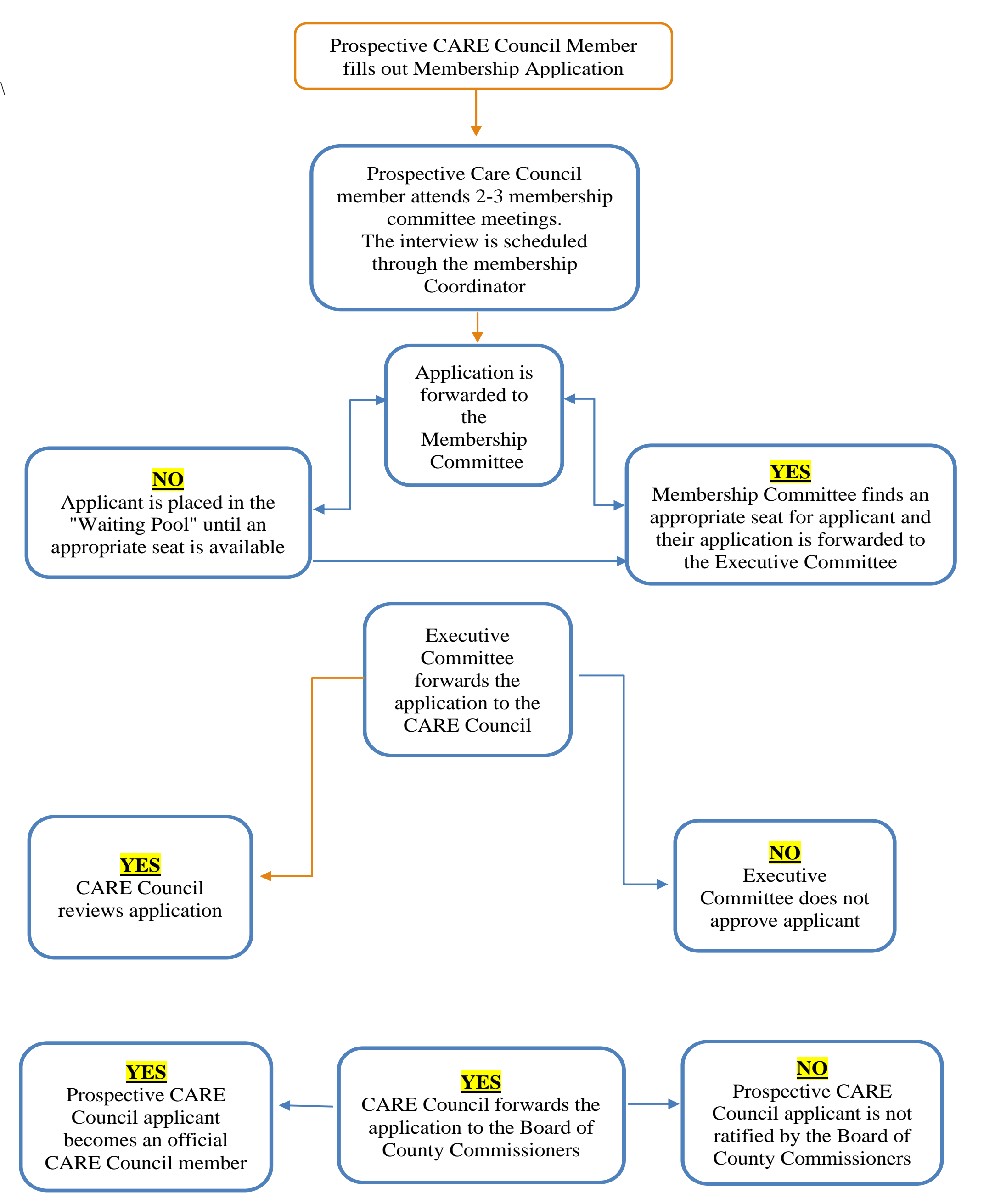
5/26/22

Casey Messer, DHSc, PA-C, AAHIVS
Ryan White Program Manager

Chris Dowden, PharmD, BCPS, AAHIVP
CARE Council Chair

Membership Roles and Responsibilities

Prospective Care Council Member Application Process



Palm Beach Care Council Bylaws

ARTICLE I NAME, AREA OF SERVICE, FUNDING AUTHORITIES, AUTHORIZATION

SECTION 1: The name of this entity shall be the "Palm Beach County HIV Comprehensive AIDS Resources Emergency Council," hereinafter referred to as the "CARE Council."

SECTION 2: The area of service shall be defined as Palm Beach County.

SECTION 3: The CARE Council shall work with the grantee or fiscally responsible agents for the current funding streams.

ARTICLE II MISSION AND VISION

SECTION 1: Mission: The CARE Council shall be a collaborative and balanced body of HIV infected and affected individuals, service providers, community leaders and interested individuals whose responsibilities shall be to plan, develop, monitor, evaluate and advocate for a medical and support services system for individuals and families affected by HIV/AIDS.

The CARE Council shall:

(A) Develop a comprehensive plan for the entity and delivery of health services described in the Ryan White CARE Act, as it may be amended (hereinafter referred to as the Ryan White Act) that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease.

(B) Establish priorities for the allocation of Ryan White Act Part A and Ryan White Part B funds, State of Florida 4B General Revenue and Patient Care Network, and other appropriate funds within Palm Beach County, including how best to meet each such priority and additional factors that the grantees or Lead Agency shall consider based on:

- Documented needs of the HIV infected population;
- Cost and outcome effectiveness of proposed service strategies and interventions, to the extent that such data are reasonably available (either demonstrated or

probable);

- Priorities of the HIV infected communities for whom the services are intended; and
- Availability of other governmental and non-governmental resources.

(C) Assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area. Establish a grievance procedure to address grievances filed against the CARE Council. Develop model consumer grievance procedures which may be implemented at the discretion of the CARE Council to address grievances filed against
Providers of HIV/AIDS services; assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs.

(D) Participate in the development of a Statewide Coordinated Statement of Need initiated by the State Public health Agency responsible for administering grants under Ryan White Part B of the Ryan White Act.

(E) Establish methods for obtaining input on community needs and priorities which may include public meeting, conducting focus groups, and convening Ad hoc panels.

(F) Coordinate service provision and planning outcomes with the designated Lead Agencies for the administration of Ryan White Part B funds and State of Florida 4B General Revenue and Patient Care Network.

(G) Work with community members and other planning bodies to ensure a coordinated system of care.

(H) Maintain diversity and inclusion reflective of the epidemic in Palm Beach County in the CARE Council membership.

(I) Perform such other duties as the CARE Council may, from time to time, deem appropriate and /or necessary.

SECTION 2: Vision:

(A) A community where individuals who live with HIV/AIDS do so without prejudice, abandonment, or social stigma.

(B) A community where people living with HIV/AIDS are afforded a comprehensive range of medical and support services assuring the person's wellness, independence, and self-sufficiency.

(C) A community where HIV medical and support services are eligibility accessed based upon need, and approved CARE Council guidelines.

ARTICLE III CARE COUNCIL MEMBERS

SECTION 1: The CARE Council is intended to be a collaborative organization of the affected community, service providers, and non-elected community leaders. Membership of the CARE Council shall be evenly divided among members of these three groups. Every effort shall be made to ensure that the representation of the infected community reflects the demographics of the epidemic in Palm Beach County, with particular consideration given to disproportionately affected and historically under-served groups and subpopulations. Additional membership categories to comply with federal requirements will be complied with as they arise.

SECTION 2: Candidates for membership on the CARE Council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard. Membership shall include:

(A) PEOPLE LIVING WITH HIV & COMMUNITY

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

(B) 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

(C) PUBLIC HEALTH & HEALTH PLANNING

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

(D) FEDERAL HIV PROGRAMS

- RWHAP Part B recipients
- RWHAP Part C recipients
- RWHAP Part D recipients
- Recipients under other federal HIV programs[11]

* 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' 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

◆t Including HIV prevention services

SECTION 3: (A) A CARE Council Member shall be defined as any resident of Palm Beach County, Florida who applied for membership in accordance with the official nominations process for CARE Council Membership prescribed in the policies of the CARE Council, has been recommended for membership by the CARE Council, officially appointed by the Palm Beach County Board of County Commissioners, has complied with financial disclosure requirements of the Board of County Commissioners, and who has maintained attendance and committee participation requirements prescribed by the CARE Council. CARE Council members shall maintain the right to vote on any issue before the CARE Council, with which they have no conflict of interest, following appointment by the Board of County Commissioners.

(B) A CARE Council member is required to actively participate on at least one standing committee to retain CARE Council membership. Failure to actively participate will result in removal from council membership. The removal process shall be defined by CARE Council policy.

(C) An affiliate member shall be defined as an individual who has not been approved for full CARE Council membership by the Palm Beach County Board of County Commissioners,
But who is a member of a CARE Council committee. Affiliate members may not vote on issues brought before the full CARE Council

SECTION 4: A member may represent only one of the three mandated membership categories. (i.e., Affected Community, Non-Elected Community Leader or Service Provider)

SECTION 5: At least one third (33%) of the CARE Council members must be PLWHA (People Living With HIV/AIDS) who receive Part A services and are "unaligned". "Unaligned" refers to consumers who do not have a conflict of interest, meaning they are not staff, consultants, or Board members of Ryan White Part A funded agencies. The CARE Council shall maintain a formal program to support participation by HIV positive members. Every effort shall be made to ensure that these members reflect the demographics of the epidemic in Palm Beach County with particular consideration given to disproportionately affect and historically under-served groups and subpopulations, as mandated by HRSA.

SECTION 6: The total CARE Council membership shall be a balanced membership of no more than thirty-three (33) members.

SECTION 7: The CARE Council member term of office shall be three years. There shall be a limit of three (3) consecutive three-year terms that a member can serve. This provision is effective as of

March 1, 2013, and applies to any member who is appointed or reappointed subsequent to that date.

SECTION 8: Attendance and participation at CARE Council meetings is crucial to the operation of the CARE Council.

(A) Members shall be automatically removed by the Palm Beach County Board of County Commissioners for lack of attendance. Lack of attendance is defined as a failure to attend three (3) consecutive meetings or a failure to attend more than one-half (1/2) of the meetings scheduled during preceding calendar year. Participation for less than three-fourths (3/4) of a meeting shall be the same as a failure to attend a meeting. Excused absences due to illness, if approved by majority vote of the CARE Council, shall not constitute lack of attendance. Excused absences shall be entered into the minutes. Members removed pursuant to this paragraph shall not continue to serve on the CARE Council and such removal shall create a vacancy, such members who have been removed may continue as affiliate members.

(B) Upon accumulation of three (3) consecutive excused absences or any excused absences from more than fifty percent (50%) of CARE Council meetings during the calendar year inclusive of the month of the last absence, members will be asked to discuss their future CARE Council participation with the Membership Committee. The Membership Committee Chair or designee will report to the Executive Committee with the Membership Committee's recommendation for removal or continued membership. The CARE Council shall make a finding for removal or continued membership. In application of this provision, no decisions shall be made which are in conflict with the provisions of *Article Ill, Section 8, and Part A.*

(C) This attendance requirement applies only to the regularly scheduled CARE Council meetings, and not to emergency meetings.

SECTION 9: Vacancies resulting from death, automatic removal, involuntary removal, or voluntary resignation of any member shall be filled pursuant to the policies, procedures and bylaws of the CARE Council.

Proposed Amendments 7.31.2020

ARTICLE IV OFFICERS

SECTION 1:

The CARE Council will elect the Chair, Vice Chair, Treasurer and Secretary from the CARE Council membership by a majority vote of the quorum of the members present at the Annual Meeting. The officers are elected for a one (1) year term or until their successors are elected. In filling vacancies for unexpired terms, an officer who has served more than half a term in an office is considered to have served a full term. All elected officers will begin their term at the conclusion of the meeting at which they were elected. No officer shall hold the same office for more than three (3) consecutive terms. Officers may be removed from office upon a three-fourths (¾) vote of the membership present and voting at any legally noticed meeting of the CARE Council where a quorum is present. No member who is employed by a grantee shall be eligible to serve as an officer of the CARE Council.

SECTION 2: The Chair's duties and responsibilities include, but are not limited to:

(A) With the consent of the CARE Council, represent the CARE Council to the Grantees, Lead Agency, Health Resources and Services Administration (HRSA) and other interested parties;

(B) Presiding at all meetings of the CARE Council and Executive Committee;

(C) Appointing the Chair of all CARE Council Committees, subject to the ratification of the CARE Council membership except as otherwise provided herein;

(D) Be an ex-officio member of all committees, subcommittees, advisory or ad hoc committees, except that a Chair who is affiliated with a Recipient or Sub recipient of Coordinated Services Network Funding, (Ryan White Part A, MAI, Ryan White Part B, State of Florida 4B General Revenue, and Patient Care Network), shall not be an ex-officio member of the Priorities and Allocations Committee;

(E) Conduct the business of the CARE Council as authorized by the Bylaws and Policies.

SECTION 3:

The Vice Chair shall be the Chair of the Bylaws and Grievance Committees and be responsible for maintaining the policies and procedures of the CARE Council. All powers and duties of the Chair shall

be performed by the Vice Chair in the absence of the Chair. When fulfilling these duties, the Vice Chair will be considered to be the acting Chair.

SECTION 4:

The Treasurer shall be Chair of the Priorities and Allocations Committee and shall not be affiliated with a Recipient or Sub recipient of Coordinated Services Network Funding as defined in Article IV, Section 2(D). All powers and duties of the Chair shall be performed by the Treasurer in the absence of the Chair and Vice Chair. When fulfilling these duties, the Treasurer will be considered to be the acting Chair.

SECTION 5:

The Secretary shall be the Chair of the Membership Committee and maintain and have responsibility for overseeing Government in the Sunshine meeting notices; recording of minutes; maintenance of CARE Council, committee and subcommittee membership rosters; and act as Chair of the Membership Committee. As funding permits, with the exception of Chairing the Membership Committee, these duties may be delegated to a staff function. All powers and duties of the Chair shall be performed by the Secretary in the absence of the Chair, Vice Chair, and Treasurer. When fulfilling these duties, the Secretary will be considered to be the acting Chair.

SECTION 6: Succession

(A) In the event the office of the Chair of the CARE Council becomes vacant, the Vice Chair shall serve the unexpired term of the Chair. In the event the Vice Chair is unable to serve the unexpired term of the Chair, a special election will be held at the next legally noticed meeting of the CARE Council.

(B) In the event the office of Vice-Chair, Treasurer or Secretary becomes vacant, the Chair will nominate at least one member of the CARE Council to fill the vacant office and an election, open to nominations from the floor, will be held.

(C) In the event of succession or special election to replace vacancy, the remaining time served shall not count as time served under Section I, Article IV.

ARTICLE V COMMITEES

SECTION 1: The CARE Council's Standing Committees may include:

(A) Executive Committee

(B) Planning Committee

(C) Priorities and Allocations Committee

(D) Membership Committee

(E) Community Awareness Committee

(F) Local Pharmaceutical Assistance Program Committee (LPAP)

(G) Quality Management and Evaluation Committee

(H) LGBTQ Health Equity Committee

SECTION 2: The CARE Council's Ad hoc Committees may include, but are not limited to:

(A) Bylaws Ad hoc Committee

(B) Grievance Ad hoc Committee

(C) Ad-Hoc Housing Committee

The CARE Council Chair may authorize the creation, prescribe the terms, and define the power and duties of any other Ad hoc Committee's as May, from time to time, be necessary or useful in conducting CARE Council business. The Ad hoc Committee's shall be created and managed according to the Policies and Procedures of the CARE Council.

SECTION 3: Executive Committee:

The Executive Committee shall consist of the Chair, Vice Chair, Treasurer, and Secretary of the CARE Council. The Executive Committee shall also consist of the Chair of each Standing Committee of the CARE Council. At least one committee member with HIV must be present to constitute a quorum for

decisions.

The Executive Committee will ~~meet on a regularly scheduled basis. It may also~~ be convened by the Chair of the CARE Council and/or at the request of a ~~Grantee or Lead Agency~~, the recipient, to take action on time- sensitive issues relating to prioritization or allocation of funds which make it impractical to convene the CARE Council.

The duties and responsibilities of the Executive Committee shall include, but are not limited to, oversight of the grant application process, contracting processes implemented by Grantees or Lead Agencies on behalf of the CARE Council, and implementation of policy or actions established by the CARE Council. Emergency actions taken by the Executive Committee shall be subject to ratification of the CARE Council.

SECTION 4: Priorities and Allocations Committee:

The Priorities and Allocations Committee, utilizing available data and information generated from Grantees and Administrative Agencies, and other CARE Council Committees, through a group process, establishes a list of services appropriate and necessary to enhance the medical condition and improve the quality of life for persons living with HIV/AIDS in Palm Beach County. The Committee is also charged with establishing priorities for these services, and allocating available and/or potential funding to these services. The Priorities and Allocations Committee works closely with current funding streams to redirect underspent funds to those service categories most in need of additional dollars throughout the year.

SECTION 5: Planning Committee:

The Planning Committee is charged with the overall development of major planning activities of the CARE Council. Included in these activities is the development of a ~~CARE Council Comprehensive Plan~~

~~for HIV/AIDS Services for Palm Beach County Florida~~ Palm Beach Integrated HIV Prevention and Patient Care Plan. In a collaborative nature, the Committee will work with all other planning/funding entities in Palm Beach County to ensure the plan encompasses all needed services and available resources. In addition1 the Planning Committee is charged with the development of a Needs Assessment as outlined in HIV/AIDS Bureau (HAB) publications

~~The Planning Committee is also responsible for the development and implementation of evaluation tools and programs to ensure quality services are provided to persons utilizing HIV/AIDS services in Palm Beach County.~~

SECTION 6: Membership Committee:

Charged with identifying and recruiting members for the CARE Council and its Committees who are reflective of the HIV AIDS epidemic in Palm Beach County. The Membership Committee is responsible for the following activities:

- Developing and implementing recruitment plan; recruiting new members;
- Training new and existing members of the CARE Council in CARE Council responsibilities, policies and procedures the CARE Council uses to address its responsibilities;
- Ensuring the CARE Council membership list complies with necessary grant requirements; monitoring membership attendance as required by Policies and Procedures.

SECTION 7: Community Awareness Committee:

The Community Awareness Committee is responsible for the following activities:

- Conducting outreach to HIV/AIDS service consumers;
- Acting as an informal caucus to bring consumer issues to the CARE Council, or CARE Council committees as appropriate. (This would be especially true if there was a general consumer; concern regarding a specific service or service provider);

- Helping identify ways to reach People Living with HIV/AIDS (PLWHA) communities served, including minority and other special populations;
- Providing an ongoing link with the community. Bringing community issues to the CARE Council, as well as information about available treatment, research, and care information to the community.

SECTION 8: Local Pharmaceutical Assistance Program Committee:

The Local Pharmaceutical Assistance Program Committee is responsible for the following activities:

- Compiling a written formulary, as well as the process and procedures to add or remove medications. The LPAP Committee shall develop a procedure for clinical review for prior authorization approval as needed;
- Ensure the system of care meets the LPAP requirements as outlined in the HRSA/HAB Division of Metropolitan HIV/AIDS Program Monitoring Standards and local Standards of Care (SOC) as approved;
- Provide input on a statement of need, submitted with the annual Ryan White grant application. The statement of need shall include an assessment of the need for an LPAP including the financial feasibility and evaluation of all available resources for medications, and the reasons these resources do not meet the needs of the clients;
- LPAP stakeholders may include affected community, prescribing providers, pharmacy professionals, and AIDS Drug Assistance Program (ADAP) representative, to the extent possible.
- Provide feedback to the recipient regarding health outcomes measures and quality improvement projects.

SECTION 9: Quality Management and Evaluation Committee:

The Quality Management and Evaluation Committee (QMEC) is responsible for ensuring that HIV funded agencies participating in the Coordinated Services Network (CSN) comply with standards of care established by the CARE Council in the delivery of services to their clients with HIV/AIDS. The QMEC is responsible for detailed planning and oversight of all services relating to the general health of persons living with HIV/AIDS who receive services funded through the collaborative funding sources of the CARE Council.

The QMEC is responsible for the following activities:

- ~~Overseeing the CARE Council's Quality Management Program;~~
- Receive and evaluate quality performance measures prepared by the Recipient.
- ~~Developing written Quality Management and Evaluation plans;~~
- Provide feedback to the recipient regarding health outcome measures and quality improvement
- projects.
- ~~Establishing quality management and evaluation activities including cost effectiveness analysis, monitoring medical records and support services standards of care, outcome indicators {specific information that tracks a program's success}, and client-level outcomes (benefits or changes for clients during or after receiving services);~~
- Develop and maintain service delivery standards for Ryan White Part A service categories rendered with the Palm Beach County EMA.
- ~~Assisting HIV funded agencies participating in the CSN in implementing continuous quality~~
- ~~improvement activities that are consistent with the CARE Council's Standards of Care. Working collaboratively with other quality management and evaluation entities in Palm Beach~~
- ~~County including persons living with HIV/AIDS;~~
- ~~Working with the Planning Committee to develop service definitions relating to each of the funded services;~~
- ~~Working with the Planning Committee on development of the CARE Council's Integrated Plan.~~

SECTION 10: LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer) Health Equity Committee: The LGBTQ Health Equity Committee is responsible for the following activities:

- Creating a platform where individuals are able to lend a significant voice to the issues, barriers and

- Gaps in prevention, medical care and treatment, and biomedical intervention;
- Conducting community outreach and improved engagement in the LGBTQ community;
- Identifying barriers to linkages to care, treatment, and other social services to LGBTQ individuals
- infected/affected by HIV/AIDS.
- Working with the Planning Committee on development of the CARE Council's Integrated Plan.

SECTION 11: The following provisions shall apply to committees:

(A) Membership on a committee shall be defined by policy.

(B) Committee attendance shall be defined by policy.

(C) Ad Hoc Committees shall be defined by policy.

ARTICLE VI Meetings

SECTION 1: All meetings of the CARE Council and its Committees and Sub-Committees shall be open to the public

and shall be subject to the requirements of Section 286.011, Florida State Statutes as may be amended.

SECTION 2: There shall be an Annual Meeting of the CARE Council in the first half of each calendar year. The primary purpose of the Annual Meeting shall be to elect officers for the coming year.

SECTION 3: The CARE Council will meet at least four times per year.

SECTION 4: CARE Council and Committee meeting quorums shall be defined by policy.

SECTION 5: A request for a special meeting of the CARE Council may be made by the Executive Committee, Ryan White Part B Lead Agency, or by the Grantee to take action on time sensitive issues. The meeting shall be scheduled for the exclusive purpose of addressing the specific issue identified in the request for the special meeting.

SECTION 6: The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the CARE Council and its Committees in all cases to which they are applicable and in which they are not inconsistent with these bylaws the policies and procedures of the Palm Beach County Board of the County Commissioners and any special rules of order the CARE Council may adopt.

SECTION 7: Participation of CARE Council Members at CARE Council and Committee meetings is defined as follows:

(A) Attendance at CARE Council meetings, committee meetings, special events, and workshops in

compliance with applicable policy.

(B) Voting on CARE Council and committee issues.

(C) Completing agreed tasks.

(D) Sharing of skills, time, and other resources appropriate to the CARE Council or committee(s).

ARTICLE VII VOTING AND CONFLICT OF INTEREST

SECTION 1: Members of the CARE Council and all Committees established by the CARE Council shall abide by the

Ryan White Act, Florida State Statute 112.3143 and Palm Beach County Code of Ethics R-94-693 (as

may be amended) regarding voting conflicts.

SECTION 2: The CARE Council may not be directly involved in the administration or procurement of a grant under

Ryan White Part A of the Ryan White Act. With respect to compliance with the preceding sentence, the

CARE Council may not designate (or otherwise be involved in the selection of) particular entities as

recipients of any amounts provided in the grant. CARE Council members shall not participate in the Ryan

White Part a RFP (Request for Proposal) process.

SECTION 3: Each CARE Council member present shall vote on every issue with which they have no conflict of interest. Any CARE Council member with a conflict of interest on a specific issue will abstain from voting on that specific issue. In the event a member abstains from a vote due to conflict, he or she must sign a Conflict of Interest Disclosure Form within three days of the vote.

SECTION 4: Attendees at a CARE Council meeting who are not members of the CARE Council may participate in discussions, at the discretion of the Chair, but may not vote. Only CARE Council members may vote.

SECTION 5: It shall be the responsibility of members to inform the CARE Council Secretary in writing of any affiliation as an employee, board member, independent contractor, vendor or supplier to agencies receiving or seeking funding under the prioritization/allocation process of the CARE Council. A CARE Council member who has an identified conflict of interest and does not abstain from voting on issues related to that conflict will be removed from the CARE Council. The motion for removal of a member due to conflict of interest may be made at one CARE Council meeting for discussion and voted upon at the next regularly scheduled CARE Council meeting. The CARE Council member being discussed must be given an opportunity to respond prior to a removal vote. If the resulting vote is in the affirmative, a recommendation for removal shall be forwarded to the Palm Beach County Board of County Commissioners. Their determination shall be considered final.

ARTICLE VIII GRIEVANCE PROCEDURES

The CARE Council shall maintain a policy to resolve grievances brought forward against the CARE Council.

ARTICLE IX OPERATING PROCEDURES

The CARE Council shall maintain published policies and operating procedures governing the administration and day-to-day functioning of the CARE Council.

ARTICLE X AMENDMENTS

SECTION 1: These Bylaws may be altered, amended or repealed and new Bylaws may be adopted by a two-thirds (2/3) majority vote of CARE Council members present at a CARE Council meeting. At least ten

(10) days prior, written notice setting forth the proposed action will be sent to the CARE Council membership and all interested parties.

SECTION 2: That the CARE Council staff be authorized to correct article and section designations, punctuation, and cross-references and to make such other technical and conforming changes as may be necessary to reflect the intent of the CARE Council in connection with keeping the Bylaws grammatically correct.

CERTIFICATION OF ADOPTION: By my signature below, I certify these Bylaws were officially adopted by a two third (2/3) majority vote of the membership of the CARE Council.

Chris Dowden PharmD, BCPS, AAHIVP
CARE Council Chair
May 23, 2022

CARE Council Bylaws Approved January 31, 2005 Page 8 of 12

CARE Council Bylaws Approved April 29, 2013 Page 6, Section 7

CARE Council Bylaws Approved February 23, 2015 Pages 1-10

CARE Council Bylaws Approved October 26, 2015 Pages 6,9,12 -15, moved page 11 to page 16 (the end)

CARE Council Bylaws Approved June 26, 2017 Pages 9, 11, 12

CARE Council Bylaws Approved July 24, 2017 Page 10

CARE Council Bylaws Approved November 27, 2017 Pages 9, 12

CARE Council Bylaws Approved July 2018, Pages 6, 7, 13, 15

CARE Council Bylaws Approved June 24, 2019, Pages 5, 6, 11

CARE Council Bylaws Approved July 31, 2020, Page 8

CARE Council Bylaws Approved May 23rd 2022 Page 11, 12, 13,14,15,16

CARE Council Policy

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CARE Council Policy

Policy Number 1

Policy Number: **1**
Amended: **February 23, 2015**

Issue: **CARE Council Member Leave of Absence**

Any member of the CARE Council may request a Leave of Absence due to medical reasons, for up to three (3) consecutive months in duration in a twelve-month period. The member must submit the request in writing and include a date of anticipated return.

The request must be voted upon and approved by the CARE Council, with the date of anticipated return recorded in the minutes of the meeting.

Upon three (3) consecutive months of absences in a twelve-month period, the member may request one (1) additional month. This request must be approved by the CARE Council. In the event the member is not able to return after a total of four (4) months of absences, he or she will be asked to discuss continued membership. Decisions will be made in accordance with the *Bylaws* and applicable *Policies and Procedures*.

Those on Leave of Absence shall not be included in the total membership count for purposes of determining a quorum.

A CARE Council member granted a Leave of Absence shall be considered to be on Leave of Absence from all committees on which they are a member.

Resignation from the CARE Council shall not preclude an individual from future application for membership or current participation on a committee.

Approved 04/30/01; Amended 02/23/15.

CARE Council Policy

Policy Number 2

Policy Number: **2**
Amended: **June 25, 2018**

Issue: **Request for Excused Absences from CARE Council Meetings**

This policy determines the process for requesting excused absences from CARE Council meetings. The policy does not apply to committee meetings.

It is the member's responsibility to request from CARE Council staff that an absence be excused.

A written request is the preferred method of notification; however, a telephone request is permissible. Advanced notice of an absence from a CARE Council meeting is preferred if practical.

All requests for excused absences will be in accordance with the CARE Council Bylaws and Palm Beach County Board of County Commissioners Resolution R-2002-1606 and per special exception approved in February 2003 pertinent to the CARE Council. No other reason will be considered by the CARE Council as an excused absence.

The only acceptable reason for an excused absence is a medical reason.

A member should be prepared to make a request for an excused absence at the next regularly scheduled CARE Council meeting unless the request has been previously given to the appropriate staff.

Failure to request excused absences within two (2) regularly scheduled meetings of the CARE Council shall result in the absences being classified as unexcused. In special circumstances, the member may request reconsideration by application to the Membership Committee, which will make a recommendation to the CARE Council.

This policy, in no case, shall conflict with the CARE Council Bylaws or related Policies and Procedures.

Approved 04/30/01; Amended 01/26/04, 02/23/15.

CARE Council Policy

Policy Number 3

Policy Number: **3**
Amended: **June 25, 2018**

Issue: **Committee Member**

It is a policy of the CARE Council that a "Committee Member" shall be defined as: Any interested individual, whether or not a member of the CARE Council who meets the following criteria, may qualify for membership on a committee:

Membership Request by Individual:

- Announce your intention to become a member and be voted in by the committee.
- Priorities and Allocations Committee membership is also subject to Policy 21, hereinafter.
- Membership on the Membership Committee shall be limited to full CARE Council members.

Membership Request by CARE Council:

- CARE Council members and Affiliate members may be asked to serve by the Committee Chair or the Chair of the CARE Council;

  Membership is determined by:

- Approval through committee vote; or
- Appointment by the CARE Council Chair or Committee Chair with ratification by the committee.

Approved 04/30/01; Amended 09/24/12, 02/23/15.

CARE Council Policy

Policy Number 4

Policy Number: **4**
Amended: **November 27, 2017**

Issue: **Committee Attendance and Participation**

This policy applies to all Standing, ~~Program Support~~, and Ad hoc Committees unless exception is made in another policy of the CARE Council.

It is the policy of the CARE Council to recognize each seat on a committee as an important and meaningful position of public trust. In order to fully support the commitment of individual members of committees, the following activities will be employed to support member participation.

Feedback to individual members about how their active participation benefits the CARE Council is a responsibility of each Committee Chair. In order to support active members and a fully functioning Committee, the committee may evaluate the following member activities:

- Participation at committee meetings, attendance at committee meetings, special events and workshop
- Attendance at meetings in compliance with applicable policy
- Making a vote on CARE Council and committee issues
- Completing agreed tasks
- Sharing of skills, time, and other resources appropriate to the committee or CARE Council

Attendance and participation at committee meetings is the responsibility of the committee member. Upon accumulation of three (3) consecutive excused absences or any excused absences from more than fifty percent (50%) of committee meetings during the calendar year, inclusive of the month of the last absence, members will be asked to discuss their future committee participation with the committee. The committee will vote for removal or continued membership on the committee. If the committee member is not available to discuss the issue with the committee, the committee may proceed to vote for removal or continued membership.
Attendance and participation records are maintained for each committee member to assist in providing appropriate support to ensure members maintain necessary levels of participation.
Approved 04/30/01; Amended 02/25/02.

CARE Council Policy

Policy Number 5

Policy Number: **5**
Amended: **October 26, 2015**

Issue: **CARE Council Quorum Requirements**

It is the policy of the CARE Council that a quorum for CARE Council meetings be defined as follows:

- Unless otherwise herein accepted, a quorum shall consist of fifty-percent (50%) plus one of the CARE Council members.
- At least one HIV positive CARE Council member must be present at any meeting of the CARE Council.
- A majority of those CARE Council members present and voting at any quorum meeting shall be sufficient to enable taking action.

Total membership count shall consist of members in good standing, excluding those on officially sanctioned Leave of Absence.

Approved 04/30/01, Amended 02/23/15

CARE Council Policy

Policy Number 6

Policy Number: **6**
Amended: **November 27, 2017**

Issue: Standing Committee Quorum Requirements

The CARE Council's Standing Committees, in accordance with the Bylaws, include the Executive Committee, Planning Committee, Priorities and Allocations Committee, Membership Committee, Community Awareness Committee, Local Pharmaceutical Assistance Program Committee, Quality Management and Evaluation Committee and LGBTQ Health Equity Committee.

It is the policy of the CARE Council that a quorum for each Standing Committee be defined as follows:

Executive

The CARE Council Chair or Vice Chair and three other CARE Council members. One of those committee members present shall be HIV positive.

Planning

The Committee Chair or Vice Chair and two other Committee members. One of those committee members present shall be HIV positive.

Priorities and Allocations

The Committee Chair or Vice Chair and two other Committee members. One of those committee members present shall be HIV positive.

Membership

The Committee Chair or Vice Chair and two other Committee members. One of those committee members present shall be HIV positive.

Community Awareness Committee

The Committee Chair or Vice Chair and two other Committee members. One of those committee members present shall be HIV positive.

Local Pharmaceutical Assistance Program Committee

The Committee Chair or Vice Chair and two other Committee members.
One of those committee members present shall be HIV positive.

Quality Management and Evaluation Committee

The Committee Chair or Vice Chair and two other Committee members.
One of those committee members present shall be HIV positive.

LGBTQ Health Equity Committee

The Committee Chair or Vice Chair and two other Committee members.
One of those committee members present shall be HIV positive.

CARE Council Policy

Policy Number 7

Policy Number: **7**
Amended: **February 23, 2014**

Issue: **Ad hoc Committee Quorum Requirements**

It is the policy of the CARE Council that a quorum for any Ad hoc Committee shall be defined as the Committee Chair or Vice Chair and two other Committee members. One of those committee members present should be HIV positive.

CARE Council Policy

Policy Number 9

Policy Number: **9**
Approved: **April 30, 2001**

Issue: **Grievance Policy**

Purpose
The purpose of this policy is to provide a mechanism for individuals and or organizations to bring forth grievances relative to the allocation or prioritization of HIV and AIDS medical and support services provided in Palm Beach County, Florida under Part A of the Ryan White Act.

Authority
This policy is required by the Ryan White CARE Act Amendments of 1996, Public Law 104-146, as amended, hereinafter referred to as the Ryan White Act.

Section A: Persons Eligible to File a Grievance
Only individuals or entities directly affected by the outcome of a decision related to the prioritization or allocating of funding under Part A of the Ryan White Act may file a grievance under this policy. Such individuals include, but are not limited to, providers eligible to receive Ryan White Part A funding and consumer groups, persons living with HIV or AIDS (PLWH/A) coalitions or caucuses.

Section B: Actions Which May Be Grieved
These procedures relate to the process of establishing priorities of service categories and allocating funds to those categories and any subsequent process to change the priorities and allocations. Persons wishing to file a grievance relating to the process of selecting contractors, making awards, and any subsequent process to change contractors or awards must follow the grievance procedures established by the Palm Beach County Board of County Commissioners.

At least one of the following basic criteria must be the form and basis of the grievance which is being filed:

1. Alleged deviations from the established, written priority setting or resource setting process (such as failure to follow established conflict-of-interest rules).

2. Alleged deviations from an established, written process for any subsequent changes to priorities or allocations.

3. Inconsistency with the findings of the locally published Needs Assessment or Comprehensive Plan for HIV/AIDS Services in Palm Beach County, Florida.
Grievances filed merely on the basis of dissatisfaction with the outcome of the prioritization or allocation process will not be accepted unless one of the above deviations is alleged.

Section C: Internal Non-Binding Procedures
The grievance must be filed with the CARE Council within five (5) working days[1] of the date of action by the Planning Council which is being grieved. Grievances must be filed on the form entitled "Palm Beach County HIV CARE Council Grievance Form", a copy of which is attached hereto as Exhibit "A". All grievances will initially be handled through the internal non-binding grievance process.

The CARE Council Chair will review the grievance within five (5) working days of filing to determine if the basis for a grievance exists. If such a determination is made, the Chair will appoint a grievance committee within three (3) working days of a determination to initiate the non-binding process.

The non-binding process will be handled by the grievance committee appointed by the Council Chair. A hearing will be scheduled before the committee within five (5) working days of appointment. The committee shall have five (5) working days to render a decision on the grievance and notify the parties. The grievant shall have five (5) working days from receipt of the final decision of the grievance committee to make a request for third party mediation.

Section D: Third Party Mediation
If a grievant does not accept the decision of the grievance committee, the grievant may request that the grievance be submitted to a third party mediator. A request for third party mediation shall be made within five (5) working days from receipt of the final decision of the grievance committee as described in section C above. A request for third party mediation shall be filed with the CARE Council on a "Request for Third Party Mediation" form, a copy of which is attached as Exhibit "B".

Upon receipt of a request for third party mediation, the HIV CARE Council Chair will establish a date and time within twenty-one (21) working days of receipt of the request for mediation through the Palm Beach County Alternative Dispute Resolution Office. The Chair shall inform the grievant within five (5) working days of receipt of the request for third party mediation as to

[1] *Working days excluding holidays and weekends.*

the date, time, and location of the requested mediation hearing. The grievant must agree that all mediation will be handled through the Palm Beach County Alternative Dispute Resolution Office and must agree to pay at the time of mediation one-half of the cost of all mediation which extends beyond two billable hours. The CARE Council shall be responsible for the other half of the cost of mediation. Mediators will be selected by mutual consent of the parties, from a list of certified mediators maintained by the Alternative Dispute Resolution Office. A copy of the current list will be made available to the parties within five (5) working days of the request for mediation. Mediators will only seek to resolve the dispute between the parties, but will not make any findings. Grievant must agree that a maximum of eight (8) hours shall be expended in attempting to resolve the dispute through the third party mediator.

Confidential information disclosed to a mediator by the parties or witnesses in the course of the mediation shall not be divulged by the mediator. All records, reports, or other documents received by a mediator while serving in that capacity shall be confidential. The mediator shall not be compelled to divulge such records or to testify in regard to mediation in any adversary proceedings or judicial forum.

If the grievance is not resolved through mediation, the grievant shall have five (5) working days from the conclusion of the mediation to make a request for binding arbitration.

Section E: Binding Arbitration

If the question is not resolved through mediation, the grievant may request binding arbitration. Such requests must be submitted to the CARE Council on "Palm Beach County HIV CARE Council Request for Binding Arbitration Form", a copy of which is attached as Exhibit "C". The hourly rate shall be determined by the Alternate Dispute Resolution Office. The check shall be made payable to the Alternate Dispute Resolution Office. Such fee shall cover one-half of two-hour arbitration. The grievant must also agree to pay one-half of the total cost of arbitration at the time of arbitration. The CARE Council will be responsible for the other half of the cost of arbitration. Grievant must identify their list of anticipated witnesses and exhibits to be admitted during arbitration. The CARE Council shall have five (5) working days from receipt of the arbitration request form to identify its anticipated witnesses and exhibits and must provide a copy to the grievant. Arbitrators will be selected by mutual consent of the parties, from an approved list maintained by the Office of Alternative Dispute Resolution, based upon availability. Hearings shall be held within ten (10) working days of the appointment of an arbitrator at the Palm Beach County Alternate Dispute Resolution Office. The arbitrator shall have fifteen (15) working days to render a decision after the hearing is concluded. Grievant shall have no further remedies after rendition of the arbitrator's order.

Section F: Remedies

It should be noted that due to the stringent time frames associated with administration of grant funds, remedies sought through this grievance procedure are limited to future actions and are not applied retroactively.

Section G: Dissemination of Grievance Procedure Process

Copies of this grievance procedure will be available at the offices of the CARE Council and the Palm Beach County Department of Community Service

Ryan White Act

Exhibit A

Exhibit A
RYAN WHITE ACT

Palm Beach County

Submission of Part A Funding Grievance to Dispute Resolution

Grievance No. Date:
(To be filled in by receiving authority)

The undersigned party (ies) submits the following dispute for resolution under the grievance procedures of the CARE Council.
Statement of Grievance (should include date questioned decision was taken, by what entity, and the reasons for filing the grievance; use back of form if necessary)
Statement of previous action taken (if arbitration is sought, indicate results of previous attempts at resolution)
Statement of what result the grievant would like (the remedy sought by the grievant; use back of form if necessary) *Note that remedies may be limited to future action and may not be able to reverse decisions retroactively.*
If the procedure to be used is binding arbitration, signature constitutes agreement to be bound by the decision of the arbitrator.

____
Name of grievant

Mail this form to:

____________________________ If grievant is an organization,	Palm Beach County HIV CARE Council
Name of authorized individual	Attention: COUNCIL Chair
____________________________ Address	
____________________________ City/state/zip code	at its current address
____________________________ Telephone number	

Fax number ______________________

Signature ______________________

STATEMENT OF UNDERSTANDING

I understand that the Palm Beach County HIV CARE Council and its representatives have no legal authority over any agency, but can act as an advocate and make recommendations to service agencies in my behalf. I understand a representative from the CARE Council will contact me for assistance and I authorize that any of my records or knowledge of me and my health, including HIV/AIDS related information as it pertains to my grievance be released to parties related to the Council. All information will be held in strictest confidence. Grievance will be registered by the staff of Palm Beach County HIV CARE Council, who will notify you of any decisions or determinations made within six weeks. There is no cost to you for voluntary mediation.

Ryan White Act

Exhibit B

Exhibit B

RYAN WHITE ACT

Palm Beach County

Part A Request for Third Party Mediation

Grievance No.__________________ Date____________________
(To be filled in by receiving authority)

The undersigned party(ies) requests the following dispute be submitted to a third party mediation under the grievance procedures of Palm Beach County, as grantee.

STATEMENT OF GRIEVANCE:
Date of questioned decision/action:

Description of questioned decision/action:

Description of why grievant believes questioned decision/action was in error:

Description of remedy sought by grievant:

Description of previous action taken:

Name of grievant:
Organization represented, if any:
Address:

Telephone Number:
Fax Number:
Signature: ____________________________

Title: ________________________________

Note: The hourly rate shall be determined by the Alternate Dispute Resolution Office made payable to the Alternative Dispute Resolution Office. This amount will cover one-half of the cost of one hour of mediation. By signing this request for third party mediation, the grievant agrees to pay one-half of the full cost of the mediation at the time of mediation. Palm Beach County will pay the remaining half of the cost of mediation.

Ryan White Act

Exhibit C

Exhibit C
RYAN WHITE ACT

Palm Beach County

Part A Binding Arbitration Request Form

Grievance No. Date:
(To be filled in by receiving authority)

The undersigned party(ies) requests the following dispute be submitted to a third party mediation under the grievance procedures of Palm Beach County, as grantee.

STATEMENT OF GRIEVANCE:
Date of questioned decision/action:

Description of questioned decision/action:

Description of why grievant believes questioned decision/action was in error:

Description of remedy sought by grievant:

Description of previous action taken:

List of witnesses anticipated to testify during arbitration (include name, address and telephone number along with a description of their anticipated testimony):

List of exhibits anticipated to be introduced during arbitration (please attach copies of all exhibits):

CARE Council Policy

Policy Number 10

Policy Number: **10**
Amended: **June 25, 2018**

Issue: **Nominations Process for CARE Council Membership**

This policy is adopted by the CARE Council (CARE Council), for the purpose of ensuring there is an open and fair nomination process which will provide for a CARE Council membership which is reflective of the AIDS epidemic in Palm Beach County, Florida. In addition, it is the intention of the CARE Council to maintain a nomination policy which complies with directives of the Division of HIV Services (DHS) and HRSA as those directives relate to the Ryan White Act.

I. Legislative Background

Section 2602(b) of the reauthorized Ryan White Act states: "Nominations to the planning council (CARE Council) shall be identified through an open process and candidates shall be selected based upon locally delineated and published criteria. Such criteria shall include a conflict of interest standard for each nominee."

II. Expectations

An open nominations process, in combination with other legislative requirements and existing DHS policy on PLWH participation, shall result in broad and diverse community inclusion and culturally competent deliberations in CARE Council processes. The CARE Council will only approve and/or appoint members who have gone through the nominations process and shall appoint members on a timely basis to ensure minimum disruption to CARE Council activities.

Nominations to the CARE Council shall be sought from a wide spectrum of potential members. Recruitment shall be made through existing CARE Council committees and through ongoing solicitation through existing CARE Council members, service providers, outreach through advertising, and staff working with consumers of HIV/AIDS services. Particular consideration shall be given to disproportionately affected and historically underserved groups and sub-populations.

Every member of the CARE Council is encouraged to actively recruit members to fill gaps in CARE Council membership. Recruitment is not just the Membership Committee's responsibility. CARE Council members should use their own network and seek key contacts in other communities to help identify potential members to fill gaps and to provide individuals to participate in CARE Council committee activities.

III. Steps in the Nominations Process:

1. When necessary advertising may be placed in various publications countywide notifying the public of the need for participation through membership on the CARE Council. Included in the advertising shall be notification of the need to fill membership positions based upon the demographics of the epidemic in Palm Beach County, and to ensure legislatively mandated positions are filled. A time limit for return of applications shall be included in the notification.
2. Potential applicants shall be invited to attend membership orientation offered quarterly and provided a nominations packet containing a letter describing roles and responsibilities of the CARE Council, duties of membership, time expectations, gaps in representations, conflict of interest standards, HIV disclosure requirements, and an overview of the selection process and timeline; within three (3) business days of request. There shall also be an application form used to gather information about: relevant experience, expertise, skills, the person's interest in serving, the perspective he or she might bring to the CARE Council, how his or her peer group might relate to groups affected by HIV, and other related information.

3. Each returned application will be issued a document number, and receipt shall be logged in for tracking purposes.

4. CARE Council staff will review all application forms and will recommend a list of persons for the Membership Committee to interview per "Procedure for Applicant Interviews". When two or more persons apply for the same slot, the committee will interview at least two applicants for the slot. Interviews shall be conducted by at least two committee members-one of which must be the Chair or Vice Chair and a staff member, according to a structured interview format. Open ended questions about past experience on boards, ideas about significant HIV/AIDS issues and professional or affected community linkages shall be incorporated into the interview.

5. After the interviews are completed, the results of each interview are discussed at the next regularly scheduled Membership Committee meeting. When reviewing candidates for membership the committee will consider the following factors: attendance at CARE Council meetings, involvement at Membership Development Sessions and involvement on committees. The Membership Committee may also consider activities as involvement in Membership Development Sessions. In addition, seat availability, the demographics of the

board and candidate qualification will be taken into consideration. The final committee recommendations will be forwarded to the Executive Committee and if approved to the CARE Council. If the recommendation is accepted by the CARE Council, the individual's name will then be forwarded to the Palm Beach County Board of County Commissioners for appointment. The candidate must document completion of the Palm Beach County ethics training prior to submission of their name to the Palm Beach County Board of County Commissioners. In the event a recommended candidate is not acceptable to the Palm Beach County Board of County Commissioners, a request for a replacement candidate, if available, will be forwarded to the Membership Committee and the Membership Committee will provide the name of another candidate to the CARE Council. If the recommendation is accepted by the CARE Council, the individuals name will then be forwarded to the Palm Beach County Board of County Commissioners for appointment.

A. Candidates must fulfill the following requirements prior to being forwarded for CARE Council Membership. Candidates must join one (1) committee and attend a CARE Council meeting or CARE Council sponsored training inclusive of annual retreat.

B. Documented exceptions to these requirements may be made, based upon the need of the CARE Council or in an extenuating circumstance, at the discretion of the Membership Committee Chair with the approval of the Executive Committee.

CARE Council Policy

Policy Number 11

Policy Number: **11**
Amended: **June 25, 2018**

Issue: **Travel and Reimbursement for CARE Council Members, Affiliate Members, and Prospective Committee Members**

I. Purpose

The purpose of this policy is to provide guidelines to CARE Council members, affiliate members, and prospective members for reimbursement for travel and other related expenses. Pursuant to the Public Health Service (PHS) Grant Policy Statement, travel expenses incurred by CARE Council members, affiliate members, and prospective members attending scheduled CARE Council and Committee meetings shall be eligible for reimbursement, subject to available funding.

This policy does not apply to individuals receiving travel reimbursements from other parties or organizations.

Travel reimbursement for prospective CARE Council members will be prioritized by HRSA seat requirements. Prospective members who do not become CARE Council members after being reimbursed to attend four (4) meetings shall no longer be eligible for reimbursement under this policy.

II. Authority

All travel reimbursements shall be made pursuant to policies and regulations established by the Palm Beach County Board of County Commissioners.

Care Council Policy

Policy Number 14

Policy Number: **14**
Approved: **April 30, 2001**

Issue: **Grievance Committee Responsibilities**

The Grievance Committee is an Ad hoc Committee called together by the CARE Council Chair to review grievance requests as defined in the *Grievance Policy.* The purpose of this review is to provide a broader consideration of a filing of a grievance to ensure that decisions are consistent with the purposes and spirit of the grievance procedure as called for in the reauthorization of the Ryan White Act.

CARE Council Policy

Policy Number 16

Policy Number: **16**
Amended: **June 25, 2018**

Issue: **Bylaws Committee Responsibilities**

The Bylaws Committee is an Ad hoc Committee convened by the CARE Council Chair to address issues relating to the *CARE Council Bylaws and Policies and Procedures.*

The Bylaws Committee shall be convened at least triennial, or as needed, to review Bylaws and Policies.

CARE Council Policy

Policy Number 17

Policy Number: **17**

Amended: **February 23, 2015**

Issue: **Removal of CARE Council Members**

It is a policy of the CARE Council, that a Council Member shall be removed from membership on the CARE Council for any of the following:

- Legal residence changes and member moves out of Palm Beach County;
- Lack of attendance as described in the CARE Council Bylaws and applicable Policies and Procedures;
- Violation of the Sunshine Law;
- Violation of the Ryan White Care Act, Florida Statute 112.3143 and Palm Beach County Code of Ethics R-94-693 (as may be amended) regarding voting conflicts;
- Non-compliance with the training mandates of Policy 25.
- Serious breaches of conduct and procedures as determined by the body according to the procedures of *Roberts Rules of Order*.

Unless the Palm Beach County Board of County Commissioners removes a member, a member may only be removed after a vote of the Membership Committee and approval by the CARE Council.

CARE Council Policy

Policy Number 18

Policy Number: **18**

Amended: **February 23, 2015**

Issue: **Removal of Committee Members**

- It is a policy of the CARE Council, that a Committee Member shall be removed from membership on a committee for any of the following: Lack of attendance as described in the CARE Council Committee Attendance Policy;

- Violation of the Sunshine Law;

- Violation of the Ryan White Care Act, Florida Statute 112.3143 and Palm Beach County Code of Ethics R-94-693 (as may be amended) regarding voting conflicts;

- Serious breaches of conduct and procedures as determined by the committee according to the procedures of *Roberts Rules of Order*.
  A member may be removed after a vote of the committee.

CARE Council Policy

Policy Number 19

Policy Number: **19**
Amended: **February 23, 2015**

Issue: **Occupancy of CARE Council Designated Seats**

It is a policy of the CARE Council, that an individual occupying a specific seat on the CARE Council who becomes ineligible to hold that seat shall relate this to the Membership Committee. The Membership Committee shall determine if another seat is available that the individual can occupy. If so, that seat shall be offered to the member. If not, the individual will no longer be a member of the CARE Council.

This policy shall not preclude the individual's participation on committees as a committee member.

CARE Council Policy

Policy Number 20

Policy Number: **20**
Amended: **February 23, 2015**

Issue: **Maximum Provider Representation**

Provider (Service Provider):
Any agency receiving Coordinated Services Network (CSN) Funding (Ryan White Part A, Ryan White Part B, State of Florida 4B General Revenue and Patient Care Network, or any future funders).

Rule:
It is a policy of the CARE Council that no more than two (2) individuals (employees or Board Members) from a service provider may be a member of the CARE Council. This policy shall not preclude the individual's participation on committees.

Exceptions:

- Maximum of one (1) part time employee (20 hours or less per week) or temporary employee (average of 20 hours or less per week);
- Individual represents a federally legislated partner such as Part D or a State Agency;
- Non-paid volunteers;
- Independent contractors.

Note:
This policy applies to all individuals no matter what designated seat they may occupy.

CARE Council Policy

Policy Number 21

Policy Number: **21**

Amended: **July 24, 2017**

Issue: **Priorities and Allocations Policy Regarding Providers**

Provider (Service Provider):
Any agency receiving Coordinated Services Network (CSN) Funding (Ryan White Part A, Ryan White Part B, State of Florida 4B General Revenue and Patient Care Network any future funders).

Rule:
It is a policy of the CARE Council that the Priorities and Allocations Committee shall consist of a maximum of fifteen (15) members with maximum of one-third (1/3) members who are providers. There shall not be more than one (1) representative from any provider agency.

Approved 04/30/01; Amended 01/26/04, 08/29/05, 02/23/15.

CARE Council Policy

Policy Number 22

Policy Number: **22**

Amended: **November 27, 2017**

Issue: **Committee Chairmanship**

The following is a policy of the CARE Council regarding Committee Chairmanship:

Standing Committees:
The Chair of any standing committee must be a member of the CARE Council.

The Vice Chair of any standing committee should be, but is not required to be a member of the CARE Council.

~~Program Support,~~ Ad hoc, and Sub-Committees:
The Chair of any ~~Program Support~~, Ad hoc, or Sub-Committee should be, but is not required to be a member of the CARE Council with the exception of the By-laws Ad hoc committee and Ad hoc Grievance committee which shall be chaired by the CARE Council Chair or Vice Chair.

Term of Office:
The term for a committee chair will be for a period of up to twelve (12) months. Following election of officers at the annual meeting, the newly elected Chair of the CARE Council will then appoint committee chairs. The selection of committee chair/s will be presented for ratification by the CARE Council. If the CARE Council does not ratify a chosen committee chair; the existing committee chair will remain until such a time an acceptable replacement is found. The newly elected Chair of the CARE Council will appoint committee chairs within one (1) meeting of being elected.

When a committee chair resigns during his/her term, a replacement will be appointed by the existing chair of the CARE Council and ratified by the CARE Council. The new chair will serve until committee chairs are appointed or reappointed following the elections.

When in conflict, the CARE Council Bylaws supersede this policy.

CARE Council Policy

Policy Number 25

Policy Number: **25**
Amended: **February 23, 2015**

Issue: **CARE Council Training Requirement**

This policy applies to all CARE Council members.
HRSA requires that all CARE Council members have competencies in the following areas:

- the CARE Act legislation, roles and responsibilities in planning, conflict of interest, and how it can affect their deliberations, how to control its impact grievance procedures and way to minimize grievances related to funding,
- meeting procedures such as *Robert's Rules of Order* or other procedures used locally,
- cultural sensitivity to viewpoints of all members and culturally competency about the needs of underserved communities in their jurisdictions,
- technical issues, like how to interpret and use data as tools for decision-making, and
- treatment requirements of HIV disease and how they affect the cost of ambulatory outpatient care, especially primary care.

After being appointed to the CARE Council members must attend at least one training per year. CARE Council members must maintain a high level of competency in all of the areas listed above.

Within the first two months of being appointed to the CARE Council, the member must attend the CARE Council Orientation which includes information on the roles and responsibilities in planning, conflict of interest, ethics, grievance procedures, and a brief summary of *Roberts Rules of Order.*

All committee chairs and CARE Council officers should attend the Chair Workshop.

It is the policy of the CARE Council to recognize each seat on a committee as an important and meaningful position of public trust and fully support the commitment of individual members of committees.
Records of attendance and participation in Membership Development Session are maintained for each CARE Council member to assist in providing appropriate support to ensure members maintain necessary levels of proficiency.

CARE Council Policy

Policy Number 26

Policy Number: **26**

Amended: **June 25, 2018**

Issue: **CARE Council Member, Affiliate Member, and Prospective Member Day Care Reimbursement Policy**

It is the policy of the CARE Council that members who request and receive reimbursement for childcare must fulfill the requirements below and submit the following to CARE Council staff prior to reimbursement:

- Birth certificates for children who need childcare. A child is considered to be an individual under 13 years of age at the time of care (IRS, Publication 503, "Child and Dependent Care Expenses"); or

- Legal document recognized by state law as giving the member legal responsibility for the child; and

- Proof of the caregiver's receipt of payment.

The childcare reimbursement is only to be used for hours when a CARE Council member, affiliate member, or prospective member is attending a meeting and commuting to and from the meeting, subject to available funding. Reimbursement shall be hourly, not to exceed current federal minimum wage guidelines, paid in half hour increments.

In special circumstances reimbursement for care giving shall be with the approval of the grantee. Such circumstances may include care of an individual who does not meet age requirements to be considered a child but is unable to care for him or herself (IRS, Publication 503, "Child and Dependent Care Expenses").

CARE Council Policy

Policy Number 27

Policy Number: **27**

Approved: **January 27, 2014**

Issue: **Process for Notification of Changes to CARE Council Membership**

This policy is adopted by the CARE Council for the purpose of ensuring that the process for system-wide notification of CARE Council membership changes is followed. In addition, it is the intention of the CARE Council to ensure policies regarding changes to CARE Council membership comply with directives and policies of Palm Beach County and HRSA as those directives relate to the CARE Council.

I. Authority

Per the grant year 2012 Notice of Grant Award, HRSA requires the Grantee to notify the Division of Grants Management Operations (DGMO) and the Project Officer, within 30 days, of any changes in Planning Council Composition that impact legislative compliance with "reflectiveness" of the mandated membership categories. Additionally, the Grantee must ensure accurate documentation of advisory board member appointments in the County Advisory Board Appointment Database.

II. Expectations

The parties that must be made aware of changes to CARE Council membership are multifaceted. To ensure solid communication across all parties this policy is being implemented.

III. Steps in the Process for Notification of Changes to CARE Council Membership:

1. Staff who receive official notification of changes to CARE Council membership (e.g. member resignation letter, Membership Committee/CARE Council removal of member, etc.) must ensure the following parties are noticed of the change: Ryan White Program Manager, Financial Analyst I, Member Liaison, CARE Council Secretary,

Membership Committee and CARE Council Chair, or appropriate staff assigned to complete the duties of the staff titles listed above.

2. Ryan White Program Manager notices the County Agenda Coordinator who manages the Advisory Board Appointment Database.

3. Ryan White Program Manager notices the HRSA Project Officer.

4. Financial Analyst I notices Grant Management.

CARE Council Policy

Policy Number 28

Policy Number: **28**

Approved: **June 24, 2019**

Issue: **Confidentiality Regarding CARE Council Members**

It is a policy of the CARE Council that we recognize the privacy of all members of the CARE Council. Whenever possible, CARE Council members and prospective members will be identified in Palm Beach County Board Appointment Applications and accompanying materials by the title “Palm Beach County resident,” and no reference will be made to a particular seat on the CARE Council that the prospective member or current member is proposed to fill.

CARE Council Policy

Policy Number 29

Policy Number: **29**

Issue: **Election Process for Annual Election during Communications Media Technology (CMT) Meeting**

It is a policy of the CARE Council that:

1. When the CARE Council is conducting meetings via Communications Media Technology (CMT), the CARE Council will elect the Chair, Vice Chair, Treasurer and Secretary from the CARE Council membership by a majority vote of the quorum of the members present at the CMT meeting that is conducted at the same time as the Annual Meeting *(as per the CARE Council Bylaws)*, or as close in time to the Annual Meeting as reasonably possible.

2. CARE Council Members may submit nominations for CARE Council Officers for a period of thirty days prior to the CMT meeting when the Annual Election is scheduled to be conducted, by transmitting those nominations to the CARE Council Coordinator.

3. At the CMT meeting when the Annual Election is conducted, each nominee who otherwise qualifies to hold the Office for which they have been nominated will be asked to confirm whether they are willing to serve in the position for which they have been nominated, and will be given an opportunity to make a brief introduction.

4. For each Office where only one individual has been nominated, votes shall be cast by a voice vote of CARE Council members.

5. For each Office where more than one individual has been nominated, votes shall be case by roll call of CARE Council members participating in the CMT meeting.

6. In the event that there is not a majority vote for any one official, the members shall vote again choosing between the candidates with the two highest vote totals.

7. Results shall be announced following the vote for each Office.

CARE Council Policy

Policy Number 30

Policy Number: **30**
Created: April 23rd. 2021

Issue: **CARE Council Member Travel Outside of Palm Beach County**

PURPOSE

Member request for travel outside of Palm Beach County to a meeting or conference directly related to the work of the HIV CARE Council shall be submitted, in writing, to CARE Council staff at least 90 days prior to travel dates. Either the Executive Committee or the full CARE Council must approve such requests.

- Travel expenses shall be limited to $1000 per request.
- There shall be two travel expense allowances permitted per grant year for the CARE Council.
- The Executive Committee or full CARE Council may make exceptions to the above upon request and approval.
- All travel approvals are contingent on availability of funds in the member travel line item of the CARE Council budget.

Florida Sunshine Law

Brief Overview

The Wedding Song by Noel "Paul" Stookey of Peter, Paul and Mary (1971)

He is now to be among you at the calling of your hearts
Rest assured this troubador is acting on His part.
The union of your spirits, here, has caused Him to remain
For whenever two or more of you are gathered in His name
There is Love. There is Love.

Florida's Sunshine Law

– Applies to any gathering of two (2) or more members of the same board to discuss some matter which will foreseeably come before that board for action.

Sunshine Law - 3 Requirements

1. Meetings of public boards, commissions, advisory boards must be open to the public;
2. Reasonable notice of such meetings must be given; and
3. Minutes of the meetings must be taken and promptly recorded.

Sunshine Law

– E-mail, text messages, and other written communications between board members

The Sunshine Law requires boards to meet in public; boards may not take action on or engage in private discussions of board business via written correspondence, e-mails, text messages, or other electronic communications. See AGO 89-39 (members of a public board may not use computers to conduct private discussions among themselves about board business).

Example 1 – Mary W. speaks to Chris before a meeting about an agenda item
Example 2 – Helene emails Mary K., Mary Jane, and Kim with a recipe
Example 3 – Helene conference calls Mary W. and Mary K. about an agenda item
Example 4 – Chris posts on facebook about an upcoming CARE Council event and Mark comments on the post

A knowing violation of the Sunshine Law is a misdemeanor of the second degree, punishable up to 60 days imprisonment and/or fined up to $500.

ROBERT'S RULES OF ORDER

To Do This...	You Say This...	May You Interrupt the Speaker?	Do You Need a Second?	Is it Debatable?	Can it be Amended?	What Vote is Needed?	Can it be Reconsidered?
ADJOURN MEETING	"I move that we adjourn."	No	Yes	No	No	Majority	No
CALL AN INTERMISSION	"I move that we recess for..."	No	Yes	No	Yes	Majority	No
TEMPORARILY SUSPEND CONSIDERATION OF AN ISSUE	"I move to table the motion."	No	Yes	No	No	Majority	No
END DEBATE AND AMENDMENTS	"I move the previous question."	No	Yes	No	No	2/3	No ***1**
POSTPONE DISCUSSION FOR A CERTAIN TIME	"I move to postpone the discussion until..."	No	Yes	Yes	Yes	Majority	Yes
GIVE CLOSER STUDY OF SOMETHING	"I move to refer the matter to committee."	No	Yes	Yes	Yes	Majority	Yes ***2**
AMEND A MOTION	"I move to amend the motion by..."	No	Yes	Yes ***3**	Yes	Majority	Yes
INTRODUCE BUSINESS	"I move that..."	No	Yes	Yes	Yes	Majority	Yes
PROTEST BREACH OF RULES OR CONDUCT	"I rise to a point of order."	Yes	No	No	No	No Vote ***4**	No
VOTE ON A RULING OF THE CHAIR	"I appeal from the chair's decision."	Yes	Yes	Yes	No	Majority ***5**	Yes
SUSPEND RULES TEMPORARILY	"I move to suspend the rules so that..."	No	Yes	No	No	2/3	No
AVOID CONSIDERING AN IMPROPER MATTER	"I object to consideration of this motion."	Yes	No	No	No	2/3 ***6**	- ***7**
VERIFY A VOICE VOTE BY HAVING MEMBERS STAND	"I call for a division" or "Division!"	Yes	No	No	No	No Vote	No
REQUEST INFORMATION	"Point of information."	Yes	No	No	No	No Vote	No
TAKE UP A MATTER PREVIOUSLY TABLED	"I move to take from the table..."	No	Yes	No	No	Majority	No
RECONSIDER A HASTY ACTION	"I move to reconsider the vote on..."	Yes	Yes	- ***8**	No	Majority	No

***1 = Unless vote on question is not yet taken**

***2 = Unless the committee has already taken**

***3 = Only if the motion to be amended is debatable**

***4 = Except in doubtful cases.**

***5 = A majority vote in negative needed to revert ruling of chair**

***7 = Only if the main question or motion was not, in fact, considered**

***8 = Only if motion to be reconsidered is debatable.**

HIV/AIDS Integrated Needs Assessment 2017 Palm Beach County

Prepared by Health Council of Southeast Florida

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Appendix A: Integrated HIV Needs Assessment – Palm Beach County 2016 75

Introduction

The Palm Beach County Department of Community Services (Ryan White Part A) contracted with the Health Council of Southeast Florida (HCSEF) to support the local Needs Assessment of individuals living with HIV in Palm Beach County. HCSEF conducted and coordinated primary data collection via a Client Survey. The resulting data is part of a broader Needs Assessment effort in Palm Beach County, and represents a subset of HIV-related need throughout the county. This report contains a summary and analysis of those findings.

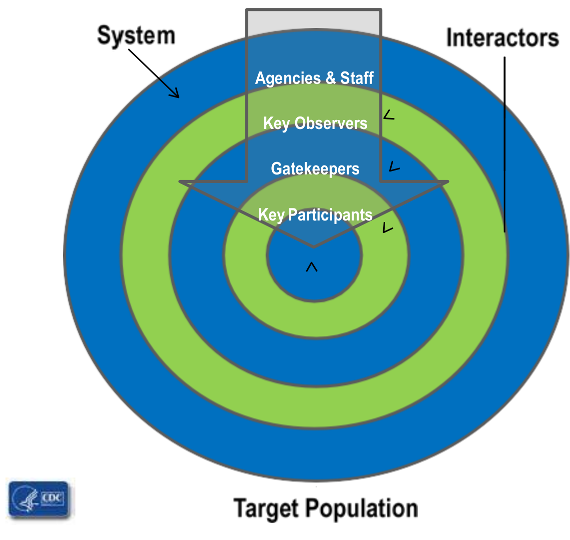
Client Survey
Background

Community Engagement Model

The Community Identification (CID) Process is a core component of Community PROMISE, a CDC community-level prevention intervention. Outlined as a key recommendation of HCSEF's RARE 2015 project, which encourages system-wide adoption, HCSEF utilizes CID, as a formative process to collect important information and learn from the perspective of the community. So, this approach was integrated into the data collection plan for the Palm Beach County HIV Needs Assessment. Ultimately, it increases community engagement, particularly among those who have been more challenging to reach. Another benefit is that it establishes a degree of parity between providers and the community.

Additionally, with increased diversity among the participants, some of the barriers to sharing, e.g. language, cultural, and stigma, are also reduced. Essentially, this approach creates a 2-way conversation with the community.

Figure 1: Community Identification Process



Integrating Prevention

The 2016 Ryan White Needs Assessment was conducted as an integrated effort that included patient care and prevention, reflective of the National and Statewide guidance and trends. Traditionally, prevention efforts target HIV-negative and HIV-status unknown populations; however, health management and risk reduction for individuals living with HIV is a critical prevention strategy.

Therefore, this assessment includes both patient care and prevention to help determine gaps in services and opportunities in the system of care. Information might also inform resource allocation and service delivery models.

Methodology

In accordance with the community engagement model described above, the data collection process began with a systems analysis through the local HIV service providers, as reflected in the outermost ring of the CID model shown in the figure above. Then, individuals who were actively involved in the community, such as through HIV planning bodies, committees, and advisory groups were engaged. Also in these early stages, clients were identified, engaged, and surveyed, as well as offered the opportunity to serve as survey administrators for peer-to-peer data collection. This is critically important, as this approach provides key perspectives and valuable information because of the deeper penetration in the community, particularly when successful in reaching those who are not consistently engaged in the system of care, may be out-of-care, or are not actively involved with any of the planning bodies.

Individuals were surveyed using a hard copy questionnaire, which was administered primarily by peers, as well as HCSEF and Palm Beach County staff during the initial phases. Language barriers were mitigated by using Spanish-speaking and Haitian Creole-speaking staff at some of the sites. All participants were assured that the survey was anonymous and voluntary. Respondents were offered a

$15 gift card for their time and participation. Additionally, clients who chose to be survey administrators were similarly incentivized.

The Client Survey tool (Appendix A) was adapted from the Statewide Needs Assessment Tool developed by the University of Florida for the Florida Department of Health's HIV/AIDS Section. While no questions were omitted, some, relating to HIV prevention, were added. The tool consisted of 77 questions, including demographic information.

HCSEF staff entered the data from the hard copy surveys into Survey Monkey, a web-based survey administration and analytical program. It should also be noted that responses to open-ended questions were transcribed verbatim, except in a few instances where minor edits to grammar and/or spelling were made to facilitate a better understanding of the comment. The results reported herein include feedback provided by the 357 respondents who completed the survey.

Respondent Demographics

The following section includes data regarding client demographics for the 357 respondents.

Resident Zip Codes

The first question on the survey asked, *"What is your Zip Code?"* Three hundred forty-eight respondents answered this question.

The most frequently reported zip codes were 33407 (79 or 22.1%), which is northern West Palm Beach, 33401 (39 or 10.9%), which is West Palm Beach, 33435 (33 or 9.2%), and 33430 (31 or 8.7%) which is Boynton Beach. Nine individuals (2.5%) did not respond to this question.

Table 1: Respondents by Zip Code, Palm Beach County Client Survey, 2016

Zip Code	Number	Percentage
33407	79	22.1%
33401	39	10.9%
33435	33	9.2%
33430	31	8.7%
33444	28	7.8%
33404	18	5.0%
33460	16	4.5%
33436	9	2.5%
33415	8	2.2%
33405	7	2.0%
Other	80	22.4%
No Answer	9	2.5%

Total	357	100.0%

Gender

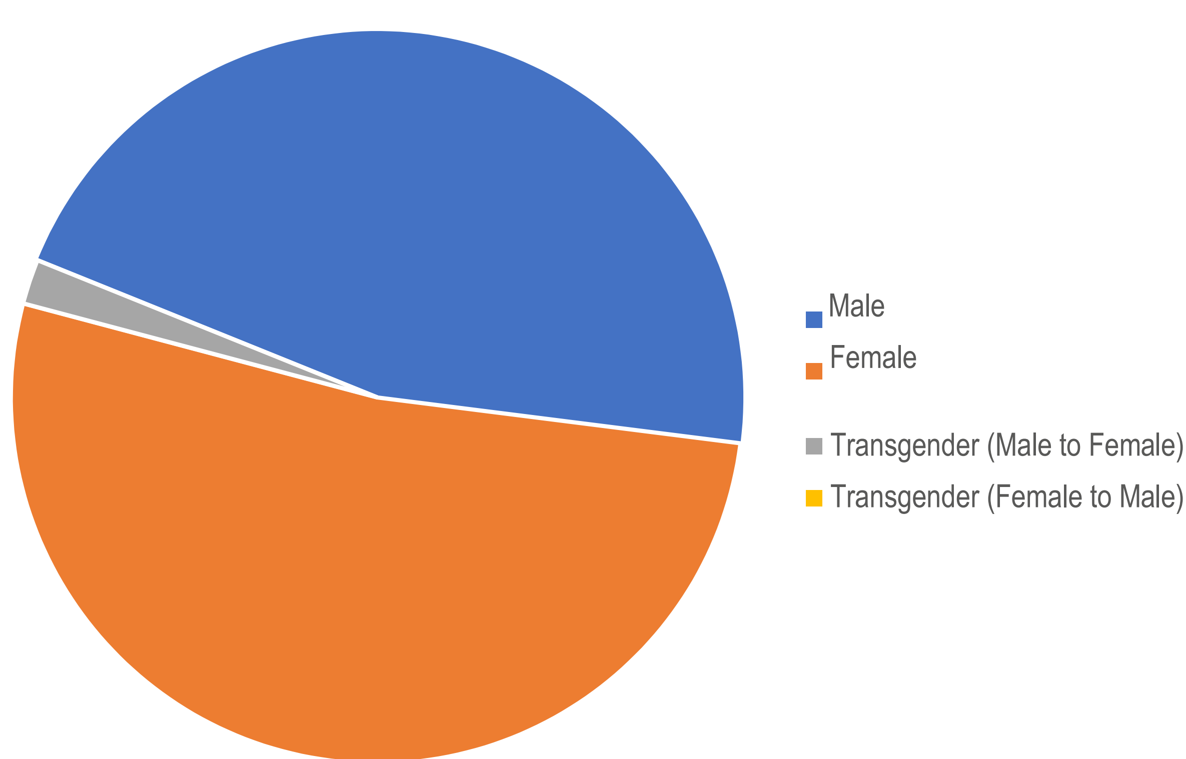
The third question on the survey asked respondents, "*What is your gender*?"

Three hundred fifty-three respondents answered this question. More than half (51.5% or 184) of the respondents were '*Female*' and 45.4% (162) were '*Male*.' Seven (2.0%) respondents identified as '*Transgender (Male to Female)*' and 4 (1.1%) did not respond to the question.

Table 2: Respondents by Gender, Palm Beach County Client Survey, 2016

Gende r	Number	Percentage
Male	162	45.4%
Female	184	51.5%
Transgender (Male to Female)	7	2.0%
Transgender (Female to Male)	0	0.0%
No Response	4	1.1%
Total	357	100.0%

Figure 3: Respondents by Gender, Palm Beach County Client Survey, 2016


Male
Female
Transgender (Male to Female)
Transgender (Female to Male)

Sexual Orientation

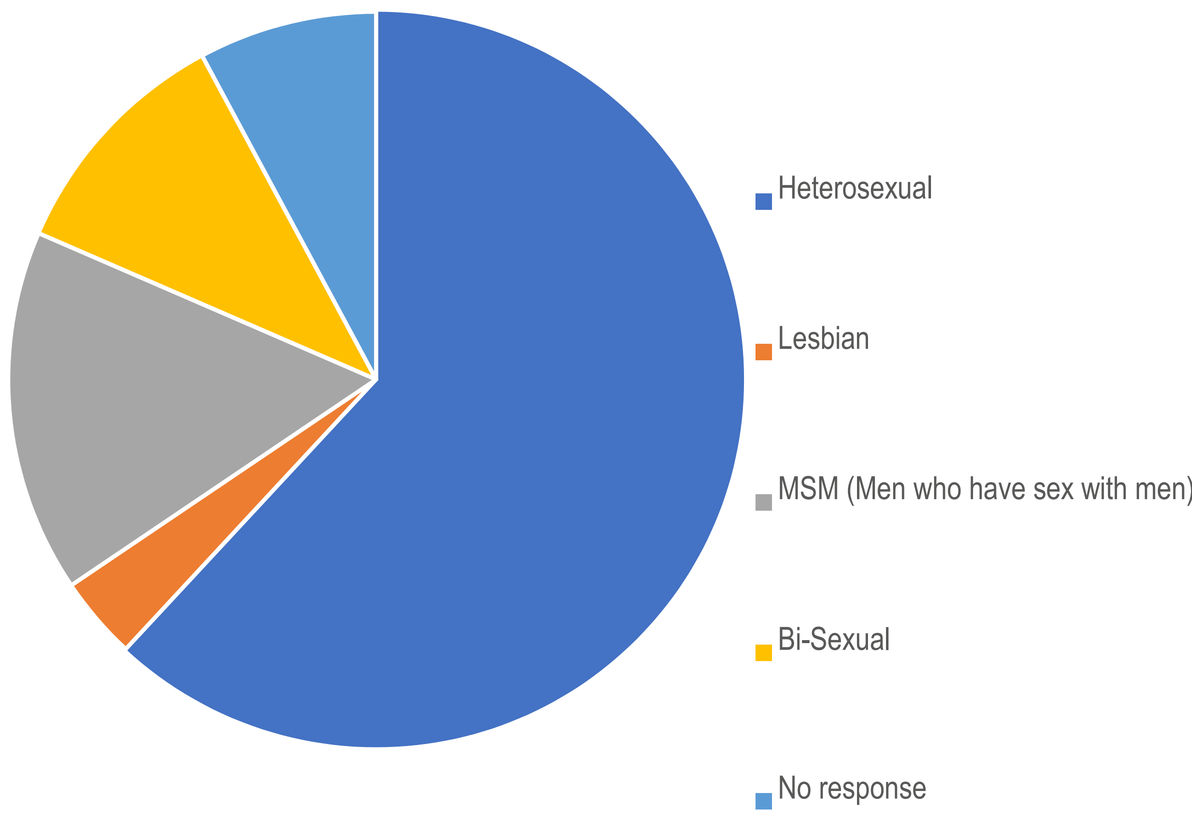
The next question asked respondents, *"How do you identify yourself?"*

Three hundred twenty-nine respondents answered the question. The majority (221 or 61.9%) identified as *'Heterosexual'*, followed by fifty-seven (16.0%) respondents that identified as *'MSM (Men who have sex with men),'* thirty-eight (10.6%) identified as *'Bi-Sexual,'* and thirteen (3.6%) of the respondents identified as *'Lesbian.'* There were 28 individuals who did not respond to this question.

Table 3: Respondents by Sexual Orientation. Palm Beach County Client Survey, 2016

Sexual Orientation	Number	Percentage
Heterosexual	221	61.9%
Lesbian	13	3.6%
MSM (Men who have sex with men)	57	16.0%
Bi-Sexual	38	10.6%
No response	28	7.8%
Total	357	100.0%

Figure 4: Respondents by Sexual Orientation. Palm Beach County Client Survey, 2016



Race

The survey also included a question on race, with the following response options:

- '*White/Caucasian'*
- *'Black or African-American'*
- *'Asian', 'Native Hawaiian or Pacific Islander'*
- '*American Indian or Alaskan Native'*
- *'Mixed/more than one race'*

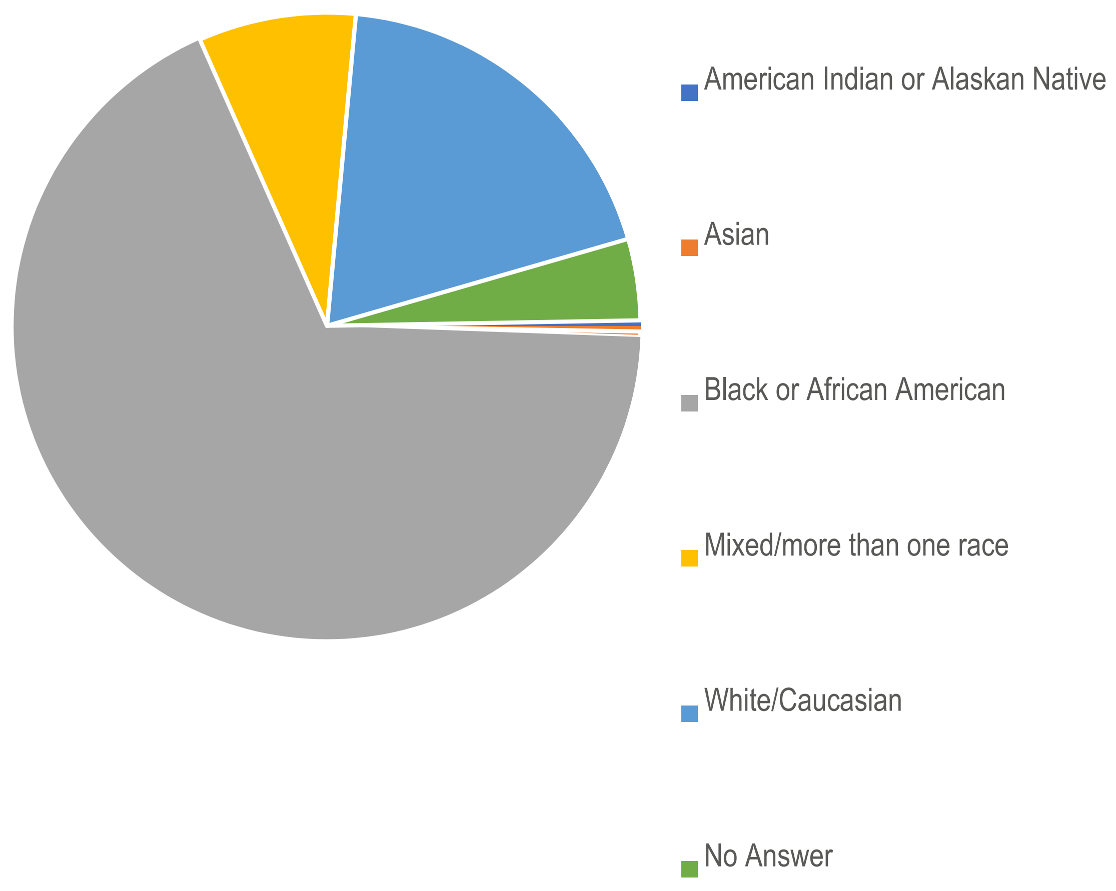
Three hundred forty-two respondents answered this question.

The majority (242 or 67.8%) of respondents identified as '*Black or African American,'* followed by '*White/Caucasian'* (68 or 19.0%), twenty-nine (8.1%) that reported as '*Mixed/more than one race,'* two (0.6%) reported as *'American Indian or Alaskan Native,'* and one (0.3%) respondent identified as '*Asian.'*

Table 4: Respondents by Race, Palm Beach County Client Survey, 2016

Race	Number	Percentage
American Indian or Alaskan Native	2	0.6%
Asian	1	0.3%
Black or African American	242	67.8%
Mixed/more than one race	29	8.1%
White/Caucasian	68	19.0%
No Response	15	4.2%
Total	357	100%

Figure 5: Respondents by Race, Palm Beach County Client Survey, 2016



Ethnicity

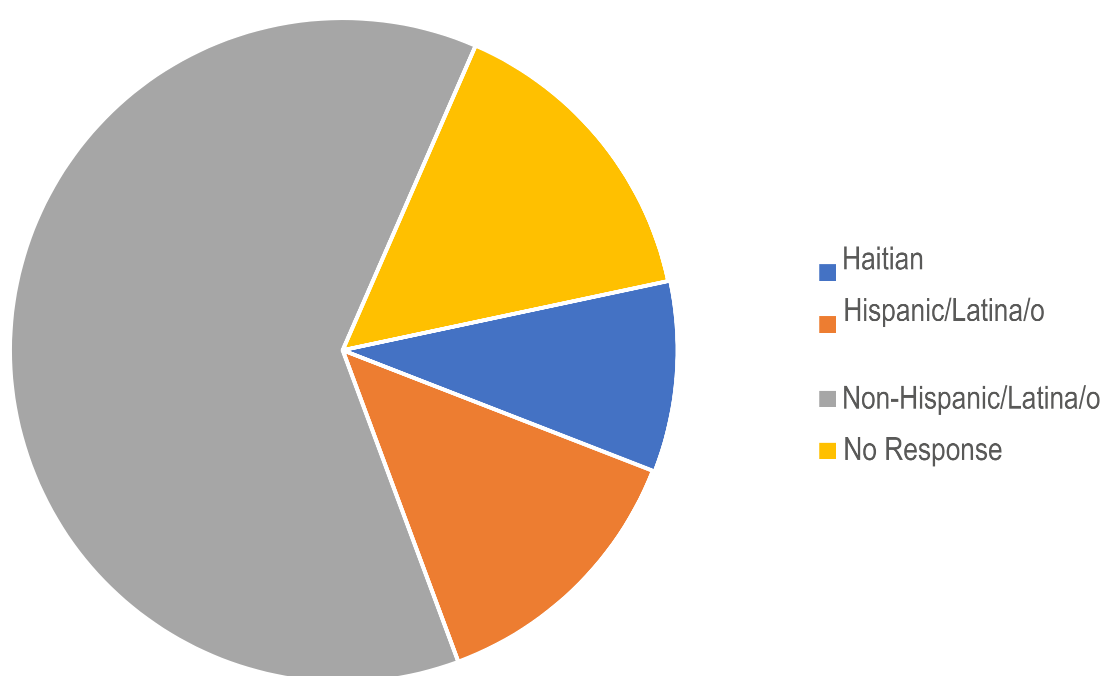
The survey also included a question on ethnicity. Three hundred three individuals responded to the question, "*What is your Ethnicity?*"

Most (222 or 62.2%) identified as '*Non-Hispanic or Latino,'* forty-eight (13.4%) reported as Hispanic/Latino. Thirty-three (9.2%) of participants identified as '*Haitian'* and fifty-four (15.1%) of participants did not answer the question.

Table 5: Respondents by Ethnicity, Palm Beach County Client Survey, 2016

Ethnicit y	Number	Percentage
Haitian	33	9.2%
Hispanic/Latina/o	48	13.4%
Non-Hispanic/Latina/o	222	62.2%
No Response	54	15.1%
Total	357	100%

Figure 6: Respondents by Ethnicity, Palm Beach County Client Survey, 2016



Age

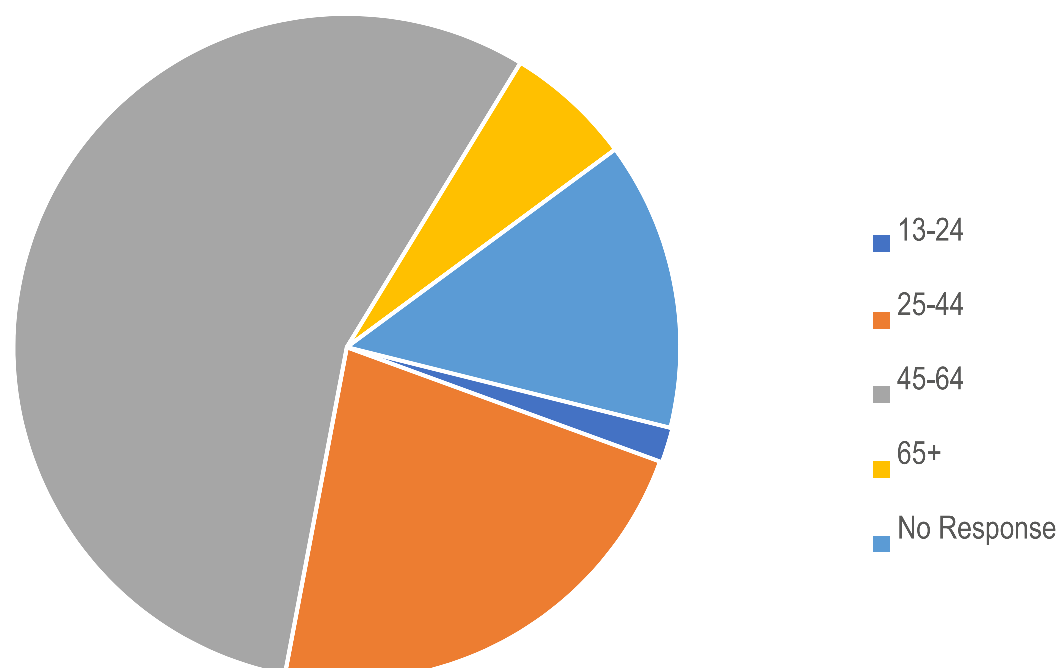
Three hundred seven respondents answered the question *"What year were you born?"* This was an open-ended question.

Responses for year of birth ranged from 1943 to 1998 and the most common age group was 45-64 (199 or 55.7%), which coincides with current prevalence rates by age group in Palm Beach County.

Table 7: Respondents by Age, Palm Beach County Client Survey, 2016

Age	Number	Percentage
13-24	6	1.7%
25-44	80	22.4%
45-64	199	55.7%
65+	22	6.2%
No Response	50	14.0%
Total	357	100.0%

Figure 6: Respondents by Age, Palm Beach County Client Survey, 2016


13-24
25-44
45-64
65+
No Response

Education Level

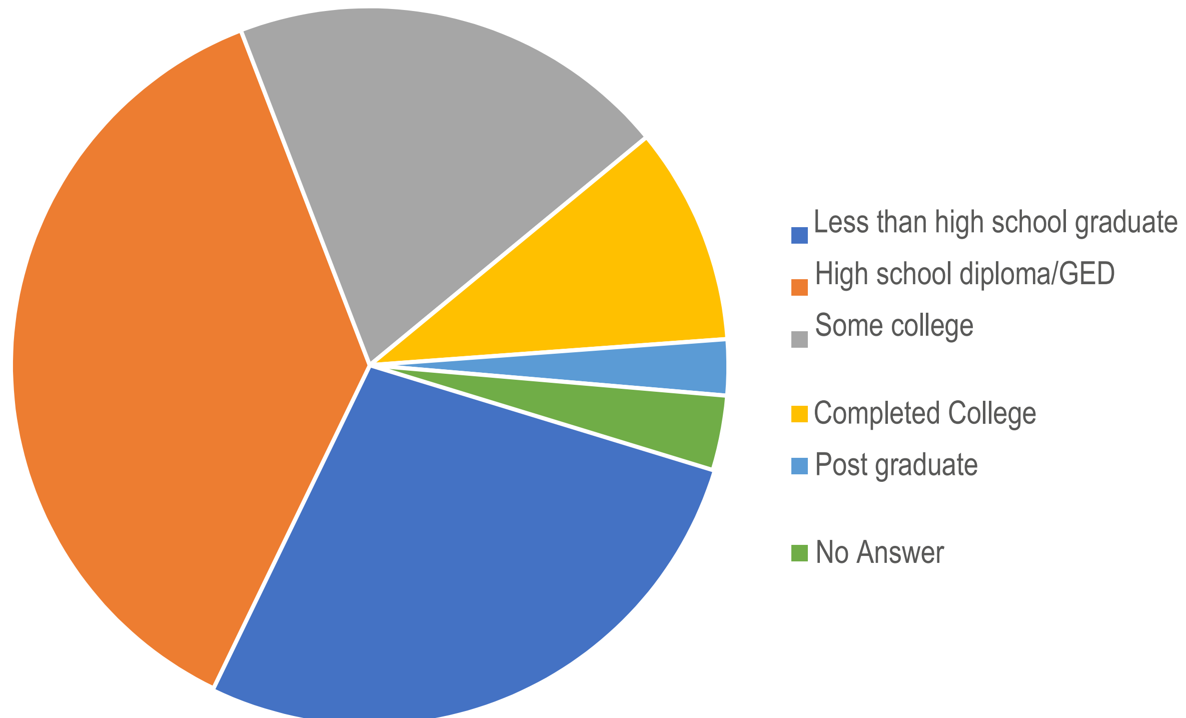
Three hundred forty-five individuals responded to the question, *"What is your education level?"*

Most participants (64.5%) reported having a high school education or less. Nearly 20% reported having some college and just over 12% reported having completed college or post graduate studies. Twelve individuals did not respond to this question.

Table 7: Respondents by Education Level, Palm Beach County Client Survey, 2016

Education	Number	Percentage
Less than high school graduate	98	27.5%
High school diploma/GED	132	37.0%
Some college	71	19.9%
Completed College	35	9.8%
Post graduate	9	2.5%
No Response	12	3.4%
Total	357	100.0%

Figure 8: Respondents by Education Level, Palm Beach County Client Survey, 2016



Employment

Three hundred fifty individuals responded to the question *"What best describes your current work situation?"* This question also allowed multiple responses, as respondents were asked to mark all that applied to them, so the percentages will exceed 100.

Nearly half the respondents reported that they were '*Not currently working.'* Approximately one-quarter reported that they were working, either full-time (10.9%) or part-time (14.6%). Another 10.6% said they were *'Looking for a job/unable to find employment.'* Fourteen percent were *'Retired,'* while 18% (63) reported *'[having] been unemployed over a year.*' There were 7 individuals that did not respond to the question.

Table 8: Respondents by Employment Status, Palm Beach County Client Survey, 2016

Employmen t	Number	Percentage
Working full-time job	38	10.9%
Working part-time job	51	14.6%
Student	10	2.9%
Looking for a job/unable to find employment	37	10.6%
Retired	49	14.0%
Not currently working	172	49.1%
I have been unemployed for over a year	63	18.0%
No Response	7	1.90%

County of Residence

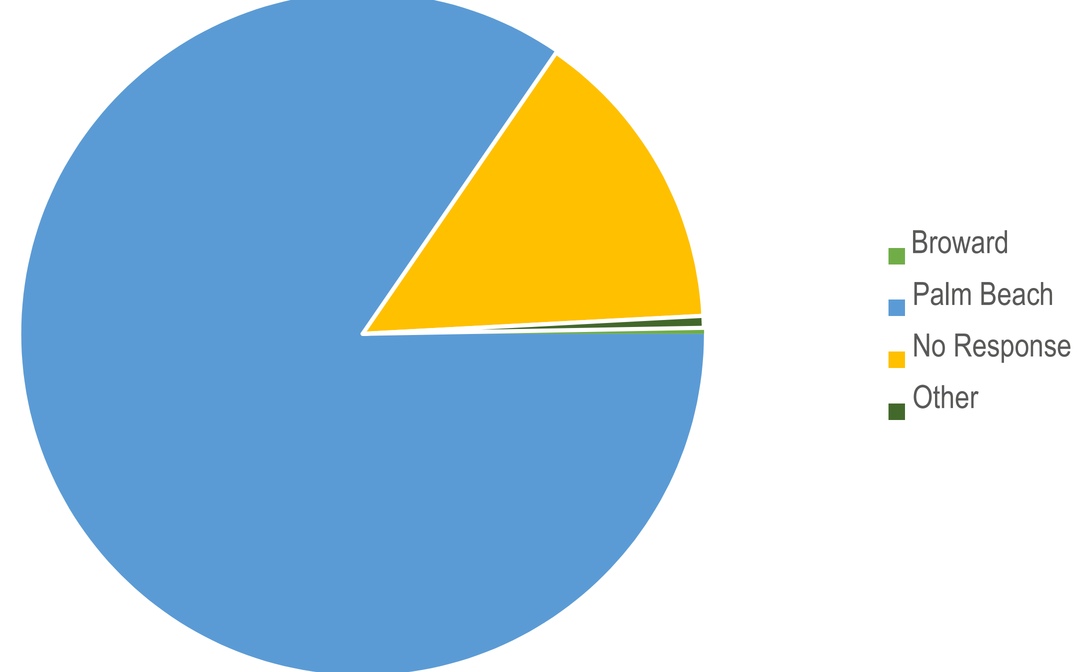
Three hundred fifty-five responded to the next open-ended question, "*What county do you live in currently*?"

Most of the respondents (302 or 84.6%) reported to reside in Palm Beach County and one (0.3%) person reporting Broward as their county of residence. Just over 15% either did not respond or listed 'other.'

Table 9: Participants by County of Residence, Palm Beach County Client Survey, 2016

County of Residence	Number	Percentage
Broward	1	0.3%
Palm Beach	302	84.6%
No Response	52	14.6%
Other	2	0.6%
Total	357	100.0%

Figure 10: Respondents by County of Residence, Palm Beach County Client Survey, 2016



Results and Themes

HIV Diagnosis

The next question asked, *"How old were you when you tested positive?"*

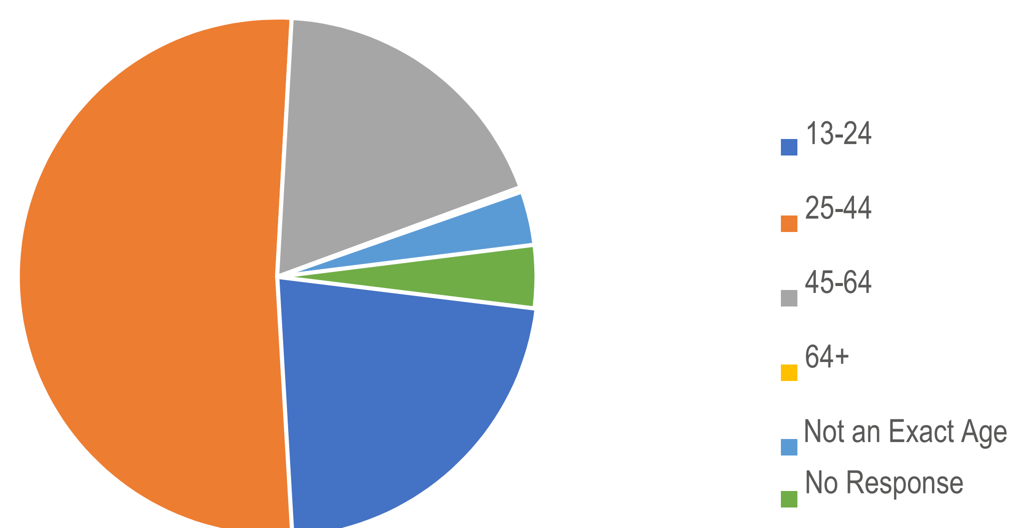
This was an open-ended question, 331 respondents answered this question with a number or an exact age, while a small number of respondents (3.4%) provided an estimated age, a range, a year, or other response. Fourteen individuals did not respond to this question.

Answers were grouped into the following age groups, *'13-24,' '25-44,' '45-64,' and '65+.'* More than half of respondents (51.8%) reported being between '*25 – 44*' when they tested positive. Twenty-two percent reported being between 13 and 24, 18.5% said they were between 45 and 64. One individual reported being over the age of 65.

Table 10: Respondents by Age at Time of First Positive HIV Test, Palm Beach County Client Survey, 2016

Age	Number	Percentage
13-24	79	22.1%
25-44	185	51.8%
45-64	66	18.5%
65+	1	0.3%
Not an Exact Age	12	3.4%
No Response	14	3.9%
Total	357	100.0%

Figure 11: Respondents by Age at Time of First Positive HIV Test, Palm Beach County Client Survey, 2016



Three hundred fifty individuals responded to the question, *"Where were you living when you first tested positive for HIV?"* The responses were:

- *'In the same county I live in now'*
- *'In another county in Florida'*
- *'In another state'*
- *'Outside of the United States'*

The majority (259 or 72.5%) of respondents reported *'In the same county I live in now'* (which would be Palm Beach County), 12.0% (43) reported, *'In another state'*, 10.9% (39) reported, *'In another county in Florida'*, and 2.5% (9) of respondents reported *'Outside of the United States'*.

For the respondents who reported somewhere else other than Palm Beach County, places of residence included:

Florida Counties

- Broward
- Dade
- Duval
- Hillsborough
- Hollywood
- Lee
- Leesburg
- Miami-Dade
- Orange
- Orlando
- Perry

States outside of Florida

- Arizona
- Massachusetts
- California
- Connecticut
- Washington DC
- Georgia
- North Carolina
- New Jersey
- New York
- Ohio
- Pennsylvania
- South Carolina
- Virginia
- Wisconsin
- West Virginia

Countries outside of the U.S.

- Bahamas
- Cuba
- Haiti
- Italy
- Korea
- Puerto Rico

Table 11: Respondents by Residence at Time of First Positive HIV Test, Palm Beach County Client Survey, 2016

Residenc e	Number	Percentage
In the same county I live in now	259	72.5%
In another county in Florida. County	39	10.9%
In another state	43	12.0%
Outside of the United States. Country	9	2.5%
No Response	7	2.0%
Total	357	100.0%

HIV Medical Care

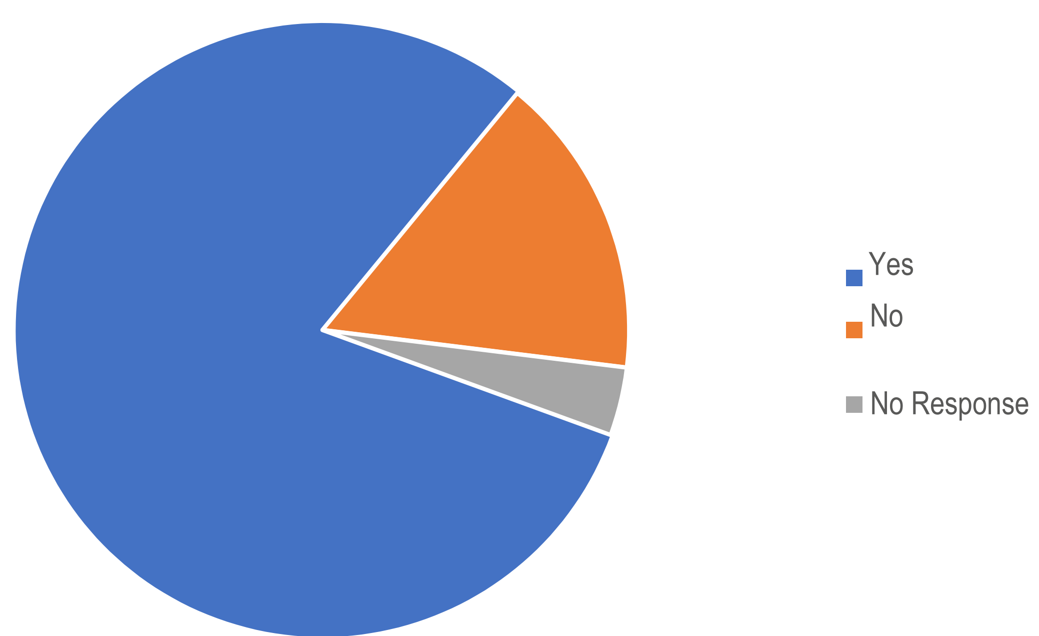
The next set of questions asked respondents about medical care and medication adherence.

Question 13 asked, *"Were you in care for HIV/AIDS between June 1st, 2015 and May 31st, 2016?"* Three hundred forty-four respondents answered this question. Fifty-seven (16.0%) of respondents reported not being in care between June 1, 2015 and May 31, 2016.

Table 12: Respondents by Utilization of Medical Care, Palm Beach County Client Survey, 2016

Utilization of Medical Care	Numbe r	Percentage
Yes	287	80.4%
No	57	16.0%
No Response	13	3.6%
Total	357	100.0%

Figure 12: Respondents by Utilization of Medical Care, Palm Beach County Client Survey, 2016

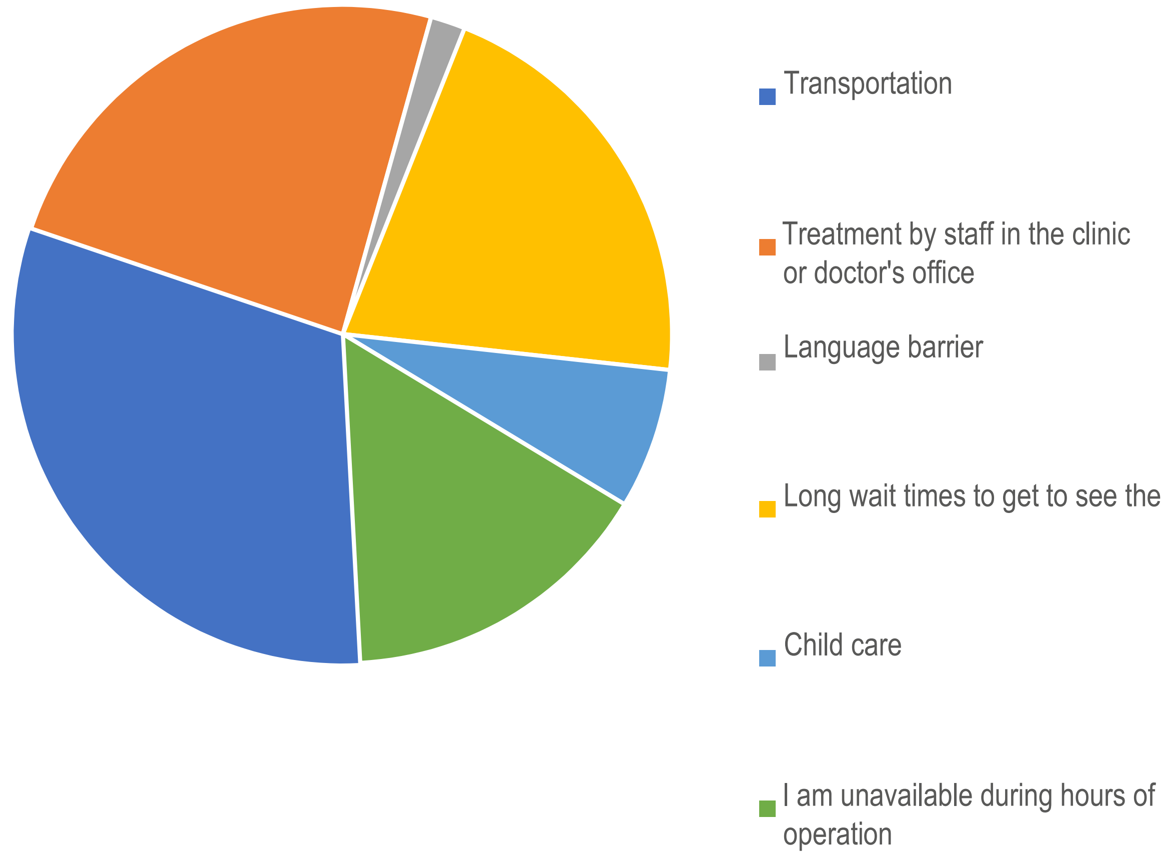


The subsequent question gleans further insight, with the question, *"What are the reasons you are not in care?*" and 52 of the 57 participants responded. The table below displays the reasons why medical care was received. Within the 52 respondents, eighteen (34.6%) reported '*Transportation,'* fourteen (26.9%) reported '*Treatment by staff in the clinic or doctor's office,'* twelve (23.1%) reported '*Long wait times to get to see the doctor,*' four (7.7%) reported '*child care,'* and one (1.9%) respondent reported '*Language barrier'* as their reason not in care.

Table 13: Respondents by Reasons why not receiving Medical Care, Palm Beach County Client Survey, 2016

Reason not in care	Number	Percentage
Transportation	18	34.6%
Treatment by staff in the clinic or doctor's office	14	26.9%
Language barrier	1	1.9%
Long wait times to get to see the	12	23.1%
Child care	4	7.7%
I am unavailable during hours of operation	9	17.3%

Figure 13: Respondents by Reasons for not receiving Medical Care, Palm Beach County Client Survey, 2016



Three hundred two responded to the next question, *"In which Florida county or counties did you get your HIV/AIDS medical care between June 1st, 2015 and May 31st, 2016?"* This was an open-ended question. Most (259 or 72.5%) reported that Palm Beach was where they received medical care. The table below displays locations where medical care was received.

Table 14: Respondents by Location of Medical Care Received, Palm Beach County Client Survey, 2016

Location	Number	Percentage
Palm Beach	259	72.5%
Broward	7	2.0%
No Response	55	15.4%
Other	36	10.1%
Total	357	100.0%

The next question asked, *"If you get your HIV/AIDS medical care in a different county than you live, please indicate why. Please mark only one answer."*

A total of two hundred ninety-four participants answered this question. Two hundred seventy-one (75.9%) participants reported, *'This does not apply to me, I get medical care in the same county I live in,'* while a small number (2.5%) said *'I got care at a clinic that is located closer to where I live or work'*, and five *(1.4%)* reported 'Other.'

For the participants who reported *'Other,'* a few noted that they were not currently 'in care.'

Table 15: Respondents by Cause for Services that were utilized in a Different County, Palm Beach County Client Survey, 2016

Cause	Responses	Percentage
This does not apply to me. I got medical care in the same county I live in.	271	75.9%
Services were not available in my county	3	0.8%
Dissatisfied with services provided in my county	1	0.3%
I did not want people to know that I have HIV	5	1.4%
I got care at a clinic that is located closer to where I live or work	9	2.5%
Other	5	1.4%
No Response	63	17.6%
Total	357	100.0%

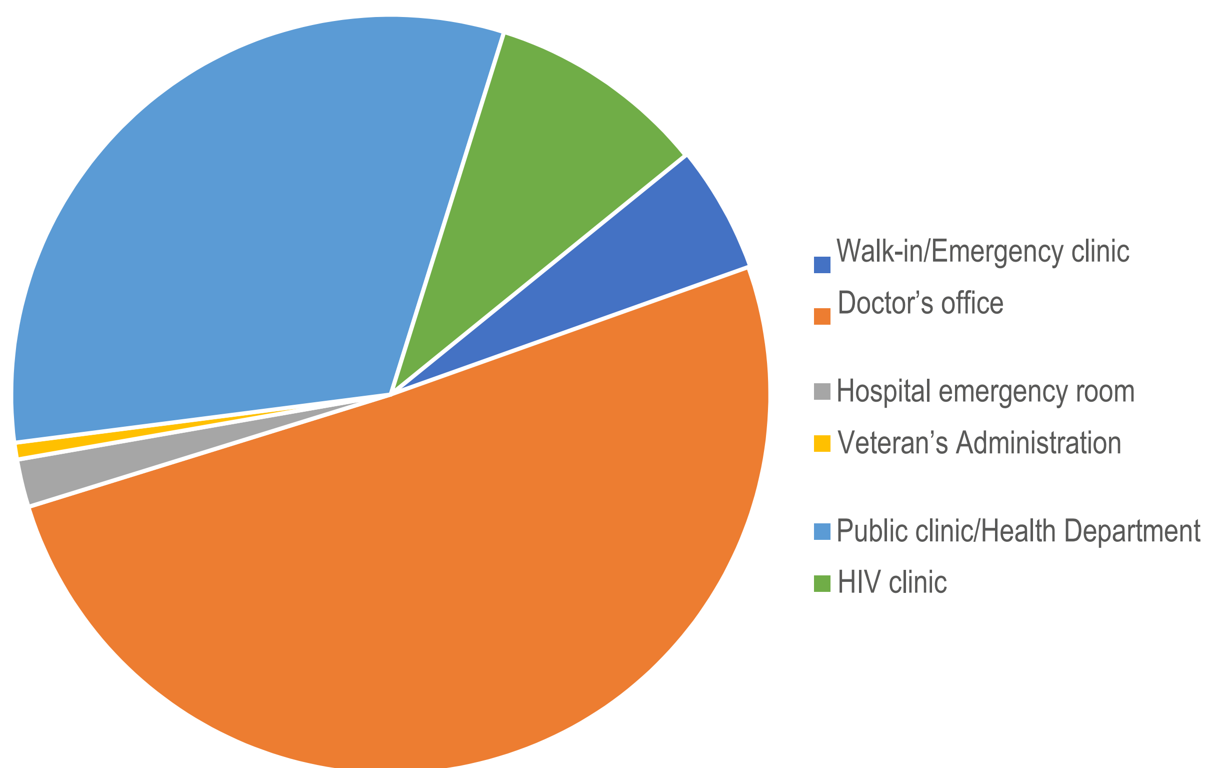
A total of three hundred thirty participants answered the next question, *"Where did you regularly receive your HIV/AIDS medical care between June 1st, 2015 and May 31st, 2016? Please mark only one answer*."

One hundred fifty-one (42.3%) respondents reported '*Doctor's Office,'* ninety-five (26.6%) respondents reported, *'Public clinic/health department,'* thirty-two (9.0%) respondents reported *'Federally Qualified Community Health Center (FQHC),'* and twenty-eight (7.8%) reported *'HIV Clinic.'*

Table 16: Respondents by Location of Medical Services Utilized, Palm Beach County Client Survey, 2016

Location of Medical Services	Number	Percentage
Walk-in/Emergency clinic	16	4.5%
Doctor's office	151	42.3%
Hospital emergency room	6	1.7%
Veteran's Administration	2	0.6%
Public clinic/Health Department	95	26.6%
HIV clinic	28	7.8%
Federally Qualified Community Health Center (FQHC) debated yes or no?	32	9.0%
No Response	27	7.6%
Total	357	100.0%

Figure 14: Respondents by Location of Medical Services Utilized, Palm Beach County Client Survey, 2016



Anti-retroviral Therapy & Adherence

For the question regarding HIV medication, the survey asked participants "*Are you on antiretroviral (HIV medication) therapy?*" Only three participants did not answer this question, and 74.2% (265) of respondents reported 'Yes.' Antiretroviral therapy continues to be the most effective form of treatment for HIV/AIDS and is the key component to viral suppression.

Table 17: Respondents by Antiretroviral Therapy, Palm Beach County Client Survey, 2016

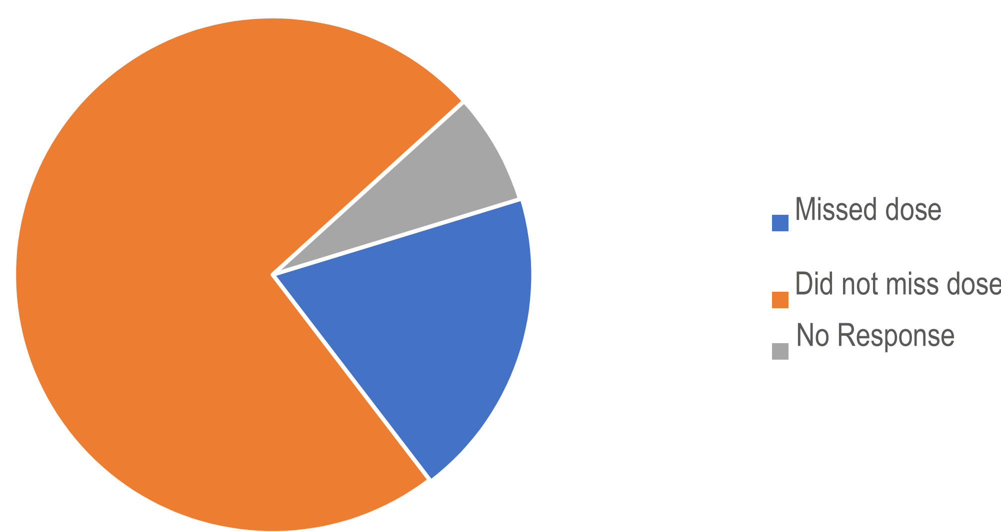
Antiretroviral Therapy	Number	Percentage
Yes	265	74.2%
No	89	24.9%
No Response	3	0.8%
Total	357	100.0%

A total of three hundred thirty-two individuals responded to the question, *"Did you miss any of your HIV medications over the past month?"* The majority (263 or 73.7%) of respondents reported that they did not miss taking their medication in the past month, and just under 20% or 69 of respondents reported that they had missed taking their medication during the previous month.

Table 18: Respondents by Medication Adherence, Palm Beach County Client Survey, 2016

Medication Adherence	Number	Percentage
Yes	69	19.3%
No	263	73.7%
No Response	25	7.0%
Total	357	100.0%

Figure 15: Respondents by Medication Adherence, Palm Beach County Client Survey, 2016



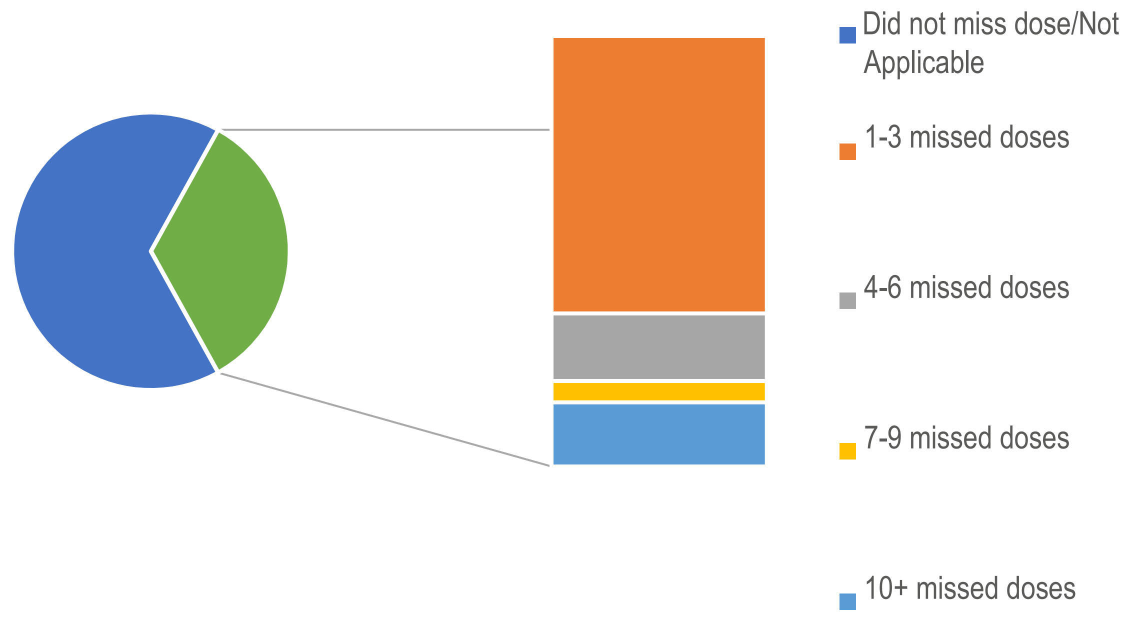
The survey asked another question regarding medication adherence, *"How many times in the past month have you missed taking your medication?"* and yielded more respondents acknowledging missed doses.

Table 19: Respondents by Frequency of Missed Medication, Palm Beach County Client Survey, 2016

Frequency	Number	Percentage
1-3 missed doses	78	21.8%
4-6 missed doses	19	5.3%
7-9 missed doses	6	1.7%
10+ missed doses	18	5.0%
N/A	236	66.1%
Total	357	100.0%

From the 121 respondents that reported lack of adherence, over 20% reported *'1-3 missed doses,'* about 5% reported *'4-6 missed doses,'* 1.7% *reported '7-9 missed doses,'* and eighteen reported *'10 or more times.'*

Figure 16: Respondents by Frequency of Missed Antiretroviral Medication, Palm Beach County Client Survey, 2016



The following question inquired further asking, *"If yes, what are some of the reasons why you missed taking your HIV medication?"* Of the respondents, fifty-nine (15.8%) respondents stated, *'I Forgot,'* twenty-one (5.6%) said *'Needed to get my prescription renewed,'* thirteen (3.5%) reported *''Change insurance plan*.' In addition, *'Cost'* and *'Side-effects'* were each reported by a small number of the respondents. Twenty-four respondents cited 'Other' reasons, including:

- No insurance, no medication
- Insurance dropped
- Fell asleep
- Timing and schedule
- No food to take medication
- Living arrangements
- No documents
- Did not go to the doctor
- Bad taste and hard to swallow
- Out of pills
- Drug use
  Transportation
- Not in care
- Life issues
- Lost medicine
- ADAP claims fell through cracks. Could not get in touch with ADAP
- I was in the ER
- Did not want to take them
- Daughter messed with medication
- Homeless and misplaced medication

Table 20: Respondents by Cause for Missed Medication, Palm Beach County Client Survey, 2016

Cause for Missed Medication	Number	Percentage
Cost	5	1.3%
Change insurance plan	13	3.5%
Needed to get my prescription renewed	21	5.6%
Forgot	59	15.8%
I had side effects	5	1.3%
My Eligibility documentation for ADAP was not completed timely	11	2.9%
Other	24	6.4%
N/A	235	63.0%

Viral Suppression

The following question, *“In your last blood test was your viral load greater than 1000?”* was answered by most (353) of the respondents. Just over a quarter of the respondents reported *‘Yes,’* 42.6% said *‘No*,’ and nearly a third said, *‘I don’t know.’*

Table 21: Respondents by Viral Load Greater than 1,000, Palm Beach County Client Survey, 2016

Viral Load Greater than 1,000	Number	Percentage
Yes	92	25.8%
No	152	42.6%
I don't know	109	30.5%
No Response	4	1.1%
Total	357	100.0%

A total of 355 respondents answer the question, *“In your last blood test, was your viral load below 200?’* Just over one-third of the participants reported, *‘Yes,’* nearly another third reported *‘No,’* and nearly another third said, *‘I don’t know.* And nearly 6% of the respondents reported *‘No, but it has been going down.’*

Table 22: Respondents by Viral Load below 200, Palm Beach County Client Survey, 2016

Viral Load Below 200	Number	Percentage
Yes	122	34.2%
No	106	29.7%
No, but it has been going down	20	5.6%

I don't know	107	30.0%
No Response	2	0.6%
Total	357	100.0%

Substance Use

The succeeding question asked, *"In the past month, how often did you smoke cigarettes?"* A total of three hundred fifty-one respondents answered this question. Two hundred four (57.1%) respondents reported *'Not at all,'* 102 (28.6%) reported *'Every day,'* and forty-five (12.6%) reported *'Some days.'*

Table 23: Respondents by Cigarette Use, Palm Beach County Client Survey, 2016

Cigarette Use	Numbe r	Percentag e
Every day	102	28.6%
Some days	45	12.6%
Not at all	204	57.1%
No Response	6	1.7%
Total	357	100.0%

Most participants (352) answered the next question, *"In the past month, how often have you used marijuana?"* Many participants (274 or 76.8%) reported *'Not at all,'* 13.7% (49) of participants reported *'Some days,'* and 8.1% (29) of participants reported, *'Every day.'*

Table 24: Respondents by Marijuana Use, Palm Beach County Client Survey, 2016

Marijuana Use	Numbe r	Percentag e
Every day	29	8.1%
Some days	49	13.7%
Not at all	274	76.8%
No Response	5	1.4%
Total	357	100.0%

A total of three hundred fifty-four individuals responded to the following question, *"In the past month how often did you consume illegal drugs other than marijuana (cocaine, crack, meth, heroin, etc.)?"* While most (83.8% or 299) reported *'Not at all,'* 43 respondents or 12.0% reported using illegal drugs 'Some days' and 12 (3.4%) respondents reported using illegal drugs 'Every day.'

Table 25: Respondents by Illegal Drug Use, Palm Beach County Client Survey, 2016

Illegal Drug Use	Number	Percentage
Every day	12	3.4%
Some days	43	12.0%
Not at all	299	83.8%
No Response	3	0.8%
Total	357	100.0%

The next question asked, *"In the past month, how often did you share needles?"* Most participants (354) answered this question, with one respondent reporting *'Every day'* and 10 respondents reported *'Some days.'* However, most (96.1%) reported *'Not at all'* to sharing needles.

Table 26: Respondents by Sharing of Needles, Palm Beach County Client Survey, 2016

Sharing of Needles	Number	Percentage
Every day	1	0.3%
Some days	10	2.8%
Not at all	343	96.1%
No Response	3	0.8%
Total	357	100.0%

In the next question, most participants (352) answered to, *"In the past month, how often did you have unprotected sex?"* Two hundred ninety-three (82.1%) participants reported *'Not at all,'* 49 (13.7%) reported *'Some days'* and ten (2.8%) participants reported *'Every day.'*

Table 27: Respondents by Unprotected Sex Activity, Palm Beach County Client Survey, 2016

Unprotected Sex Activity	Number	Percentage
Every day	10	2.8%
Some days	49	13.7%
Not at all	293	82.1%
No Response	5	1.4%
Total	357	100.0%

Hospitalization

Most (355) participants answered the question, *"Have you been hospitalized for an HIV/AIDS related condition between June 1st, 2015 and May 31st, 2016? If so what was it for?"* Three hundred twenty- three (90.5%) participants responded *'No'* and thirty-two (9.0%) respondents reported *'Yes.'*

Of the thirty-two who reported *'Yes,'* the listed the following as causes for their hospitalization.

- Bronchitis
- Pneumonia
- Tuberculosis
- Excessive weight loss and fatigue
- Cold
- HPV
- Hernia
- Dizziness from ear infection
- Enlargement of the spleen and lymph nodes
- Low viral load
- Gallbladder
- Fever

It is important to note that the term "HIV-related" may be interpreted differently, possibly affecting the responses to this question.

Table 28: Respondents by Hospitalization, Palm Beach County Client Survey, 2016

Hospitalization	Numbe r	Percentage
Yes	32	9.0%
No	323	90.5%
No Response	2	0.6%
Total	357	100.0%

Medical and Support Services

The next set of questions was related to the various services provided to persons living with HIV/AIDS in Palm Beach County. The Survey asked respondents to *"Please fill in the boxes next to the services that you have used or needed in the past 12 months."*

The survey listed the following services:

- Outpatient Medical Care
- Case Management
- Medications
- Dental/Oral Health
- Mental Health Services
- Substance Abuse Treatment
- Nutritional Counseling
- Early Intervention Services
- Home Health Care
- Hospice Services
- Food Bank or Food Vouchers
- Transportation
- Outreach
- Health Education/Risk Reduction
- Treatment Adherence
- Legal Support
- Rehabilitation
- Peer Mentoring
- Housing
- Other

The following were answer options:

- *I received this service without difficulty*
- *I received this service but it was difficult to get*
- *I needed this service but was unable to get it*
- *I did not need this service*

The table below presents the responses. It is important to note that most respondents indicate that they have been able to access many services they needed, even when they had challenges or difficulty doing so. That said, there were a few services that participants said they had been unable to access: dental/oral health, housing, transportation, food bank vouchers, nutritional counseling, and health insurance.

Table 29: Utilization of Medical and Support Services, Palm Beach County Client Survey, 2016

Medical/Support Service	Received Service Without Difficulty		Received Service but with Difficulty		Unable to Receive Service		Service Not Needed	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Outpatient Medical Care	267	74.8%	21	5.9%	22	6.2%	35	9.8%
Case Management	262	73.4%	23	6.4%	34	9.5%	32	9.0%
Medications	269	75.4%	26	7.3%	31	8.7%	19	5.3%
Dental/Oral Health	203	56.9%	29	8.1%	59	16.5%	53	14.8%
Health Insurance	206	57.7%	28	7.8%	44	12.3%	66	18.5%
Mental Health Services	148	41.5%	21	5.9%	34	9.5%	144	40.3%
Substance Abuse Treatments	68	19.0%	9	2.5%	29	8.1%	239	66.9%
Nutritional Counseling	158	44.3%	18	5.0%	39	10.9%	126	35.3%
Early Intervention Services	149	41.7%	16	4.5%	28	7.8%	152	42.6%
Home Health Care	60	16.8%	11	3.1%	28	7.8%	246	68.9%
Hospice Services	41	11.5%	10	2.8%	21	5.9%	271	75.9%
Food Bank/Food Vouchers	190	53.2%	20	5.6%	50	14.0%	89	24.9%
Transportation	185	51.8%	14	3.9%	44	12.3%	104	29.1%
Outreach	113	31.7%	16	4.5%	25	7.0%	188	52.7%
Health Education/risk Reduction	211	59.1%	10	2.8%	27	7.6%	99	27.7%
Treatment Adherence	215	60.2%	14	3.9%	28	7.8%	86	24.1%
Legal Support	140	39.2%	13	3.6%	29	8.1%	161	45.1%
Rehabilitation	79	22.1%	9	2.5%	29	8.1%	225	63.0%
Peer Mentoring	152	42.6%	18	5.0%	34	9.5%	138	38.7%
Housing	118	33.1%	25	7.0%	70	19.6%	133	37.3%

Barriers to Accessing Services

The subsequent question was a follow-up question regarding difficulty-receiving services. The question asked, *"If you had problems receiving services between June 1st, 2015 and May 31st, 2016, what were some of the reasons? Mark all that apply."*

The following were answer options:

- *'This does not apply to me. I had no problems receiving services'*
- *'I did not know where to get services'*
- *'I could not get an appointment'*
- *'I could not get transportation'*
- *'I could not get childcare'*
- *'I could not pay for services'*
- *'I did not want people to know that I have HIV'*
- *'I could not get time off work'*
- *'I was depressed'*
- *'I had a bad experience with the staff'*
- *'Services were not in my language'*
- *'I did not qualify for services'*
- *'Other'*

A total of three hundred thirty-one participants answered this question. Two hundred twenty-nine (64.1%) (229) reported, *"This does not apply to me. I had no problems receiving services"*, twenty –six (7.3%) of respondents reported '*I did not want people to know I was HIV positive*', twenty-two (6.2%) listed *'I did not know where to get services'*, fifteen (4.2%) reported '*I could not get transportation*', fourteen (3.9%) reported '*I could not pay for services'*, eight (2.2%) reported '*I could not get time off work'*, six (1.7%) reported '*I could not get an appointment'*, and one (0.3%) respondent reported '*I could not get childcare*'.

The respondents specified the following for '*Other*':

- Did not use services
- The process was long
- Lack of communication
- Housing not available
- Process was invasive
- Difficulty finding documents for services
- Services were not covered by insurance
- Lack of follow up

- Eligibility
- Difficulty with prescriptions
- Homeless

This data suggests that most of the sample population could obtain and utilize the services they needed. However, transportation and insurance eligibility processes influence the ability to obtain services and therefore affecting overall health and wellness.

Table 30: Respondents by Barriers to Accessing Medical/Support Services, Palm Beach County Client Survey, 2016

Barriers to Medical/Support Services	Number	Percentage
This does not apply to me. I had no problems receiving services.	229	64.1%
I did not know where to get services	22	6.2%
I could not get an appointment	6	1.7%
I could not get transportation	15	4.2%
I could not get childcare	1	0.3%
I could not pay for services	14	3.9%
I did not want people to know I have HIV	26	7.3%
I could not get time off work	8	2.2%
I was depressed	22	6.2%
I had a bad experience with the staff	21	5.9%
Services were not in my language	3	0.8%
I did not qualify for services	13	3.6%
Other (please specify)	18	5.0%
No Response	26	7.3%

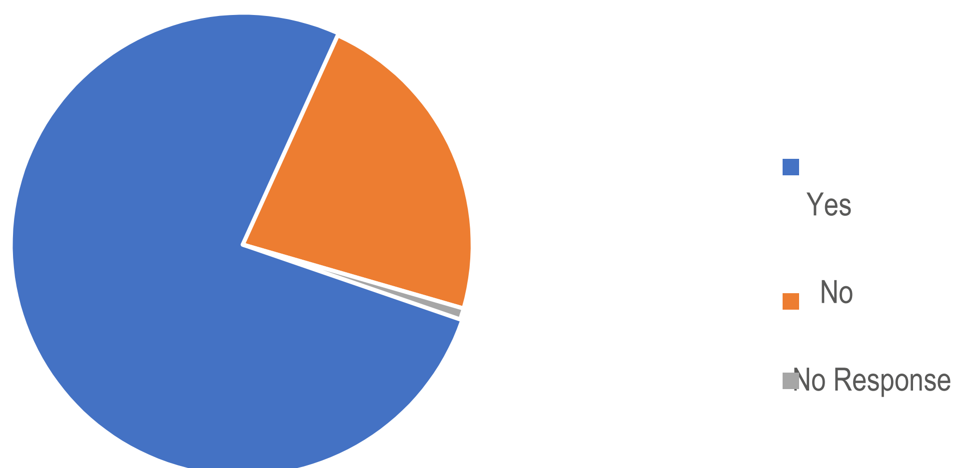
Health Insurance

The question regarding health insurance asked, *"Do you have insurance?"* Most participants (354) answered this question, with 76.5% (273) reporting *'Yes'* and 22.7% (81) reporting *'No'*. This data suggests that clients experience differing challenges accessing healthcare services and likely poorer health outcomes. Respondents may have varied interpretations of what they consider "insurance" (Ryan White, Medicaid, Marketplace, Healthcare District).

Table 31: Respondents by Health Insurance Status, Palm Beach County Client Survey, 2016

Health Insurance Status	Number	Percentage
Yes	273	76.5%
No	81	22.7%
No Response	3	0.8%
Total	357	100.0%

Figure 17: Respondents by Health Insurance Status, Palm Beach County Client Survey, 2016



The next question asked, *"Has your health insurance status or plan changed between June 1st, 2015 and May 31st, 2016?"* The following were answer options:

- *'Yes, from uninsured to insured'*
- *'Yes, from insured to uninsured'*
- *'Yes, I changed insurance plan'*
- *'No, I have been insured for all that period'*
- *'No, I have been uninsured for all that period'*

Three hundred forty-seven participants answered this question. Of the two hundred seventy-three respondents who reported having health insurance, 55.2% (197) also reported *'No I have been insured for all that period*', 16.0% (57) reported *'No I have been uninsured for all that period'*, which speaks to the importance of healthcare coverage for all individuals of greatest need.

Table 32: Respondents by Change in Health Insurance Status, Palm Beach County Client Survey, 2016

Change in Health Insurance Status	Number	Percentage
Yes, from uninsured to insured	36	10.1%
Yes, from insured to uninsured	24	6.7%
Yes, I changed insurance plan	33	9.2%
No, I have been insured for all that period	197	55.2%
No, I have been uninsured for all that period	57	16.0%
No response	10	2.8%
Total	357	100.0%

The next question asked, *"What are some of the reasons why you do not have health insurance? Mark all that apply."* Three hundred fifteen participants answered this question. The following were answer options:

- *'This does not apply to me. I have health insurance'*
- *'I have not looked into it'*
- *'My employer does not offer insurance'*
- *'I am not eligible for Medicaid or Obama Care Also known as Marketplace'*
- *'I find the premiums too expensive'*
- *'I didn't look into it'*
- *"Other'*

About two-thirds (66.7% or 238) of participants reported, '*This does not apply to me. I have health insurance*', twenty-three (6.4%) reported '*I have not looked into it'*, eighteen (5.0%) reported *'I find the premiums too expensive*', sixteen (4.5%) reported '*I am not eligible for Medicaid or Obama Care (also known as Marketplace)*', nine (2.5%) reported '*My employer does not offer insurance'* and 4.5% reported '*Other*'. Of those respondents who reported *'Other*', the following reasons for not having health insurance were:

- Did not receive services/Not in care
- Housing not available
- Long process
- Lack of communication
- Process seemed invasive
- Difficulty getting documents for services
- Services not covered by insurance
- Did not return phone calls
- Eligibility problems
- Difficulty with prescriptions
- Homeless

Table 33: Respondents by Barriers to Health Insurance, Palm Beach County Client Survey, 2016

Barriers to Health Insurance	Number	Percentage
This does not apply to me. I have health insurance	238	66.7%
I have not looked into it	23	6.4%
My employer does not offer insurance	9	2.5%
I am not eligible for Medicaid or Obama Care (also known as Marketplace)	16	4.5%

I find the premiums too expensive	18	5.0%
I didn’t look into it	4	1.1%
Other	16	4.5%
No Response	42	11.8%

Two hundred eight-one individuals responded to the question, *"What type of health insurance do you have?"* 111 (31.1%) participants reported *'Medicaid'*, fifty-seven (16.0%) reported *'ADAP Premium Plus AIDS Drug Assistance Program'*, thirty-one (8.7%) reported 'Other Private Insurance', twenty-seven (7.6%) of participants reported *'Medicare'*, twenty-six (7.3%) reported *'Healthcare District'*, seventeen of (4.8%) participants reported *'Market place insurance through the ACA',* nine (2.5%) participants reported *'Employer-sponsored private insurance'* and *three (0.8%) reported 'Veterans'* insurance. Of the 281 participants that answered this question, it should be noted that zero respondents reported having 'Tricare' as health insurance.

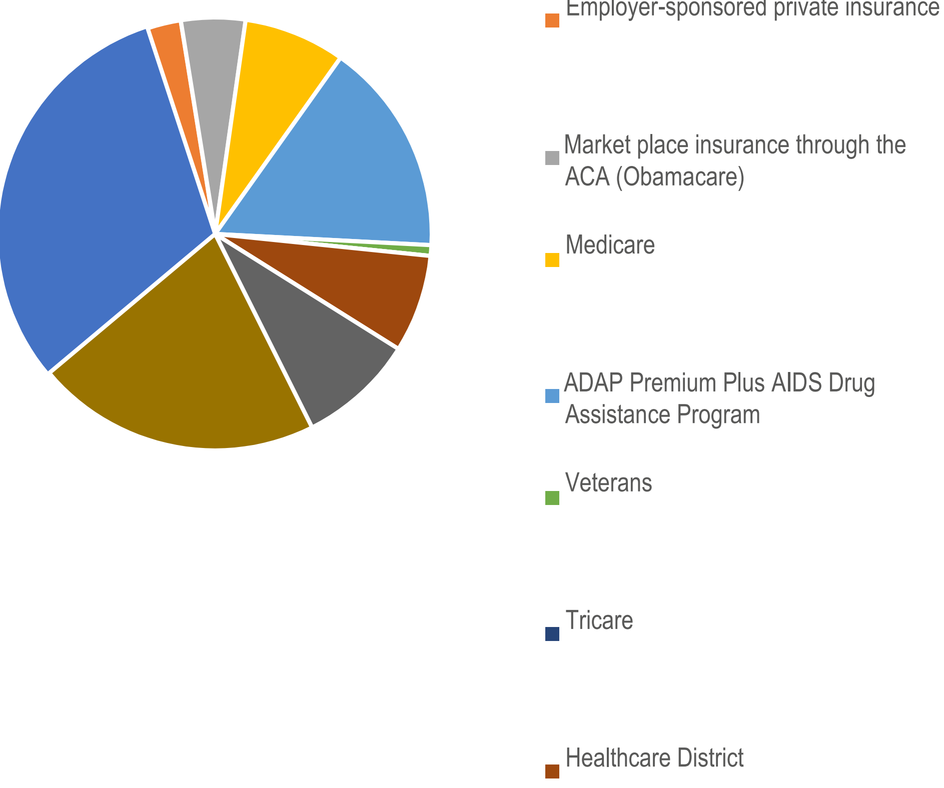
As more clients enroll in health insurance, they will be able to access other services outside of the Ryan White network and therefore improve overall health and wellness.

Table 34: Respondents by Type of Health Insurance, Palm Beach County Client Survey, 2016

Type of Health Insurance	Number	Percentage
Medicaid	111	31.1%
Employer-sponsored private insurance	9	2.5%
Market place insurance through the ACA (Obamacare)	17	4.8%
Medicare	27	7.6%
ADAP Premium Plus AIDS Drug Assistance Program	57	16.0%
Veterans	3	0.8%
Tricare	0	0.0%
Healthcare District	26	7.3%
Other Private Insurance	31	8.7%
No Response	76	21.3%
Total	357	100.0%

Figure 18: Respondents by Type of Health Insurance, Palm Beach County Client Survey, 2016

Medicaid


Employer-sponsored private insurance
Market place insurance through the ACA (Obamacare)
Medicare
ADAP Premium Plus AIDS Drug Assistance Program
Veterans
Tricare
Healthcare District

Patient Satisfaction

A total of two hundred ninety-six participants answered the question, *"How would you rate your satisfaction with the health insurance that you currently have?* The responses available were:

- *'I am very satisfied'*
- 'I am satisfied'
- 'Neutral'
- 'I am dissatisfied'
- I am very dissatisfied'

One hundred ninety-seven (55.2%) participants responded, *'I am very satisfied'*, forty-seven (13.2%) participants responded, *'I am satisfied',* twenty-nine *(8.1%)* participants responded *'Neutral',* thirteen (3.6%) reported *'I am dissatisfied',* and ten *(2.8%)* responded *'I am very dissatisfied'.* This evidence suggests that most of the sample population is satisfied with their health insurance and therefore the health insurance coverage is meeting their needs.

Table 35: Respondents by Level of Satisfaction with Health Insurance, Palm Beach County Client Survey, 2016

Level of Satisfaction with Health Insurance	Numbe r	Percentage
I am very satisfied	197	55.2%
I am satisfied	47	13.2%
Neutral	29	8.1%
I am dissatisfied	13	3.6%
I am very dissatisfied	10	2.8%
No Response	61	17.1%
Total	357	100.0%

The follow-up question to the previous asked, “*If you rated your satisfaction with your insurance as neutral or below, what are some aspects of your insurance you are dissatisfied with? Mark all that apply.”* Two hundred sixty-eight participants answered this question, and 89 participants skipped the question. More than half (57.1% or 204) respondents reported satisfaction with their health insurance. Twenty-one (5.9%) listed ‘*The co-pays on visits/medications are too high*’, twenty-six (7.3%) reported, ‘*It does not cover all the providers I want (e.g. I had to change doctors)’,* eight (2.2%) participants reported *‘My premiums are too high’*, seven (2.0%) reported ‘*My deductible is too high’*, and four (1.1%) respondents reported ‘*I do not like my doctor but I cannot find another one in my area that my insurance will cover*’.

It is important to note that costs and lack of coverage influence clients’ satisfaction with health insurance, which also affects their ability to obtain services such as doctor’s visits and medications.

Table 36: Respondents by Cause for Dissatisfaction with Health Insurance, Palm Beach County Client Survey, 2016

Cause for Dissatisfaction with Health Insurance	Number	Percentage
This does not apply to me. I am satisfied with my health insurance	204	57.1%
The co-pays on visits/medications are too high	21	5.9%
My premiums are too high	8	2.2%
My deductible is too high	7	2.0%
It does not cover all the providers I want (e.g. I had to change doctors)	26	7.3%
I do not like my doctor but I cannot find another one in my area that my insurance will cover	4	1.1%
I don’t understand how it works	17	4.8%
No Response	89	24.9%

Three hundred forty-nine participants answered the next question, *“Do you have a doctor that you regularly see for HIV/AIDS medical care?*” Most (83.8% or 299) respondents reported ‘*Yes’*

and fifty (14.0%) respondents reported '*No*'. This data suggests that most clients regularly seek medical care and treatment, however the term "regularly" is subjective and while 100% indicated consistent care, this does not align with the "Linkage Gap" observed in Palm Beach County's HIV Continuum of Care for retention in care.

Table 37: Respondents by Use of Regular Doctor for Medical Care, Palm Beach County Client Survey, 2016

Use of Regular Doctor for Medical Care	Number	Percentage
Yes	299	83.8%
No	50	14.0%
No Response	8	2.2%
Total	357	100.0%

The following question asked, *"How would you rate your satisfaction with the health doctor you usually see for your HIV/AIDS care?"* Over half (63.9% or 228) of respondents reported, *'I am very satisfied,'* forty-seven (13.2%) reported, *'I am satisfied,'* twenty-eight (7.8%) of participants reported, *'I am dissatisfied' and one (0.3%) participant reported 'I am very dissatisfied'*. This evidence suggests that clients typically have positive experiences with their medical doctor, which is an important factor in retention to care.

Table 38: Respondents by Level of Satisfaction with Medical Doctor, Palm Beach County Client Survey, 2016

Level of Satisfaction with Medical Doctor	Number	Percentage
I am very satisfied	228	63.9%
I am satisfied	47	13.2%
Neutral	28	7.8%
I am dissatisfied	7	2.0%
I am very dissatisfied	1	0.3%
No Response	46	12.9%
Total	357	100.0%

The next question asked, *"If you rated your satisfaction with your provider as neutral or below, what are some reasons why you are dissatisfied? Mark all that apply."*

The following were the response options:

- *'This does not apply to me. I am satisfied with my health care provider.'*
- *'I feel like my health care provider judges me'*
- *'I feel like my health care provider doesn't know enough about HIV/AIDS'*
- *'I feel like I cannot trust my health care provider'*
- *'I feel like my health care provider doesn't care about me'*
- *'The duration of the visit is too short and rushed'*
- *'It takes a long time to get an appointment'*
- *'It is far to go for the appointment'*
- *'Other (please specify)'*

Two hundred sixty-seven individuals responded to the question. 227 or 59.3% of participants reported, *'This does not apply to me. I am satisfied with my health care provider'*, thirteen (3.4%) participants reported, *'It takes a long time to get an appointment'*, twelve (3.1%) reported, *'I feel like my health care provider doesn't really listen to me',* nine (2.3%) reported *'The duration of the visit is too short and rushed',* six (1.6%) reported *'I feel like my health care provider judges me',* five (1.3%) reported *'I feel like my health care provider doesn't know enough about HIV/AIDS',* four (1.0%) reported *'I feel like I cannot trust my health care provider',* four (1.0%) reported *'I feel like my health care provider doesn't care about me'* and three (0.8%) reported *'It is far to go for the appointment'.*

This data is important to note because doctors and other medical providers can have a direct impact on helping to retain clients in medical care.

Table 39: Respondents by Cause for Dissatisfaction with Medical Doctor, Palm Beach County Client Survey, 2016

Cause for Dissatisfaction with Medical Doctor	Number	Percentage
This does not apply to me. I am satisfied with my health care provider	227	59.3%
I feel like my health care provider judges me	6	1.6%
I feel like my health care provider doesn't know enough about HIV/AIDS	5	1.3%

I feel like I cannot trust my health care provider	4	1.0%
I feel like my health care provider doesn't really listen to me	12	3.1%
I feel like my health care provider doesn't care about me	4	1.0%
The duration of the visit is too short and rushed	9	2.3%
It takes a long time to get an appointment	13	3.4%
It is far to go for the appointment	3	0.8%
Other	10	2.6%
No Response	90	23.5%

AIDS Drug Assistance Program (ADAP)

The following questions asked about the Aids Drugs Assistance Program (ADAP) application process as well as the services. The survey asked, “*Between June 1st, 2015 and May 31st, 2016, have you had difficulty getting HIV medications for any of the following reasons?*” About half of participants reported ‘No’ to all the ADAP related questions. This data suggests a need to assist individuals in the eligibility and application process.

Table 40: Respondents by Difficulty with ADAP, Palm Beach County Client Survey, 2016

Type of ADAP Difficulty	Yes		No		N/A	
	Number	Percent	Number	Percent	Number	Percent
Long wait to get an appointment with case worker or doctor	55	15.4%	213	59.7%	75	21.0%
Difficulty with the ADAP application process	46	12.9%	178	49.9%	115	32.2%
Unenrolled from ADAP without an explanation	32	9.0%	167	46.8%	139	38.9%
Difficulty seeing case worker or doctor at least twice a year to remain enrolled in ADAP	46	12.9%	177	49.6%	113	31.7%

The table below shows responses regarding ADAP funds that can cover health insurance costs and hardship exemptions. One hundred fifty-three (2.9%) of participants reported that they were not aware that *‘ADAP can cover “hardship exemptions”* and 123 (34.5%) of participants reported that they were not aware that ADAP can cover costs associated with health insurance. This data shows the need for improved awareness and education about ADAP and its benefits that can reduce financial burdens for clients who have a financial need.

Table 41: Respondents by Knowledge of ADAP Coverage, Palm Beach County Client Survey, 2016

Knowledge of ADAP Coverage	Yes		No		N/A	
	Number	Percent	Number	Percent	Number	Percent
ADAP can cover health insurance costs	106	29.7%	123	34.5%	112	31.4%
ADAP can cover “hardship exemptions”	93	26.1%	153	42.9%	95	26.6 %

Disclosure of Status

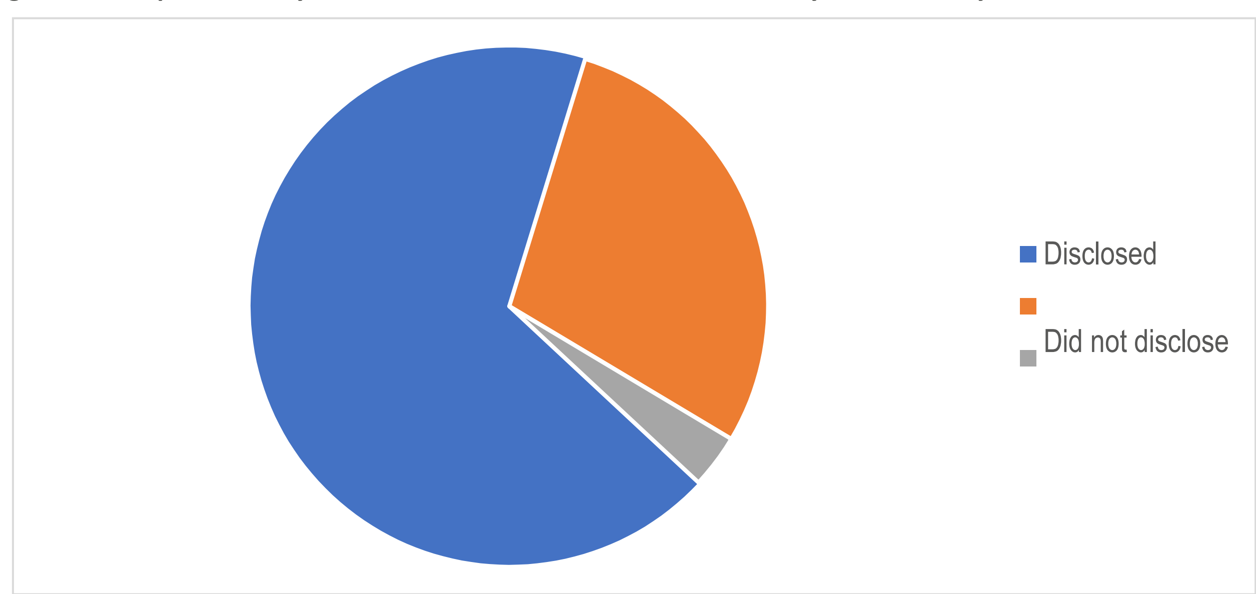
The next questions asked participants, "*Have you disclosed your HIV status to anyone? (If no skip to question 46)*".

Three hundred forty-five participants answered this question. More than two-thirds (67.8%) of participants responded 'Yes'. This suggests reduction in stigma and other factors that affect clients' willingness and likeliness of disclosing their status, which contributes to isolation, lack of support and stress.

Table 42: Respondents by HIV Status Disclosure, Palm Beach County Client Survey, 2016

HIV Status Disclosure	Number	Percentage
Yes	242	67.8%
No	103	28.9%
No response	12	3.4%
Total	357	100.0%

Figure 19: Respondents by HIV Status Disclosure, Palm Beach County Client Survey, 2016

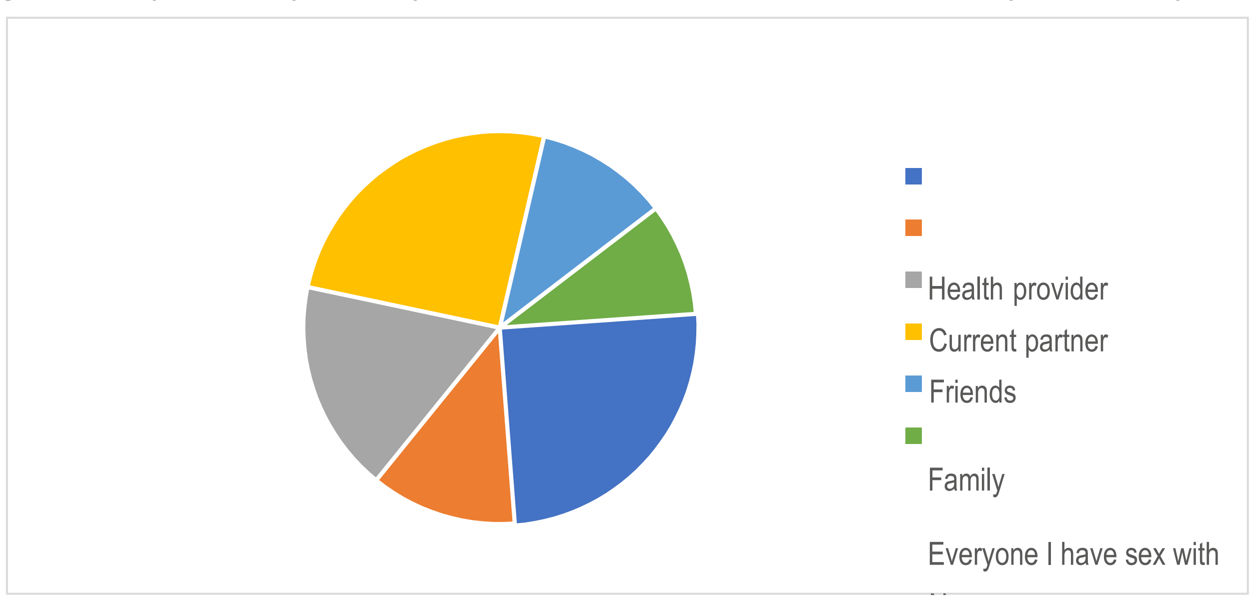


The next question asked, *"Who have you disclosed your HIV status to?* Sixty-one participants answered this question and they selected all answers that applied to them. Of the 287 that reported, 191 (66.6%) of participants reported, *'Family'*, 188 (65.5%) reported *'Health Provider'*, 132 (46.0%) reported *'Friends'* and ninety-one (31.7%) reported *'Current partner'*. Eighty-three (28.9%) of the participants reported disclosing their status to everyone they have sex which points to a larger issue of disclosure, the fear of retaliation and perception of risk living with HIV/AIDS. It is noteworthy that respondents were much more likely to disclose their status to family versus sexual partners. This suggests that trust and comfort level affects individual's decision to disclose more than the risk of transmission.

Table 43: Respondents by who they disclosed their HIV status to, Palm Beach County Client Survey, 2016

Person Disclosed to	Number	Percentage
Health provider	188	65.5%
Current partner	91	31.7%
Friends	132	46.0%
Family	191	66.6%
Everyone I have sex with	83	28.9%
No response	70	24.4%

Figure 20: Respondents by who they disclosed their HIV status to, Palm Beach County Client Survey, 2016



HIV & Prevention

Most (337) participants answered the next question, *"Did you talk to your partner about taking medication to prevent HIV? (PrEP)."* Ninety-seven (27.2%) of respondents reported, *'No, I currently do not have a sexual partner,'* ninety-one (25.5%) reported *'Yes and he/she is taking medication,'* seventy- six (21.3%) reported, *'No, I have not yet had the conversation,'* thirty-two, (9.0%) reported*, 'No, but he/she is also HIV+,'* twenty-seven (7.6%) reported *'Yes but he/she decided not to take the medication,'* and fourteen respondents reported, *'No, I do not know there are medications to prevent HIV.'*

Table 44: Respondents by Conversation with partner about taking Medication to Prevent HIV, Palm Beach County Client Survey, 2016

Conversation with Partner about Medication to Prevent HIV	Number	Percentage
Yes, and he/she is taking medication	91	25.5%
Yes, and he/she decided not to take medication	27	7.6%
No, but he/she is also HIV+	32	9.0%
No, I currently do not have a sexual partner	97	27.2%
No, I do not know there are medications to prevent HIV	14	3.9%
No, I have not yet had the conversation	76	21.3%
No response	20	5.6%
Total	357	100.0%

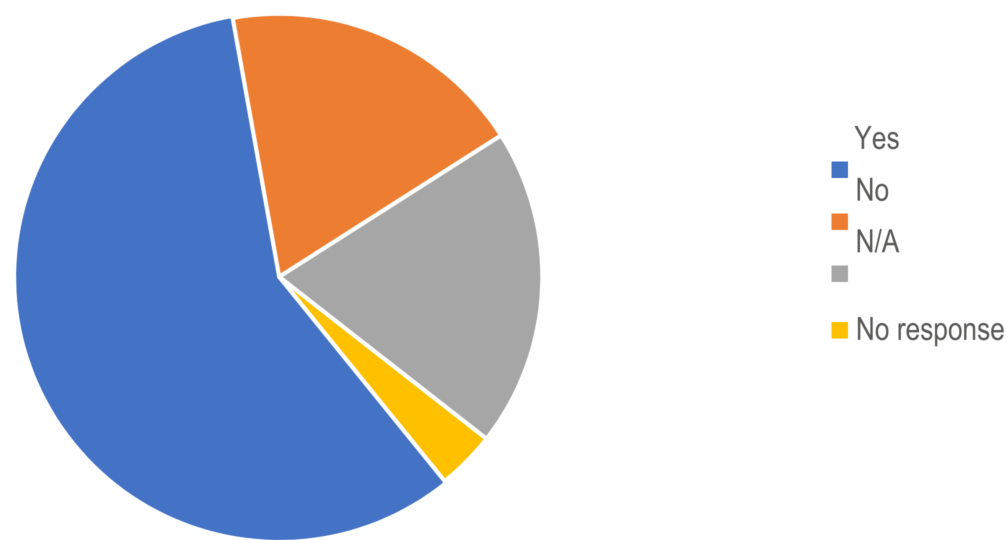
Condom Usage

The next question asked, *"Do you always wear a condom?"* Most (344) respondents answered this question, with 58.0% (207) of participants responding *'Yes'*, 19.6% responded *'N/A,'* and 18.8% responded *'No.'*

Table 45: Respondents by Condom Usage, Palm Beach County Client Survey, 2016

Condom Usage	Numbe r	Percentag e
Yes	207	58.0%
No	67	18.8%
N/A	70	19.6%
No response	13	3.6%
Total	357	100.0%

Figure 21: Respondents by Condom Usage, Palm Beach County Client Survey, 2016



The next question was a follow-up question regarding the reasons for not using condoms. The question asked, “If no, what are the reasons you do not?” Eighty participants answered this question and ‘I don’t like the way condoms feel’ was the reason reported most frequently (31.3% or 25).

The responses listed for ‘Other’ were:

- Not sexually involved
- Abstinent
- In a monogamous relationship
- Don’t like using condoms

It is important to note that the response, “My partner does not like to use condoms” points to the power dynamics in sexual relationships. In addition, the responses, “My partner is also HIV positive,” “I don’t like the way condoms feel,” “I’m on birth control, or my partner is,” suggests a lack of awareness about re-infection and virus resistance, which can hinder the ability to effectively treat the disease.

Lastly, a few (5) respondents mentioned that “[they] don’t want to spend money on condoms.

Table 46: Respondents by Barriers to Condom Use, Palm Beach County Client Survey, 2016

Barriers to Condom Use	Number	Percentage
I don’t like the way condoms feel	25	31.3%
My partner is also HIV positive	16	20.0%
My partner does not like to use condoms	16	20.0%
Not enough time	4	5.0%
I’m on birth control or my partner is	3	3.8%
I don’t want to spend money on condoms	5	6.3%
Other	20	25.0%
No response	277	346.3%

Prevention Information

The next set of questions asked participants about prevention related information if, *"In the last six months have you received information on:"*

- *'How to prevent HIV transmission'*
- *'How to protect one's-self from reinfection'*
- *'How to use a condom or other barrier'*
- *'How viral load is linked to HIV prevention'*
- *'How to talk to partners about condom use'*
- *'How to disclose HIV status to partners'*
- *'How to clean needles or other items that cause infection'*

Over seventy percent of participants reported *'Yes'* for *'How to prevent HIV transmission'*, *'How to protect one's-self from reinfection', 'How to use a condom or other barrier', 'How Viral Load is linked to HIV prevention'*, *'How to talk to partners about condom use'* and *'How to disclose HIV status to partners'*.

Almost fifty percent (177) of participants reported *'Yes'* for *'How to clean needles or other items that can cause infection'.*

Table 47: Respondents by Prevention Information Type of Prevention Information Received, Palm Beach County Client Survey, 2016

HIV Prevention Information	Yes		No	
	Number	Percent	Number	Percent
How to prevent HIV transmission	284	79.6%	64	17.9%
How to protect one's-self from reinfection	281	78.7%	68	19.0%
How to use a condom or other barrier	283	79.3%	65	18.2%
How Viral Load is linked to HIV prevention	282	79.0%	65	18.2%
How to talk to partners about condom use	275	77.0%	72	20.2%
How to disclose HIV status to partners	267	74.8%	79	22.1%
How to clean needles or other items that can cause infection	177	49.6%	159	44.5%

The next question was a follow-up question to the previous question. The survey asked, *"Where did you receive the information above*?" Three hundred twenty-eight respondents answered this question and selected all answers that applied to them. The majority, 61.3%, of participants responded, '*Medical Provider,'* about half responded, '*Case manager,'* just about 12% responded 'Internet Search,' and just under 5% reported utilizing social media. Another 12.8% (42) reported receiving prevention information from their family members or friends. And 20.1% selected '*Other.'*

The following are the responses from participants who responded '*Other'*

- Walk In clinic
- School
- Community Organizations
- Educators
- Jail/Prison
- Outreach workers
- AA meetings
- Jerome Golden Center
- Own knowledge
- Television, radio, magazines
- Peer Mentors
- Department of Health
- Nurses

Table 48: Respondents by Where Prevention Information was Received, Palm Beach County Client Survey, 2016

Source of Prevention Information	Number	Percent
Medical Provider	201	61.3%
Case Manager	163	49.7%
Internet Search	38	11.6%
Social Media	16	4.9%
Family member or friend	42	12.8%
Other	66	20.1%

The next question asked, *"Where do you generally receive health-related information."* Three hundred thirty-eight respondents answered this question and were asked to select all

answers that applied to them. The category with the most responses, 73.1% (247) was *'Medical provider'*, 'Case Manager' was selected by 46.2% (156) of respondents, 'Internet Search' was selected by 15.7% (53) of respondents, 'Family member or friend' was selected by 12.1% (41), and 'Social Media' was selected by 4.4% (15) respondents.

For “Other”, participants listed:

- Community Organizations
- Word of mouth
- Walk in Clinic
- YouTube
- Employer
- Jail/Prison
- Health Fairs

- Cell phone
- AA Meetings/Support Groups
- Outreach
- Books/Literature
- Hospital
- Radio/TV

Health Department

Priorities and Allocations Process

Policy Number 31

Policy Number: **31**
Created: **May 11th 2022**
Issue: **Resource Allocation and Reallocation Process for RWHAP Part A/MAI Funding**

This policy determines the process for the CARE Council to allocate and reallocate RWHAP Part A/MAI funding. The policy works to ensure the National HIV/AIDS Fiscal Monitoring Standards are followed; specifically the standards for the EMA. Demonstrate the ability to expend fund efficiently by expending 95% of its formula funds in any grant year, have an annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB and recognize the consequences of unobligated balances and evidence of plans to avoid a reduction of services. Penalties include: Future year award offset by the amount of the unobligated balance less any approved carry over. Future year award reduced by amount of unobligated balance less the amount of approved carry over. Not eligible for a future year supplemental award.

The CARE Council shall approve the budget for the RWHAP grant application using the process below:

- Recipient shall prepare and present data from prior grant year at annual data presentation.
- Data presented should include: prior grant year expenditures, utilization, cost analysis by service category, needs assessment (including unmet need), quality management metrics and indicators, epidemiological profile, resource inventory, and any other relevant data as requested. Data relevant to MAI populations shall be presented separately from Part A. (Target completion date: May)
- Recipient shall determine the amount of funding available for allocations for Part A and

- MAI based on the funding ceiling established by grant guidance. (Target completion date: Upon release of grant guidance)
- Recipient shall determine the maximum funding amount: Part A and MAI Administration 10%, CQM 5%, Part A and MAI Services 85% (core 75% and support services 25%). (Target completion date: Upon release of grant guidance)
- The Recipient prepares and presents all of the above and an allocation spreadsheet to
- Priorities and Allocations Committee for priority setting and resource allocation process. (Target completion date: June)
- Recipient shall prepare and present allocation proposal from Priorities and Allocations Committee to CARE Council. (Target completion date: June)

The CARE Council shall approve carryover request for Unobligated Balance Allocation using the process below:

- Recipient shall determine the amount of the unobligated balance available for allocations
- for Part A and MAI based on the final expenditure report for prior grant year. (Target
- completion date: July)
- Recipient shall prepare and present unobligated balance amount in reallocation worksheet
- to Priorities and Allocations Committee. (Target completion date: July/August)

This policy determines the process for the CARE Council to allocate and reallocate RWHAP Part A/MAI funding. The policy works to ensure the National HIV/AIDS Fiscal Monitoring Standards are followed; specifically the standards for the EMA to 1. Demonstrate the ability to expend fund efficiently by expending 95% of its formula funds in any grant year, have an annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB in the Federal Financial Report (FFR), and recognize the consequences of unobligated balances and evidence of plans to avoid a reduction of services. Penalties include: a. Future year award offset by the amount of the unobligated balance less any approved carry over b. Future year award reduced by amount of unobligated balance less the amount of approved carry over c. Not eligible for a future year supplemental award.

- Recipient shall prepare and present allocation proposal from Priorities and Allocations Committee to CARE Council. (Target completion date: August)

The CARE Council shall approve a reallocation plan using the process below:

- Recipient, within the first 6 months of the grant year, shall evaluate and project the
  - expenditures and service utilization.
  - Recipient shall provide the reallocation recommendations to the Priorities & Allocations

- (P&A) Committee, for review. Their final recommendation shall be submitted to the CARE
- Council for review.
- The CARE Council shall review the reallocation plan and approve it or
- amend it as necessary

This policy, in no case, shall conflict with the CARE Council Bylaws or related

Policies and Procedures

Month Year

Palm Beach County HIV CARE Council

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

All meetings will be held via Webex & in-person

ALL MEETINGS WILL BE HELD AT COMMUNITY SERVICES - 810 Datura Street, West Palm Beach, FL 33401 or **Mayme Frederick Building 1440 Martin Luther King Blvd Riviera**

For more details visit: http://discover.pbcgov.org/carecouncil/Lists/Ryan%20White%20Calendar/calendar.aspx

FOR UPDATES VISIT: www.carecouncil.org *ALL MEETINGS ARE SUBJECT TO CHANGE*

CARE Council Member/Committee Members

Mileage Reimbursement Form

Name: Mary Jane Reynolds — Role: CARE Council Member

Date	Place of Origin (Location & City)	Place of Destination (Location & City)	Miles Driven
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Total Miles x $ 0.545 = ________

Total = ___________

ACCOUNT NUMBER

1010-142-1475-4007-RC13-GY22

Month: ______________________________ Year:_______

I HEREBY CERIFY THAT THE ABOVE EXPENSES HAVE BEEN INCURRED BY THE UNDERSIGNED IN THE PERFORMANCE OF MY OFFICIAL DUTIES AND THAT THESE COSTS HAVE NOT BEEN PAID OR REIMBURSED FROM ANY OTHER SOURCE. I ALSO CERTIFY THAT I AM IN Compliance with AUTOMOBILE LIABILITY INSURANCE COVERAGE IN F.S. 324.02 (7) PROOF OF FINANICIAL RESPONSIBILITY.

Traveler's Signature: ______________________________Date__________

Traveler's Name: Mary Jane Reynolds

Year & Make of Vehicle: ______________________________

____

Approving Authority

 Dev. NM

Bylaws Ad hoc Meeting Agenda

Date, Time & Location

Join from the meeting link

https://pbc-gov.webex.com/pbc-gov/j.php?MTID=mb26e11f2efffeb60e31e5516e55edd1c [pbc-gov.webex.com]

Location: 1440 martin Luther King Jr Blvd, Riviera Beach, Florida -33404

I. Call to order. Roll, Introduction of Guests

II. A Moment of Reflection

A Moment of Silence

A moment of silence is observed in respect to the memory of those individuals who have succumbed to AIDS and those who are living with HIV. Let us remember why we are here today. Let us have the strength to make the decisions that will improve the care of those we serve. Let us be thankful for what we have accomplished to date.

III. Acceptance of the Current Date Committee Meeting Agenda

IV. Acceptance of Last Committee Meeting Minutes

V. Comments by the Chair:

VI. Comments by the Staff

VI. Old Business:

VII. New Business:

VIII. Other Business:

IX. Announcement

X. Adjournment:

**Conflict of Interest*

A CARE Council member who has an identified conflict of interest must abstain from voting on issues related to that conflict. A member who does not abstain from voting on issues where a conflict is identified by the County's Commission on Ethics designated legal counsel may be removed from the CARE Council.

Note: If you have any questions or require special accommodations, please contact Dr. Casey Messer at 561-355-4730 or CMesser@pbcgov.org.

PLANNING COUNCIL PRIMER

JUNE 2018

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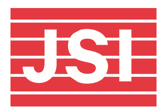
Planning Council and Transitional Grant Area Planning Body Technical Assistance Cooperative Agreement. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



EGM Consulting, LLC

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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."[2] 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[3] 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.

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

[3] 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

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.

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[4], as outlined in the legislation. Therefore this Primer should be useful to planning bodies as well as planning councils.

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[4] HRSA/HAB Letter to RWHAP Part A Grantees, 2013. Available at https://hab.hrsa.gov/sites/default/files/hab/Global/transitionalgrantareasplanningcouncilsmovingforward.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 HIVrelated medications through the AIDS Drug Assistance Program (ADAP)
- **RWHAP Part C:** Communitybased early intervention services grants for HIV medical care and support services
- **RWHAP Part D:** Communitybased grants for familycentered 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.

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

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 FDAapproved 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.

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 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 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 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 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 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 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

HRSA	CEO	PLANNING COUNCIL	RECIPIENT	CONTRACTED SERVICE PROVIDERS
• awards RWHAP funds to EMA/TGA	• receives funds • delegates administration of funds to the recipient • establishes the planning council	• assesses needs of local people living with HIV • sets services priorities • allocates resources • issues service directives	• contracts with service providers in line with planning council priorities, allocations and directives	• deliver medical care and support services to people living with HIV living in the EMA/TGA • comply with fiscal and program reporting requirements of the recipient

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.

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 HIVrelated services
- Assessment of the efficiency of the administrative mechanism
- Development of service standards
- Evaluation of program effectiveness (optional)

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 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"[5] 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 CoChairs, 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

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[5] 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" 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.[6]

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.

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[6] 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.

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

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.

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

Establishing service standards is a shared responsibility of the recipient and the planning council. While it is ultimately the responsibility of the recipient to ensure that service standards are in place, the planning council typically takes the lead in developing service standards for funded service categories.[6] ***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.

6 Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/ Planning Bodies. 2014. Available at www.targethiv.org/servicestandards

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.

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.

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 (which- ever 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.

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-cearly-intervention-services-and-capacity-development-programgrants

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) #1602, 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

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]	• Initial closeout of prior program year • Submission of Ryan White Services Report (RSR) • Review/preparation of response to conditions of award • Contracting with providers

	• Needs assessment (continued) • Review of progress on Integrated Plan	
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

Glossary

Accountability: A framework that has been created to determine how a group and its members will be responsive and responsible to itself and the community.

ACTG (AIDS Clinical Trials Group): A network of medical centers around the country in which federally-funded clinical trials are conducted to test the safety and efficacy of experimental treatments for AIDS and HIV infection. These studies are funded by the National Institute of Allergy and Infectious Diseases (NIAID).

Acute: Reaching a crisis quickly; very sharp or severe.

ADAP (AIDS Drug Assistance Program): A State-administered program authorized under Part B of the Ryan White Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

Administrative Agent or Fiscal Agent: An organization, agent, or other entity (i.e., public health department or community based organization) which assists a grantee in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals (RFPs), monitoring contracts). Not all grantees use a separate administrative or fiscal agent.

Advocacy: Representation of the needs of a particular community. This can involve education of health and social service providers, local policy makers, elected officials and the media.

AETC (AIDS Education and Training Center): Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White Act and administered by HRSA=s HIV/AIDS Bureau=s Division of Training and Technical Assistance (DTTA).

Affected Communities: Groups of people who are either infected with the HIV virus or who are family members/significant others of infected individuals.

Aggregate Data: Combined data, composed of multiple elements, often from multiple sources; for example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.

AIDS (Acquired Immunodeficiency Syndrome): A severe immunological disorder caused by a retrovirus and resulting in susceptibility of opportunistic infections and certain rare cancers. This disease is caused by the human immunodeficiency virus (H.I.V.).

AIDS Network: The AIDS Network were established to plan, develop and deliver comprehensive health and support services to meet the identified needs of individuals with HIV/AIDS in a cost effective manner. The Florida Legislature funds the Network. The department is ultimately responsible and accountable to the legislature for the network=s appropriate utilization of the funds as established.

Allocation: Total dollar amount that may be expended for a service category.

Antibody: A substance in the blood formed in response to invading disease agents such as viruses, bacteria, fungi and parasites. Antibodies defend the body against invading disease agents. Most HIV tests are antibody test including ELISA, Synthetic Peptide, Western Blot.

Antiretroviral: A substance that fights against a retrovirus, such as HIV.

ASO (AIDS Service Organization): An organization which provides medical or support services primarily or exclusively to populations infected with and affected by HIV disease.

At-Risk Communities: Specific groups of people in a defined area who have a greater chance of becoming HIV-infected due to behaviors of actions common to the group (i.e., injection drug users, men who have sex with men).

Attitude: A state of mind or feeling regarding a particular subject.

Average: A way of describing the typical value or central tendency among a group of numbers, such as average age or average income.

Bar Graph or Bar Chart: A visual way to show and compare scores or values for different categories of variables; for example, a bar chart might be used to show the number of reported AIDS cases who are from each major racial/ethnic group; the taller the bar, the larger the number of AIDS cases.

Behavioral Risk Factor Surveillance System (BRFSS): A telephone survey conducted by most states which provides information about a variety of health risk behaviors from smoking and alcohol use to seat belt use and knowledge of HIV transmission.

Behavioral Science: A science, such as psychology of sociology, that seeks to survey and predict responses (behaviors and actions) of individuals or groups of people to a given situation (i.e. why people do what they do).

BHRD (Bureau of Health Resources Development): Bureau within the Health Resources and Services Administration (HRSA, [her-sa]), U.S. Department of Health and Human Services, which is responsible for administering the Ryan White Part A, Part B and SPNS (Special Projects of National Significance), among other programs.

Bylaws: Standing rules written by a group to govern their internal function; address issues of voting, quorums, attendance, etc.

Capacity Development: Building the abilities and knowledge of individuals or groups so they may fully participate in a process or organization**.***

Casual Contact: Normal day-to-day contact (i.e, shaking hands among people at home, school, work or in the community).

CBO (Community Based Organization): An organization which provides services to locally- defined populations, which may or may not include populations infected with or affected by HIV disease.

CDC (Centers for Disease Control and Prevention): The Department of Health and Human Services (DHHS) agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants and publishes epidemiologic reports such as the HIV/AIDS *Surveillance Report*.

CD4 or CD4+Cells: Also known as T-cells, these cells are responsible for coordinating much of the immune response. HIV=s preferred targets are cells that have a docking molecule called acluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and increasing CD4 levels appear to be the best indicator for developing opportunistic infections.

CD4 Cell Count: The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm3. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.

CEO: (Chief Elected Official): The official recipient of the Ryan White Part A funds within the EMA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the Ryan White Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Ryan White Part A funds is the CEO of the city or urban county that administers the public health agency that provides out patient and ambulatory services to the greatest number of people with AIDS in the EMA. In Palm Beach County the CEO is the Board of County Commissioners.

Chronic: A prolonged, lingering or recurring state of disease.

Closed- Ended Questions: Questions in an interview or survey format that provide a limited set of predefined alternative responses; for example, a survey might ask PLWH/A respondents if they are receiving case management services, and if they say yes, ask about how often have you been in contact with your case manager for services during the past six months, either in person or by telephone?@and provide the following response options: Once a week or more, 2-3 times a month,

about once a month, 3-5 times, 1-2 times, not at all.

Coalesce: To grow together in order to form one whole unit.

Coalition: An alliance of community groups, organizations or individuals to meet a goal or purpose.

Coding: The process the data from one format to another, usually so the information can be entered into a computer to be tabulated and analyzed; often, coding involves assigning numbers to all the possible responses to a question, such as Yes=1, No=2, Not Sure =3, No Response=0.

Collaboration: A group of people or organizations working together to solve a problem in a process where individual views are shared and discussed and may be changed as the group progresses toward its goals.

Community: A group of people living in a defined area who share a common language, ethnicity, geographic area, behavior or belief.

Co-Morbidity: A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Comprehensive Planning: The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision making about services and maintain a continuum of care for PLWH/As.

Compromise: A give and take process where all points of view are considered and weighed in order to reach a common plan or goal.

Conflict: A disagreement among two or more parties.

Conflict of Interest: A conflict between one=s obligation to the public good and one=s self-interest. For example, if the board of a community-based organization is deciding whether to receive services from Company A, and one of the board members also owns stock in Company A, that person would have a *conflict of interest.*

Confidentiality: Keeping information private or secret.

Consortium/HIV Care Consortium: A regional or Statewide planning entity established by many State grantees under Ryan White Part B to plan and sometimes administer Part B services. An association of health care and support service providers that develops and delivers services for PLWH/A under Ryan White Part B.

Continuity: Having the same or a similar situation, person or group over a period of time.

Continuum of Care: An approach that helps communities plan for and provide a full range of

emergency and long-term service resources to address the various needs of PLWH/A.

Cost Effective: Economical and beneficial in terms of the goods or services received for the money spent.

County Health Department AIDS Patient Care: This funding is used for patient care services. An allocation is received by 29 of the 67 County Health Departments (CHD). The CHDs send Annual Plans to the Bureau of HIV/AIDS and report regularly as to the spending by category of these funds.

Cultural Competence: The knowledge, understanding and skills to work effectively with individuals from differing cultural backgrounds.

Data: Information that is used for a particular purpose.

Data Analysis: Careful, rigorous study of data; usually involves studying various elements of information and their relationships.

DCBP (Division of Community Based Programs): The division within HRSA=s HIV/AIDS Bureau that is responsible for administering Ryan White Part C and Part D, and the HIV/AIDS Dental Reimbursement Program.

Decimal Places: Number of digits to the right of the decimal point, which separates numbers with a value greater than one from numbers with a value of less than one; the more numbers or decimal places used, the more precise the number; for example, 34.03 has two decimal places.

Defined Populations: People grouped together by gender, ethnicity, age, or other social factors.*

Dementia: The loss of metal capacity that affects a person=s ability to function.

Department of Health and Human Services (DHHS): The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS includes more than 300 programs, covering a wide spectrum of activities. The Department's programs are administered by 11 operating divisions such as the Centers for Disease Control and Prevention, the Food and Drug Administration and the National Institutes of Health (see the entries for these agencies). DHHS works closely with state and local governments, and many DHHS-funded services are provided at the local level by state or county agencies, or through private-sector grantees. **Internet address:** **http://www.hhs.gov/.**

DHS (Division of HIV Services): The entity within Bureau of Health Resources Development (BHRD) responsible for administering Ryan White Part A and B.

Diagnosis: Confirmation of illness based on an evaluation of a patient medical history.

Dispute: A conflict in which the parties involved have brought an internal disagreement.

Diverse/Diversity: Made up of all kinds; a variety of people and perspectives in one organization, process, etc.

Double blind Study: A clinical trial design in which neither the participating individuals nor the study staff know which patients are receiving the experimental drug and which are receiving a placebo or another therapy. Double-blind trials are thought to produce objective results, since the expectations of the doctor and the patient about the experimental drug do not affect the outcome. See Blinded Study.

Drug Resistance: The ability of some disease-causing microorganisms, such as bacteria, viruses, and mycoplasma, to adapt themselves, to grow, and to multiply even in the presence of drugs that usually kill them. See Cross-Resistance.

DSS (Division of Service Systems): The division within HRSA HIV/AIDS Bureau that is responsible for administering Part A and B (including the AIDS Drug Assistance Program, ADAP).

DTTA (Division of Training and Technical Assistance): The division within HRSA=s HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.

Efficacy: Power or capacity to produce a desired effect. If a prevention program has efficacy, it has been successful in achieving what it was intended to do.

ELISA (Enzymes-Linked Immunosorbent Assay): The most common test used to detect the presence of HIV infection. A positive ELISA test result must be confirmed by another test called a Western Blot.

EMA (Eligible Metropolitan Area): The geographic area eligible to receive Ryan White Part A funds. The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend over more than one state.

Encephalitis: A brain inflammation of viral or other microbial origin. Symptoms include headaches, neck pain, fever, nausea, vomiting, and nervous system problems. Several types of opportunistic infections can cause encephalitis.

Epidemic: A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic disease can be spread from person to person or from a contaminated source such as food or water.

Epidemiologic Profile: A description of the current status and projected future spread of an

infectious disease (an epidemic) in a specified geographic area; one of the required components of a needs assessment.

Epidemiology: The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Ethnicity: A group of people who share the same place or origin, language, race, behaviors, or beliefs.

Etiquette: Different groups who have certain norms for acceptable and unacceptable behavior that is important when conflict arises.

Evidence-based: In prevention planning, evidence is based on scientific data, such as AIDS cases reported to health departments and needs assessments conducted in a scientific manner.

Exposure Category: In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, men who have sex with men, and heterosexual contact.

Family Centered Care: A model in which systems of care under Ryan White Title IV are designed to address the needs of PLWH/As and affected family members as a unit, providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated care givers.

Fiscal Year: A twelve-month period set up for accounting purposes. For example, the federal government=s fiscal year runs from October 1st to September 30th of the following year.

FDA (Food and Drug Administration): The DHHS agency responsible for ensuring the safety and effectiveness of drugs, biologic, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood-banking industry to safeguard the nation=s blood supply.

Financial Status Report (Form 269): A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the grantee organization.

Focus Group: A method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

Formula Grant Application: The application used by EMAs and States each year to request an amount of Ryan White funding which is determined by a formula based on the number of reported AIDS cases in their location and other factors; the application includes guidance from DHS on program requirements and expectations.

Forum: A meeting or other outlets that provides an opportunity to share ideas and concerns on a particular topic in order to resolve disputes.

Frequency Distribution: A tally of the number of times each score or response occurs in a group of scores or response; for example, if 20 women with HIV provided information about how they were infected with the virus, the frequency distribution might be 8=injection drug use, 5= heterosexual contact with an injection drug user, 3=other heterosexual contact, 1= blood transfusion, and 3=don=t know.

Gender: A person=s sex (i.e. male or female)

Generalizability: The extent to which findings or conclusions from a sample can be assumed to be true of the entire population from which the sample was drawn.

Genotypic Assay: A test which analyzes a sample of the HIV virus from the patient=s blood to identify actual mutations in the virus that are associated with resistance to specific drugs.

Grant: The money received from an outside group for a specific program or purpose. A grant application is a competitive process that involves detailed explanations about why there is a need for the money and how it will be spent.

Grantee: The recipient of Ryan White funds responsible for administering the funds. (for a full listing of definitions of grants management terms, see the PHS Grants Policy Statement, which can be accessed at http://www.nih.gov/grants/policy/gps/.)

Guidelines: Rules and structures for creating a program.

HAART (Highly Active Antiretroviral Therapy): An aggressive anti-HIV treatment usually including a combination of two or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels in the blood. There is a question about the virus hiding out in lymph glands, sperm, etc.

HCFA (Health Care Financing Administration): The DHHS agency that is responsible for administering the Medicaid, Medicare, and Child Health Insurance Programs.

Hepatitis: An inflammation of the live, which may be caused by bacterial or viral infection, parasitic infestation, alcohol, drugs, toxins, or transfusion of incompatible blood. Although many cases of hepatitis are not a serious threat to health, the disease can become chronic and can sometimes lead to liver failure and death. There are four major types of viral hepatitis: (1) hepatitis A, caused by infection with the hepatitis A virus, which is spread by fecal-oral contact; (2) hepatitis B, caused by infection with the hepatitis B virus (HBV), which is most commonly passed on to a partner during intercourse, especially during anal sex, as well as through sharing of drug needles; (3) non-A, non-B hepatitis, caused by the hepatitis C virus, which appears to be spread through sexual contact as well as through sharing of drug needles (another type of non-A, non-B hepatitis is caused

by the hepatitis E virus, principally spread through contaminated water); (4) delta hepatitis, which occurs only in persons who are already infected with HBV and is caused by the HDV virus; most cases of delta hepatitis occur among people who are frequently exposed to blood and blood products such as persons with hemophilia.

HICP (Health Insurance Continuation Program): A program authorized and primarily funded under Ryan White Part B that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.

High-Risk Behavior: Actions or choices that may allow HIV to pass from one person to another, especially through activities such as sexual intercourse and injecting drug use.

HIV (Human Immunodeficiency Virus): The virus that causes AIDS.

HIV/AIDS Bureau (HAB): The bureau within the Health Resources and Service Administration (HRSA) of the DHHS that is responsible for administering the Ryan White funding. Within HAB, the Division of Service Systems administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community Based Programs administers Part C, Part D, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau=s Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program.

HIV/EIS (HIV Early Intervention Services/Primary Care): Applied in the outpatient setting, HIV/EIS assures a continuum of care which include: (1) identifying persons at risk for HIV infection and offering them counseling, testing, and referral services, and (2) providing lifelong comprehensive primary care for those living with HIV/AIDS.

HIV/AIDS Dental Reimbursement Program: The program within HRSA=s HIV/AIDS Bureau Division of Community Based Programs that assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV positive patients.

HIV-Related Mortality Data: Statistics that represent deaths caused by HIV infection.

Home- and Community-Based Care: A category of eligible services that States may fund under Ryan White Part B.

Homophobia: An aversion to gay, transgender or homosexual person(s).

HOPWA (Housing Opportunities for Persons With AIDS): A program administered by the U.S. Department of Housing and Urban Development (HUD) which provides funding to support housing for PLWH/A and their families.

HRSA (Health Resources and Services Administration): The DHHS agency that is responsible

for administering the Ryan White Act.

HUD (Department of Housing and Urban Development): The federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for Persons with HIV/AIDS (HOPWA).

IDU/IVDU (Injecting Drug User/Intravenous Drug User): A term used to refer to people who inject drugs directly into their blood streams by using a needle and syringe.

IGA (Intergovernmental Agreement): A written agreement between a governmental agency and an outside agency that provides HIV services.

Immune System: An integrated body system of organs, tissues, and cells within the body that protect it from viruses, bacteria, parasites, and fungi.

Incidence: The number of new cases of a disease that occur during a specified time period.

Incidence Rate: The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 population. AIDS rates are often expressed this way.

Inclusion: An assurance that all affected communities are represented in the community planning process.

Key Informant Interview: A non-survey information collection method involving in-depth interviews with a small number of individuals carefully selected because of their experiences and/or knowledge

related to the topic of interest. An interview guide or checklist is used to guide the discussion. Also called a key person interview.

KS (Kaposi=s Sarcoma): A cancer that can involve the skin, mucous membranes, and lymph nodes; appears as grayish purple spots.

Lead Agency: The agency responsible for contract administration; also called a fiscal agent. An incorporated consortium sometimes serves as the lead agency. The lead agency for HOPWA is the City of West Palm Beach, the lead agency for Part B is Treasure Coast Health Council, the lead agency for County Health Department Patient Care and AIDS Network is the Department of Health.

Leadership: The ability or skills needed to conduct, influence or guide community groups and individuals in any effort, or the process of developing these abilities and skills.*

Lipodystrophy: A disturbance in the way the body produces, uses, and distributes fat. Lipodystrophy is also referred to as "buffalo hump," "protease paunch," or "Crixivan potbelly." In HIV disease, lipodystrophy has come to refer to a group of symptoms that seem to be related to the

use of protease inhibitor drugs. How protease inhibitors may cause or trigger lipodystrophy is not yet known. Lipodystrophy symptoms involve the loss of the thin layer of fat under the skin, making veins seem to protrude; wasting of the face and limbs; and the accumulation of fat on the abdomen (both under the skin and within the abdominal cavity) or between the shoulder blades. Women may also experience narrowing of the hips and enlargement of the breasts.

Macrophage: A type of white blood cell that surrounds and consumes infected cells, disease agents, and dead material.

Maintenance of Effort: The Part A and Part B requirement to maintain expenditures for HIV- related services/activities at a level equal to or exceeding that of the preceding year.

Mandate: A directive or command that can be used to refer to a call for change as authorized by a government agency.

Mean: Arithmetic average calculated by adding up all the values or the responses to a particular question and dividing by the number of cases; for example, to determine the mean age of 12 children in a pediatric AIDS program, add up their individual ages and divide by 12.

Measurable Objective: An intended goal that can be proved or evaluated.

Median: A type of average which calculates the central value, the one that falls in the middle of all the values when they are listed in order from highest to lowest; for example, if the annual incomes of seven families were $37,231, $35,554, $30,896, $ 27,432, $24,334, $19,766, and $18,564, the median would be $27,432.

Minority: A racial, religious, political, national or other group regarded as different from the larger group of which it is a part.

Mode: A type of average which identifies the most frequently occurring value; for example, suppose a prevention project included 13 youth of the following ages: 16,16,15,14,14,14,14,13,13,12,12,11,10; the mode would be 14, which occurs four times.

Monogamy: The practice of being married to one person, or being in an intimate relationship with a single individual.

Mutation: In biology, a sudden change in a gene or unit of hereditary material that results in a new inheritable characteristic. In higher animals and many higher plants, a mutation may be transmitted to future generations only if it occurs in germ -- or sex cell -- tissue; body cell mutations cannot be inherited. Changes within the chemical structure of single genes may be induced by exposure to radiation, temperature extremes, and certain chemicals. The term mutation may also be used to include losses or rearrangements of segments of chromosomes, the long strands of genes. Mutation, which can establish new traits in a population, is important in evolution. As related to HIV: During the course of HIV disease, HIV strains may emerge in an infected individual that differ widely in

their ability to infect and kill different cell types, as well as in their rate of replication. Of course, HIV does not mutate into another type of virus.

Myopathy: Progressive muscle weakness. Myopathy may arise as a toxic reaction to AZT or asa consequence of the HIV infection itself.

Needs Assessment: A process of obtaining and analyzing findings about the needs of the community. Needs assessments may use several methods of information and data collection to determine the type and extent of unmet needs in a particular population or community. For example studying the needs of persons with HIV (PLWH) (both those receiving care and those not in care), identifying current resources (Ryan White Act and other) available to meet those needs, and determining what gaps in care exist.

Networking: Establishing links among agencies and individuals that may not have existed previously, which strengthens links that are used infrequently. Working relationships can be established to share information and resources on HIV prevention and other areas.

NIH (National Institute of Health): The federal agency that includes 24 separate research institutes and centers, among them the National Institute of Allergy and Infectious Diseases, National Institute of Mental Health, and National Institute of Drug Abuse. Within the Office of the NIH Director is the Office of AIDS Research, which is responsible for planning, coordinating, evaluating, and funding all NIH AIDS research.

NGO (Non-Governmental Organization): A private group that is not associated with federal, state, or local agencies; however, they often have programs or services that are similar to those offered by government agencies.

NIH (National Institute of Health): A division of the federal Health and Human Services agency which conducts medical research and offers the AIDS Clinical Trials Program.

NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor): The newest class of antiretroviral agents (e.g., delavirdine, nevirapine). NNRTIs stop HIV production by binding directly onto an enzyme (reverse transcriptase) in a CD4+ cell and preventing the conversion of the HIV virus=RNA to DNA.

Nucleoside Analog: Also called NRTI (Nucleoside Reverse Transcriptase Inhibitor) is the first effective class of antiviral drugs (e.g., AZT, ddl, ddC, d4T). NRTIs act by incorporating themselves into the HIV DNA, thereby stopping the building process. The resulting HIV DNA is incomplete and unable to create new virus.

OMB (Office of Management and Budget): The office within the executive branch of the Federal government which prepares the President=s annual budget, develops the Federal government=s fiscal program, oversees administration of the budget, and reviews government regulations.

Open-Ended Questions: Questions in an interview or survey format that allow those responding to answer as they choose, rather than having to select one of a limited set of predefined alternative responses.

Opportunistic Infection (OI): An infection or cancer that occurs in persons with weak immune systems to fight off bacteria, viruses and microbes due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Karposi=s Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.

OSE (Office of Science and Epidemiology): The office within HRSA HIV/AIDS Bureau that administers the SPNS Program, HIV/AIDS evaluation studies, and the Annual Administrative Report (AAR).

Over-representation/Under-representation: Term often used to indicate that a particular sub-population makes up a larger proportion- or a smaller proportion - of a particular group than would be expected, given its representation in the total population; for example, Hispanics and African Americans are both over represented among AIDS cases, compared to their percentage in the U.S. population, while Asians/Pacific Islanders are under-represented.

Over-sampling: A procedure in stratified random sampling in which a larger number of individuals from a particular group (or stratum) are selected than would be expected given their representation in the total population being sampled; this is done in order to have enough subjects to permit separate tabulation and analysis of that group; for example, minorities are often over sampled to permit separate analyses of data by racial/ethnic group as well as comparisons among racial/ethnic groups.

Palm Beach County Board of County Commissioners: The PBC Board of County Commissioners is the CEO (grantee) of Ryan White Part A funds.

Palm Beach County Department of Community Services (DCS): The DCS acts as fiscal agent for the PBC Board of County Commissioners and is responsible for the disbursement of Ryan White Part A funds.

Pandemic: An epidemic that occurs in a large area or globally, such as with HIV and AIDS.

Parity: A situation in which all members have an equal voice, vote and input into a decision making process.

Partner Notification: The confidential process of informing the sexual and needle sharing partners of an HIV infected person that they may also be infected.

Part A: The part of the Ryan White Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV epidemic.

Part B: The part of the Ryan White Act that enables States and Territories to improve the quality, availability, and organization of health care and support services to individuals with HIV and their families.

Part C: The part of the Ryan White Act that supports outpatient primary medical care and early intervention services to people living with HIV disease through grants to public and private non- profit organizations.

Part D: The part of the Ryan White Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Part F: The part of the CARE Act that includes the AETC Program, the SPNS Project, and the HIV/AIDS Dental Reimbursement Program.

PCP (Pneumocystis Carinii Pneumonia): A form of pneumonia caused by a parasite that does not usually cause infection in people with fully functioning immune systems; the leading cause of death in people with AIDS.

Percent: Literally, per hundred; a proportion of the whole, where the whole is 100; the percent is calculated by dividing the part of interest by the whole, and then multiplying by 100; for example, if you want to know what percent of recently reported AIDS cases are women, take the number of women AIDS cases (the part of interest), divide by the number of total AIDS cases (the whole), and multiply by 100; if your community has a total of 70 recently reported AIDS cases and 14 are women, divide 14 by 70 (=.2) and multiply by 100, and you get 20%.

Percentage Point: One one-hundredth; term used to describe numerical differences between two percent without comparing relative size; for example, if 16% of AIDS cases are Hispanic and 32% are African American, the difference is 16 percentage points (32 minus 16).

Perinatal: of, involving, or occurring during the period closely surrounding the time of birth.

Phenotypic Assay: A procedure whereby a sample DNA of a patient=s HIV is tested against various antiretroviral drugs to see if the virus is susceptible or resistant to these drugs.

Public Health Service (PHS): The federal agency that addresses all issues of public health in the United States (the CDC is part of the Public Health Services).

Planning Council/HIV Health Services Planning Council: A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to establish a plan for the delivery of HIV care services in the EMA and establish priorities for the use of Ryan White Part A funds.

Planning Process: Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

Population Count: Data which describe an entire population and were obtained from that entire population without sampling; the U.S. Census conducted every ten years is a population count since it attempts to obtain information from everyone living in the United States.

Prevalence: The total number of persons living with a specific disease of condition in a defined population at a given time (compared to the incidence, which refers to the number of new cases).

Prevalence Rate: The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Primary Source Data: Original data that you collect and analyze yourself.

Priority Setting: The process used by a planning council or consortium to establish numerical priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Probability: The likelihood that a particular event or relationship will occur.

Probability Value: The probability that a statistical result- an observed difference or relationship- would have occurred by chance alone, rather than reflecting a real difference or relationship; statistical results are often considered to be significant if the probability, or **p value,** is less than .05, which means that there is less than a 5 % chance - 5 out of 100- that the result would have occurred by chance alone.

Profile of Provider Capability/Capability: A description of the extent to which the various services offered by a network of providers in the service area are available, accessible, and appropriate for PLWH/A, including particular populations.

Procurement: The process of selecting and contracting with providers, often through a competitive RFP process. For Part A, a responsibility of the grantee, not the planning council; for Part B, consortia are sometimes involved.

Prophylaxis: Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis).

Proportion: A number smaller than one, which is calculated by dividing the number of subjects having a certain characteristic by the total number of subjects; for example, if 35 new AIDS cases have been reported in the community in the past year and 7 of them are women, the proportion of female AIDS cases is 7 divided by 35 or 1/5 (.2).

Protease: An enzyme breaks apart long strands of viral protein into separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off

a cell membrane.

Protease Inhibitor: A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.

Public Health Service (PHS): An administrative entity of the U.S. Department of Health and Human Services; until October 1, 1995, HRSA was a division of the PHS.

Public Health Surveillance: An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention surveillance system for AIDS cases.

QA (Quality Assurance): A system of establishing standards and measuring performance in the attainment of those standards and with feedback of results in order to better meet those standards.

QI (Quality Improvement): A system of repetitive analysis of areas of potential improvement, ever increasing standards of performance, measurement of performance, and systems change to improve performance.

Ratio: A combination of two numbers that shows their relative size; the ratio of one number to another is simply the first number divided by the other, with the relation between the two numbers expressed as a fraction (x/y) or decimal (xy/1), or simply the two numbers separated by a colon (xy); for example, the ratio of minority to white pediatric AIDS cases in a community with 75 total cases, 45 among Hispanic and Black children and 30 among white children, would be 45/30 (45:30), 3/2 (3:2), or 1.5:1.

Raw Data: Data that are in their original form, as collected, and have not been coded or analyzed; for example, if a woman participating in an HIV nutrition workshop is tested to determine her knowledge of nutrition need and gets a score of 11, that is her raw score; if the score represented 11 correct

answers out of 20, then the score could be converted to 11 divided by 20 times 100 or 55%, which is not a raw score.

Reliability: The consistency of a measure or question, in obtaining very similar of identical results when used repeatedly; for example, if you repeated a blood test three times of the same blood sample, it would be reliable if it generated the same results each time. For example, a positive HIV test result is reliable because there are three tests on the blood sample.

Representative: Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Resource Allocation: The legislatively mandated responsibility of planning councils to assign the Ryan White Act funding amounts or percentages to established priorities across specific service categories, geographic areas, populations, or sub-populations.

Retrovirus: A type of virus that, when not infecting a cell, stores its genetic information on a single stranded RNA molecule instead of the more usual double stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell=s genetic material.

Reverse Transcriptase (RT): A uniquely viral enzyme that constructs DNA from an RNA template, which is an essential step in the life cycle of a retrovirus such as HIV. The RNA-based genes of HIV and other retro viruses must be converted to DNA if they are to integrate into the cellular genome.

RFP (Request for Proposal): An open and competitive process for selecting providers of services (sometimes called RFP or Request for Proposal).

Rounding: Presenting numbers in more convenient units; rounding is usually done so that all numbers being compared have the same level of precision (one decimal place, for example); usually numbers under 5 are rounded down while 5 and over are rounded up; for example, you would round 3.08 to 3.1 and 4.14 to 4.1.

Ryan White HIV/AIDS Treatment and Modernization Act: The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWH/As) disease and their families in the United States and its Territories. The Act was enacted in 1990 (Pub. L. 101-

381) and reauthorized in 1996, 2001 and 2006.

Salvage Therapy: A treatment effort for people who are not responding to, or cannot tolerate the preferred, recommended treatments for a particular condition. In the context of HIV infection, drug treatments that are used or studied in individuals who have failed one or more HIV drug regimens, including protease inhibitors. In this case failed refers to the inability to achieve or sustain low viral load levels.

SAMs (Self Assessment Modules): Self-assessment tools for planning bodies.

SAMHSA (Substance Abuse and Mental Health Services Administration): The DHHS agency that administers programs in alcohol abuse, substance abuse, and mental health.

Sample: A group of subjects selected from a total population or universe with the expectation that studying the group will provide important information about the total population.

SCSN (Statewide Coordinated Statement of Need): A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN is legislatively mandated and the process is convened by the Part B grantee, with equal responsibility and input by all programs. Representatives must include all Ryan White Part A, B, C, D and Part F managers, providers, PLWH/As, and public health agency(s).

Secondary Source Data: Information that was collected by someone else, which can be analyze or re-analyze.

Secondary Analysis: Re-analysis of data or other information collected by someone else; for example, you might obtain data on AIDS cases in your metro area from the Centers for Disease Control and Prevention, and carry out some additional analyses of those data.

Serology: The study of blood serum and its component parts; blood serum is the fluid that separates from clotted or blood plasma that is allowed to stand. HIV testing is conducted using blood serum from the person being tested.

Seroconversion: The development of detectable antibodies of HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies of HIV appear in the blood, a person will test positive in the standard ELISA test for HIV. This is also referred to as the window period.

Seroprevalence: The number of persons in a defined population who test HIV-population based on HIV testing of blood specimens. (Seroprevalence is often presented as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

Seroprevalence Report: A report that provides information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.

SPNS (Special Projects of National Significance): A health services demonstration, research, and evaluation program funded under Part F of the Ryan White Act. SPNS projects are awarded competitively.

Statistical Significance: A measure of whether an observed difference or relationship is larger or smaller than would be expected to occur by chance alone; statistical results are often considered to be

significant if there is less than a 5% chance -5 out of 100- that they would have occurred by chance alone.

Statistics: Information or data presented in numerical terms; quantitative data; often refers to numerical summaries of data obtained through surveys or analysis.

STD (Sexually Transmitted Disease): Infections spread by the transfer of organisms from person to person during sexual contact. Some examples are, Chlamydia, Syphilis, Gonorrhea, Pubic Lice, Herpes, Human Papilloma virus (warts).

Stratified Random Sample: A random sample drawn after dividing the population being studied into several subgroups or strata based on specific characteristics; subsamples are then drawn separately from each of the strata; for example, the population of a community might be stratified by race/ethnicity before random sampling.

Supplemental Grant Application: An application for funding that supplements the Part A formula grant, and is awarded to EMAs on a competitive bases based on demonstrated need and ability to use and manage the resources.

Surrogate Measures: Substitute measures, used to help understand a situation where adequate direct measures are not available; for example, it may be difficult to obtain good HIV surveillance data on teenagers, but incidence rates of sexually transmitted diseases (STDs) among teenagers can be used as surrogate measures of high-risk sexual behavior, since HIV is an STD, and people get STDs when they engage in unprotected sex.

Surveillance: An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases (e.g. Centers for Disease Control and Prevention surveillance system for AIDS cases).

Surveillance Reports: Reports providing information on the number of reported cases of a disease such as AIDS, nationally and for specific locations and subpopulations; the Centers for Disease Control and Prevention issues such reports, providing both cumulative cases and new cases reported during a specific reporting period, such as each of the last two years.

Survey: Data collection method in which a number of individuals (often a probability sample) are asked the same set of questions, which are usually largely multiple choice or short-answer, and their responses are tabulated, analyzed, and compared to provide quantitative data about the population surveyed..

Survey Research: Research in which a sample of subjects is drawn from a population and then interviewed or otherwise studied to gain information about the total population from which the sample was drawn.

T-cell: A type of white blood cell essential to the body=s immune system; helps regulate the immune system and control B-cell and macrophage functions.

Tabulation of Data: Ordering and counting of quantitative data to determine the frequency of responses, usually the first step in data analysis; typically involves entering data into a computer for manipulation through some form of data analyses program.

Target Population: Populations to be reached through some action or intervention; may refer to groups with specific characteristics (e.g., race/ethnicity, age, gender, socioeconomic status) or to specific geographic areas.

TA (Technical Assistance): Training and skills development, which allows people and groups to perform their jobs better. This includes education and knowledge development in areas that range from leadership and communication to creating an effective needs assessment tool and understanding statistical data.

TOPWA: (Targeted Outreach for Pregnant Women Act): A Florida General Revenue funded HIV prevention intervention project.

Transmission Category: A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc.

Trend: Movement in a particular direction in the value of variables over times.

Trend Charts: Line charts which show changes or movement in the values of a particular varible over time; usually, values are recorded periodically as points on a graph, and then connected to show how the values are changing; often used to provide comparisons, such as separate lines showing reported AIDS cases among different population groups over time.

Tuberculosis (TB): A bacterial infection caused by *Mycobacterium tuberculosis*. TB bacteria are spread by airborne droplets expelled from the lungs when a person with active TB coughs, sneezes, or speaks. Exposure to these droplets can lead to infection in the air sacs of the lungs. The immune defenses of healthy people usually prevent TB infection from spreading beyond a very small area of the lungs. If the body's immune system is impaired because of infection with HIV, aging, malnutrition, or other factors, the TB bacterium may begin to spread more widely in the lungs or to other tissues. TB is seen with increasing frequency among persons infected with HIV. Most cases of TB occur in the lungs (pulmonary TB). However, the disease may also occur in the larynx, lymph nodes, brain, kidneys, or bones (extra pulmonary TB). Extra pulmonary TB infections are more common among persons living with HIV. See Multidrug Resistant TB.

Universe: The total population from which a sample is drawn.

Unmet Needs: Service needs of those individuals not currently in care as well as those in care whose needs are only partially met or not being met. Needs might be unmet because available services are either inappropriate for or inaccessible to the target population.

URS (Uniform Reporting System): Data collection system designed by HRSA to document the use of Title I and Title II funds.

Vaccine: A liquid made from modified or denatured viruses or bacteria that is injected in to the body and produces or increases immunity and protection against a particular disease.

Validity: The extent to which a survey question or other measurement instrument actually measures what it is supposed to measure; for example, a question which asks PLWH/A with TB whether they are taking their medication every day is valid if it accurately measures their actual level of medication use (as with directly observed therapy programs in which they are observed taking the medication), and it is not valid if they are not giving honest answers, and the question is really measuring the extent to which they realize that they should take their medication.

Value: Individual response or score; for example, if people responding to a survey are asked to state their age, each age is a value.

Variable: A characteristic or finding that can change or vary among different people or in the same person over time; for example, race/ethnicity varies among individuals, and income varies for the same individual over time.

Viral Load Test: In relation to HIV: Test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression and later remission.

Viremia: The presence of virus in blood or blood plasma. Plasma viremia is a quantitative measurement of HIV levels similar to viral load but is accomplished by seeing how much of a patient=s plasma is required to spark an HIV infection in a laboratory cell culture.

Virus: Organism composed mainly of nucleic acid within a protein coat, ranging in size from 100 to 2,000 angstroms (unit of length; 1 angstrom is equal to 10-10 meters). When viruses enter a living plant, animal, or bacterial cell, they make use of the host cell's chemical energy and protein -- and nucleic acid -- synthesizing ability to replicate themselves. Nucleic acids in viruses are single stranded or double stranded, and may be DNA (deoxyribonucleic acid; see) or RNA (ribonucleic acid; see). After the infected host cell makes viral components and virus particles are released, the host cell is often dissolved. Some viruses do not kill cells but transform them into a cancerous state; some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more severe, form of disease. In humans, viruses cause -- among others -- measles, mumps, yellow fever, poliomyelitis, influenza, and the common cold. Some viral infections can be treated with drugs.

Wasting: Severe loss of weight and muscle, or lean body mass, common among AIDS patients. Leads to muscle weakness, organ failure, tissue swelling, muscle and joint pain and contributes to fatal outcomes.

Weighting: A procedure for adjusting the values of data to reflect each group=s percent in the total population; for example, race/ethnicity and oversampled minorities so you could compare findings for each group; in order to combine your findings to describe the entire population, you would weight the data to reflect the percentage of the whole population that comes from each racial/ethnic group.

Western Blot: A test for detecting the specific antibodies to HIV in a person=s blood. It is commonly used to verify positive ELISA tests. A Western Blot test is more reliable than the ELISA, but it is harder and more costly to perform. All positive HIV antibody tests should be confirmed with a Western Blot test. Synthetic Peptide test has increased the accuracy of the Western Blot test, inconclusive results are rare.

Wild Type Virus: HIV that has not been exposed to antiviral drugs and therefore has not

accumulated mutations coferring drug resistance

ACRONYMS

ADA – Americans with Disabilities Act

ADAP – AIDS Drug Assistance Program

AETC - AIDS Education Training Center

AHCA – Agency for Health Care Administration

AICP – AIDS Insurance Continuation Program

AITRP – AIDS International Training and Research Program, FIC

ART – Anti-Retroviral Treatment

ARTAS – Anti-Retroviral Treatment and Access to Services

ASO – AIDS Services Organization

ATIS – HIV/AIDS Treatment Information Service

B/START – Behavioral Science Track Award for Rapid Transition, NHMH & NIDA

CAB – Community Advisory Board

CAMCODA – Center on AIDS and Other Medical Consequences of Drug Abuse

CAP – Comprehensive AIDS Program

CAPS – Center for AIDS Prevention Studies

CBC – Congressional Black Caucus

CBO – Community Based Organization

CDC – Center for Disease Control

CFAR – Center for AIDS Research

CHD – County Health Department

CM – Case Management

CMS – Children Medical Services

CMV – Cytomegalovirus

CNS – Central Nervous System

CPCRA – Community Program for Clinical Research on AIDS

CPP – Community Planning Partnership

CSF – Cerebrospinal Fluid

CSN – Coordinated Service Network

CTL – Cytotoxic T lymphocyte

DEA – Direct Emergency Assistance

DHHS – Department of Health and Human Services

DIS - Disease Intervention Specialists

DNA – Deoxyribonucleic Acid

DOH – Department of Health

DRG – Division of Research Grants, NIH (now the Center for Scientific Review)

EBV – Epstein - Barr virus

EHB – Electronic Hand Book (HRSA reporting system)

EIIHA – Early Identification of Individuals with HIV/AIDS

EIS – Early Intervention Services

EMA – Eligible Metropolitan Area

ETI – Expanded Testing Initiative

FDOH – Florida Department of Health

FIRCA – Fogarty International Research Collaboration Award, FIC

FLAETC – Florida AIDS Education Treatment Center

FPL – Federal Poverty Level

FQHC – Federally Qualified Healthcare Center

FY – Fiscal Year

GCRC – General Clinical Research Center

GIS - Geographic Information System

HAART – Highly Active Anti-Retroviral Therapy

HAB – HIV/AIDS Bureau

HAPC – HIV/AIDS Program Coordinator

HARS – HIV and AIDS Reporting System

HBCU – Historically Black Colleges and Universities

HCD – Health Care District

HCSEF – Health Council of Southeast Florida

HHV-8 – Human Herpesvirus-8

HIPAA – Health Insurance Portability and Accountability Act

HIVIG – HIV Immunoglobulin

HMS – Health Management System

HOPWA – Housing Opportunities for Persons with AIDS

HPV – Human Papillomavirus

HRSA – Health Resources and Services Administration

HUD – Housing and Urban Development

IDU – Injecting Drug User

IHS – Indian Health Service

IVIG – Intravenous Immunoglobulin

JCV – JC Virus

LPAP – Local Pharmaceutical Assistance Program

MAC – Mycobacterium Avium Complex

MAI – Minority AIDS Initiative

MCT – Mother–to–Child Transmission

MOE – Maintenance of Effort

MSM – Men who have Sex with Men

NAFEO – National Association for Equal Opportunity in Higher Education

NHAS – National HIV/AIDS Strategy

NIH – National Institutes of Health

NOE – Notice of Eligibility

OAR – Office of AIDS Research, NIH

OARAC – Office of AIDS Research Advisory Council

OI – Opportunistic Infection

P&A – Priorities and Allocations Committee, of the CARE Council

PAC – Project AIDS Care

PBCHD – Palm Beach County Health Department

PBCSAC – Palm Beach County Substance Abuse Coalition

PBMC – Peripheral Blood Mononuclear Cell

PCN – Policy Clarification Notice (HRSA)

PIR – Parity, Inclusion and Representation

PLWHA – People Living with HIV/AIDS

PML – Progressive Multifocal Leukoencephalopathy

P & T – Pharmacy and Therapeutics

PWA/PLWA – Person with AIDS/A Person Living with AIDS

QIP – Quality Improvement Plan

RARE – Rapid Assessment Response Evaluation

RCMI – Research Center in Minority

RDR – Ryan White Program Data Report

RFP – Request for Proposals

RNA – Ribonucleic Acid

RSR – Ryan white Services Report

SAMHSA – Substance Abuse and Mental Health Services Administrations

SCID – Severe Combined Immunodeficiency

SI – Syncytia-Inducing

SMART – Specific, Measurable, Achievable, Realistic and Time Sensitive

SRA – Scientific Review Administration

STD – Sexually Transmitted Disease

STI – Structured Treatment Interruption

TB – Tuberculosis

TGA – Transitional Grant Area

TOPWA – Targeted Outreach for Pregnant Women Act

UOB – Unobligated Balance

VA – Veterans Administration

WHO – World Health Organization

WICY – Women, Infant, Children and Youth

ZDV – Zidovudine

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Target HIV