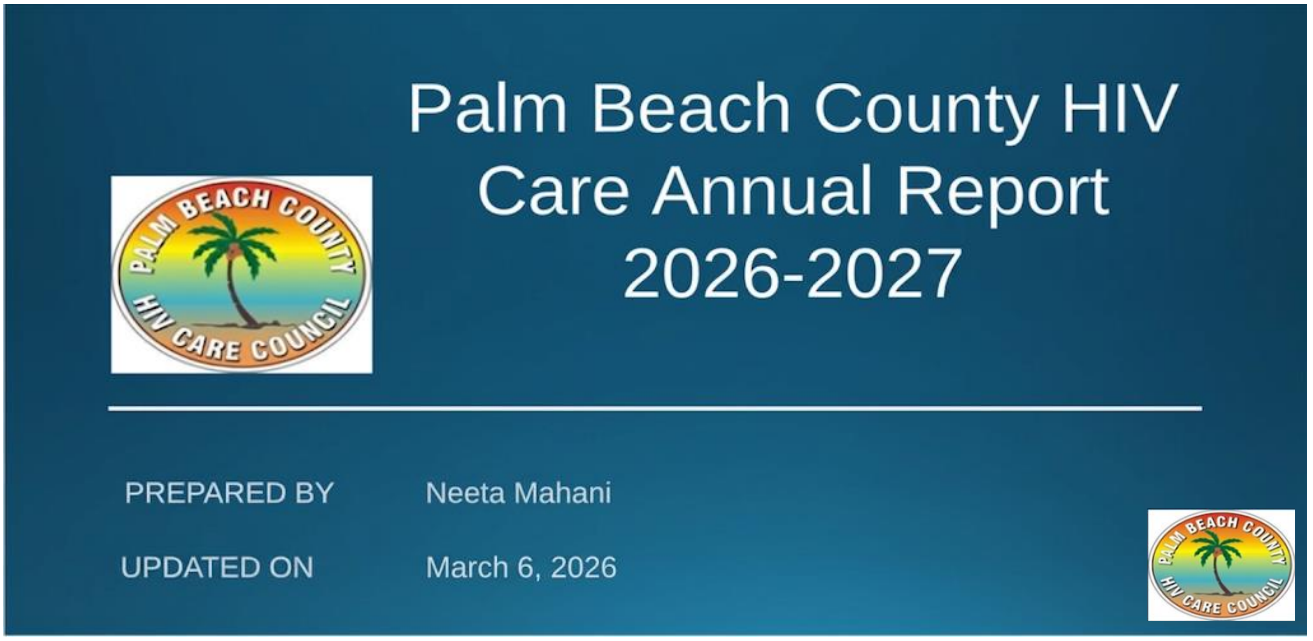


Introduction

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)
12. Conducting comprehensive needs assessments to identify service gaps, ensuring the integration of diverse healthcare resources into a seamless system of care for the community.

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 a 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:

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

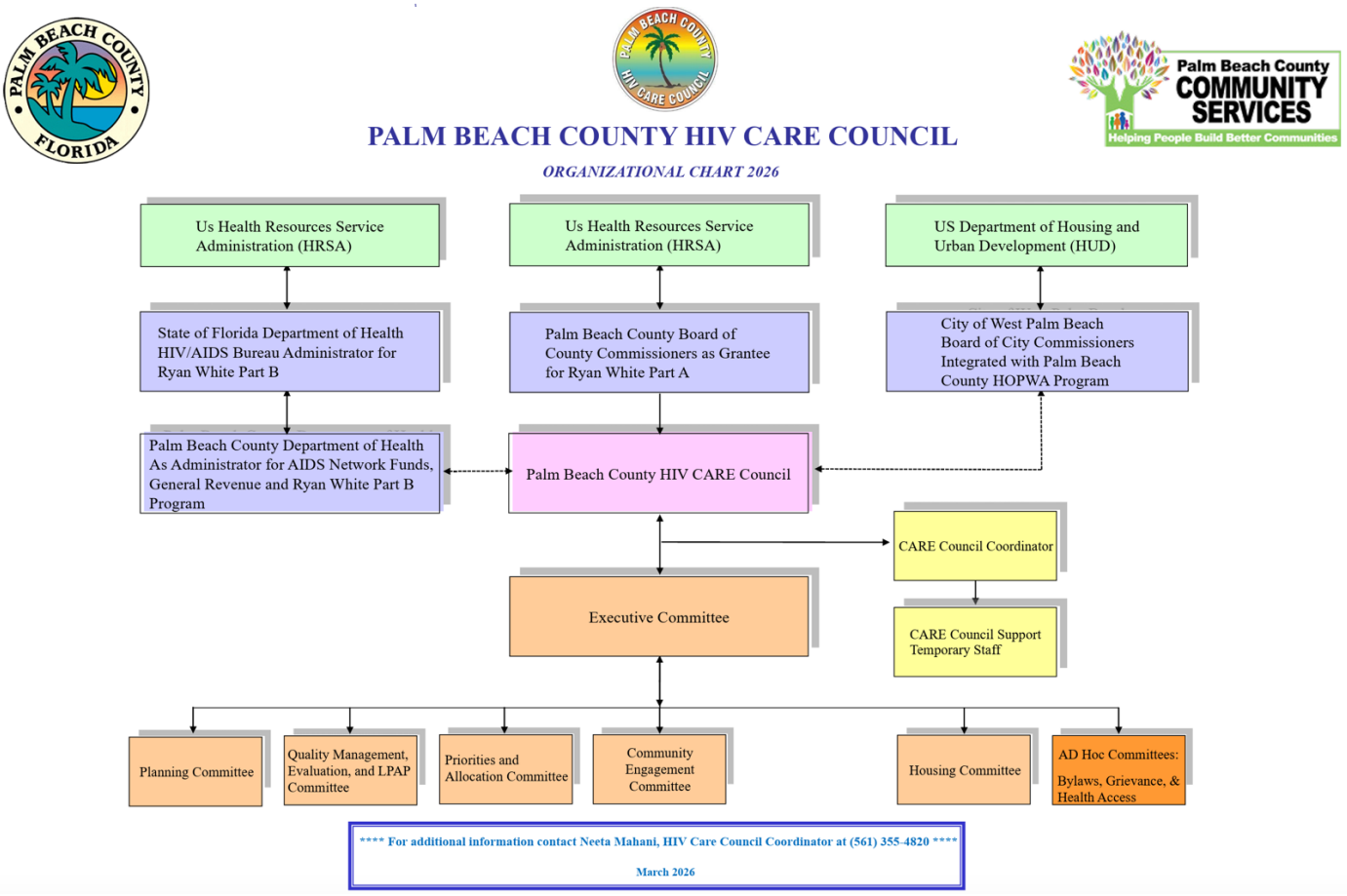
Each new member of the CARE Council is assigned a mentor. The role of the mentor is to help the new member of the CARE Council feel welcome, become comfortable with the CARE Council process and to update them on the latest CARE Council issues.

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



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:

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, which will be held before March 1 of each calendar year. 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, representing 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) Being 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 Community Engagement 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 Community Engagement Committee. As funding permits, with the exception of Chairing the Community Engagement 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) Community Engagement Committee

(E) Quality Management, Evaluation, and Local Pharmaceutical Assistance Program Committee

(F) Housing 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 Health Access Committee

The CARE Council Chair may authorize the creation, prescribe the terms, and define the power and duties of any other Ad hoc Committees as may, from time to time, be necessary or useful in conducting CARE Council business. The Ad hoc Committees 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 may be convened by the Chair of the CARE Council and/or at the request of 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 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 addition, the Planning Committee is charged with the development of a Needs Assessment as outlined in HIV/AIDS Bureau (HAB) publications

SECTION 6: Community Engagement Committee:

The Community Engagement Committee is responsible for the following:

- Conducting outreach to HIV/AIDS service consumers, providers and organizations. Plan, attend and participate in community events and activities. (Conference, community fairs, workshops, trainings, etc.).
- Developing, identifying, and implementing the strategies and recruiting new members for the CARE Council and its committees, who are reflective of the HIV/AIDS epidemic in Palm Beach County.
- 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 to 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.
- Interviewing prospective members(s) for the CARE Council as appropriate (Prospective member(s) are interviewed by voting CARE Council members only).
- Training new and existing members of the CARE Council in CARE Council responsibilities, policies and procedures.
- Ensuring the CARE Council membership list complies with necessary grant requirements and monitoring membership attendance as required by *Policy and Procedures.*

SECTION 7: Quality Management, Evaluation, and Local Pharmaceutical Assistance Program Committee:

The Quality Management, Evaluation, and Local Pharmaceutical Assistance Program Committee (QMELPAPC) 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:

- Receive and evaluate quality performance measures prepared by the Recipient.
- Provide feedback to the recipient regarding health outcome measures and quality improvement projects.
- Develop and maintain service delivery standards for Ryan White Part A service categories rendered with the Palm Beach County EMA.
- Compiling a written formula, 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 approve.
- 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 8: The Housing Committee is responsible for the following activities

- Determine priorities and make funding in policy recommendations to the recipient regarding the use of any and all housing funds.
- Make planning efforts to address housing related services and identify opportunities to expand available housing for people living with HIV and/or Aids in Palm Beach County
- Engage Key Policy Makers and Stakeholders from both Public and Private Sectors in identifying additional resources and solutions to achieve health through housing people living with HIV
- Act as a forum for people with HIV who have experienced or are currently experiencing homelessness/ housing instability

SECTION 9: The following provisions shall apply to committees:

- Membership on a committee shall be defined by policy.
- Committee attendance shall be defined by policy.
- 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 prior to March 1 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.

2026-2027 PBC HIV CARE Council & Sub Committees Roster

CARE Council Members	Executive Committee Members	Community Engagement Members
1. **Tad Fuller – Chair** 2. **Kim Rommel-Enright -Vice Chair** 3. **Youssef Motii- Treasurer** 4. **Kristen Harrington– Secretary** 5. Ashnika Ali 6. Hector Bernardino 7. Orquidea Acevedo 8. Glenn Krabec 9. Dr. Sandra Anderson 10. Dr Berthline Isma 11. Ashaki Sypher 12. Miguel Vasquez 13. Brittany Henry 14. Nancy McConnell 15. Tad Fuller 16. Cecil Smith 17. Cynthia Walker 18. Dominique Lane 19. Annette Verdal Dunn 20. Rosie Hayes 21. Richardo Jackson 22. Andinette Thomas-Wilson 23. Michelle Scott 24. Raymond Cortez Neeta Mahani	1. Tad Fuller – Care Council & Executive Chair & CEC Vice Chair 2. Brittany Henry – Planning 3. Kim **Rommel-Enright** - Vice Chair & Bylaws chair& 4. Dr. Youssef Motii- Care Council Treasurer & P&A Chair 5. Kristen Harrington – **Secretary & CEC Committee Chair** 6. Hector Bernardino – QMEC Committee chair 7. Miguel Vazquez – Housing Chair **Neeta Mahani**	1. **Kristen Harrington– Chair** 2. **Richardo Jackson - Vice Chair** 3. Arlene Griffiths 4. Cecil Smith 5. Kim Rommel Enright 6. Ashaki Sypher 7. Tad Fuller 8. Kenny Talbot 9. Annette Dunn 10. Dr Berthline Isma 11. Denise Brown **Neeta Mahani**

2025-2026 PBC HIV CARE Council &Subcommittees Roster

Planning Committee Members	Priority & Allocation Committee Members	Quality Management, Evaluation, and Local Pharmaceutical Assistance Program Committee Members
1. **Lysette Perez –(Chair)** 2. **Brittany Henry – (Vice Chair)** 3. Brad Barnes 4. Nancy McConnell 5. Cecil Smith 6. Berthline Isma 7. Annette Dunn **Neeta Mahani & Geneve Simeus**	1. **Dr. Youssef Motii (Chair)** 2. **Denise Brown (Vice chair)** 3. Glenn Krabec 4. Cecil Smith 5. Richardo Jackson 6. Ryan Adams 7. Sharon Hollis 8. Annette Dunn **Neeta Mahani & Jeffery Lesanti**	1. **Hector Bernardino-Chair** 2. **Neka MacKay – Vice Chair** 3. Cecil Smith 4. Kristen Harrington 5. Lilia Perez 6. Ashnika Ali 7. Brad Barnes 8. Berthline Isma 9. Sylvia Carr **Neeta Mahani & Jasmine Parrish**

PBC HIV CARE Council & Subcommittees Committees
Meeting Schedule 2025-2026 changes as per March 24th 2025 Care Council Meeting

MEETING SCHEDULE
CARE Council Last Monday of the month (every Month & two evening meetings annually (May 19th & September 29th 2025 and two in Western community in June 30th and November 17th 2025) 2:00p.m. - 4 p.m. & 5:30p.m. – 7:30 p.m.
Executive Committee (As Needed) Last Monday of the month prior to Care Council Meeting 12:00p.m.
P & A Committee 1st Thursday of the month 12:00 p.m. Quality Management and Evaluation Committee/LPAP 1st Thursday of the Month (quarterly) 2:00p.m. – 4:00 p.m.
Community engagement Committee Meeting (Every Month for six month) 3rd Thursday of the Month @ AHF office: 1411 N Flagler Drive Suite 9400 12:00 p.m. – 1:30 p.m.
Planning Committee(2nd Thursday of each month) 2:00 p.m. – 4 p.m.
Bylaws Adhoc Committee Mandatory one meeting per year December first week
Housing Committee(Twice a year) June 27th and 24th 2025 4th Thursday of the month 2:00 p.m.
New Member Orientation two times a year. New officers Training once a year in March Check the availability of dates

Officers Going to Belle Glade to conduct the joint meeting

- April – Tad Fuller
- May – Richardo Jackson
- June – Neeta Mahani
- September – Kristen Harrington
- October – Lysette Perez (TBD)
- November – Neeta Mahani
- January – Youssef Motti

All meeting and dates subject to change. For updates information see the calendar at http://carecouncil.org/

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 is obtained from the State, the Recipient will be responsible for arranging timely provision of this 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

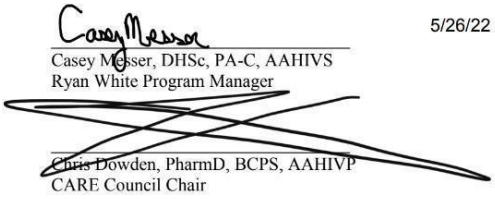
The MOU will remain in effect for 5 years unless or until the parties take action to end it or The Recipient no longer receives Part A funding for the EMA/TGA.

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



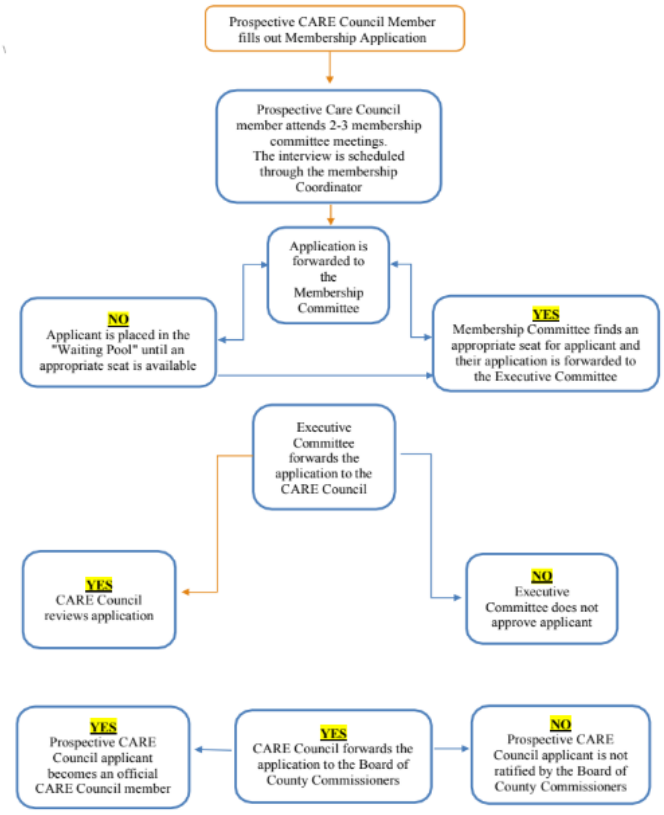
5/26/22

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



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 troubadour 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

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

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.

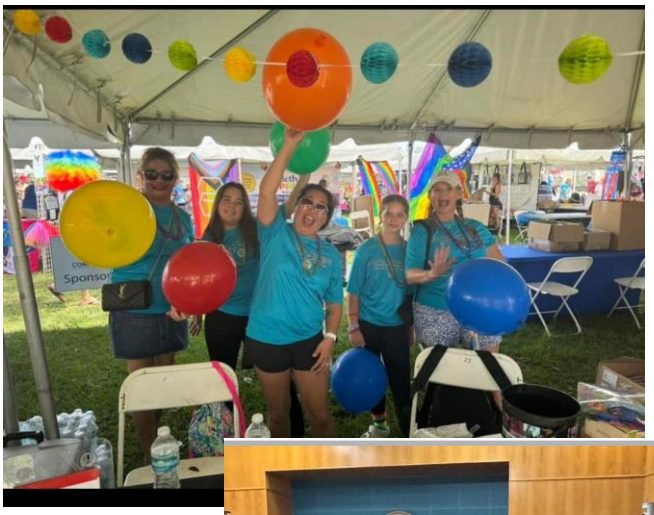
CONFLICT OF INTEREST

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.

[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].

Palm Beach County HIV Council Volunteers and Events

Ria Sharma
Palm Beach County HIV Council Volunteer - University of Pittsburgh





WPTV





Palm Beach County
Community
Services

SILLY
AUNT
TED


PALM BEACH COUNTY
HIV CARE COUNCIL
PREVENTION
SUPPORT
EDUCATION
ADVOCACY