

BYLAWS AND OPERATING PROCEDURES

WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL

I. PREFACE

In order to function as effectively and efficiently as possible, the Part A HIV Health Services Planning Council and the Part B HIV CARE Consortium voted on March 17, 1998, to merge both bodies into a single body. This merging allows for greater, more cost effective coordination in program planning, implementation and evaluation. Within this single body, it is essential to recognize the differing authority and autonomy within a Planning Council versus a Part B Consortium. For this reason, these Bylaws and Operating Procedures are organized to combine similar responsibilities while ensuring any legislated distinctions are recognized and represented.

II. DESIGNATION AND PURPOSE

A. Federal Designation

The Care Council shall conduct its activities in accordance with the provisions, interpretations and recommendations of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, its primary funding source, and with all applicable local, state, and federal law and regulations.

B. Purpose

The Care Council in keeping with the Ryan White CARE Act of 1990, as amended, will:

1. Develop and implement needs assessment activities;
2. Establish priorities and allocate funds;
3. Assess the efficiency of the administrative mechanism of the grantee;
4. Assess the effectiveness of the services supported by the Act funds;
5. Develop and adopt a comprehensive plan;
6. Participate in the development of the Statewide Coordinated Statement of Need (SCSN).

III. LOCAL IMPLEMENTATION OF THE RYAN WHITE PROGRAM

A. Part A- Relationship with Grantee

The Hillsborough County Board of County Commissioners is designated as the Chief Elected Official of the EMA. Through the County Administrator, the CEO designated the Hillsborough County Department of Health and Social Services (DHSS) to administer the Part A grant. The

CEO is ultimately responsible for administering all aspects of the Ryan White Program in the EMA and ensuring that all legal requirements are met. The DHHS is the Part A Grantee and manages the day-to-day operations of the Part A program.

Grantee responsibilities include:

1. procurement of services;
2. monitoring contracts;
3. submission of grant applications;
4. compliance with conditions of award;
5. meeting reporting requirements;
6. communicating the results of procurement to the Planning Council, defining a process that outlines how procurement results are to be communicated, and if there are differences between priorities identified by the Planning Council and the services funded by the Grantee, how differences will be resolved; and
7. developing Grantee grievance procedures.

Grantee and Planning Council shared responsibilities include:

1. conducting a comprehensive needs assessment; and
2. developing an open nominations process.

The Planning Council's responsibilities to the Grantee include:

1. establishing annual priorities and the best way to meet such priorities;
2. understanding the delineation between the Grantee's responsibility for procurement of services through contractors and the Planning Council's responsibility for prioritization and allocation of funds to services.

B. Part B - Relation with State and Local Lead Agency

The State of Florida Department of Health (DOH) was designated by Lawton Chiles as the agency responsible for administering Part B funds for the State of Florida. The DOH designated the Bureau of HIV-AIDS (BHA) to administer the State Part B program. The BHA designated the Hillsborough County Department of Health and Social Services (DHSS) as the Part B lead agency.

State responsibilities include, but are not limited to:

The State is responsible for developing and submitting a State application

which contains agreements, assurances and information the Secretary deems necessary to carry out this part. The application must include:

1. detailed description of services provided in the preceding year;
2. description of the types of programs funded by the State;
3. an accounting of the amount of funds the State has expended for such programs;
4. report on number of individuals to be served by the grant;
5. report on demographic data on the population to be served;
6. report on average cost of providing each category of services and the extent to which such cost is paid by third party payors;
7. report on aggregate amounts expended for each such category of services;
8. a comprehensive plan for the organization and delivery of HIV services;
9. a detailed description of how the allocation and utilization of resources are consistent with the Statewide coordinated statement of need; and
10. assurances that the agency will periodically convene a meeting of individuals for the purpose of developing a Statewide coordinated statement of need.

Lead agency responsibilities include:

The Lead Agencies are designated by the local consortia as being responsible for the administrative, fiscal and other responsibilities related to the Part B awards for the respective geographic regions within the state. The lead agency acts as the fiscal conduit and data coordinator for all funded providers within the consortium.

Consortium responsibilities to the State include:

The consortium acts in an advisory capacity to the state for the purpose of planning and prioritizing Part B funds as well as providing a forum for the infected and affected community, providers and others. The consortium exists to support and facilitate the provisions of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS.

Consortium responsibilities to the lead agency include:

1. Conduct needs assessment
2. Plan and set service priorities
3. Promote coordination and integration of community resources

4. Assure the provision of comprehensive outpatient health and support services
5. Evaluate the success and cost effectiveness of the consortium in responding to service needs

IV. MEMBERSHIP AND APPOINTMENT PROCESS

A. Legal Requirements

1. Members of the Ryan White Part A HIV Health Services Planning Council meet very strict membership criteria. In addition, the Planning Council must have a documented membership and nominations process which is followed. The requirements of the Consortium include the representation of health care and support service providers and community-based organizations within the service area. County represented is determined by the member's residence or place of employment.
 - a. The Planning Council shall reflect in its composition the demographics of the epidemic in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and sub-populations. Nominations for membership on the Council shall be identified through an open process and candidates shall be selected based upon locally delineated and publicized criteria. Such criteria shall include a conflict of interest standard that is in accordance with paragraph (5) . . .
 - b. The HIV Health Services Planning Council shall include representatives of
 - (1) health care providers, including federally qualified health centers
 - (2) community based organizations serving affected populations and AIDS service organizations
 - (3) social service providers, including housing and homeless services
 - (4) mental health providers
 - (5) substance abuse providers
 - (6) local public health agencies
 - (7) hospital planning agencies or health care planning agencies
 - (8) affected communities, including people living with HIV disease or AIDS and historically underserved groups and sub-populations

- (9) non-elected community leaders
- (10) state government (including the State Medicaid agency and the agency administering the program under part B)
- (11) Part B
- (12) Part C
- (13) Part D
- (14) grantees under Federal HIV programs, including HIV prevention service providers, AETC, HOPWA, SPNS, Dental Program
- (15) representatives of individuals who formerly were federal, state or local prisoners, who were released from the custody of the penal system during the preceding three years, and had HIV disease on the date on which the individuals were released

2. The HRSA-mandated categories and definitions/requirements are as follows:

- a. Health care providers: Members must receive financial remuneration from or serve as an officer of an agency that provides direct health care, or the member must be a direct health care provider (i.e., physician, dentist, nurse, physician's assistant, etc.).
- b. Community-based organizations serving affected populations and AIDS service organizations: Members must receive financial remuneration from or serve as an officer of a community-based organization or AIDS service organization that provides services to people living with HIV or AIDS.
- c. Social service providers, including providers of housing and homeless services: Members must receive financial remuneration from or be an officer of an agency that provides social services.
- d. Mental health providers: Members must receive financial remuneration from or be an officer of an agency that provides mental health services, or the member must be a direct mental health care provider (i.e., counselor, social worker, etc.).
- e. Substance abuse providers: Members must receive financial remuneration from or be an officer of an agency

that provides substance abuse services, or the member must be a direct substance abuse health care provider (i.e. counselor, social worker, etc.)

- f. Local public health agencies: Members must be employed by the Department of Children and Families or the Health Department in the EMA.
- g. Hospital or health care planning agencies: Members must receive financial remuneration from or serve as an officer of an agency that is involved in hospital or health care planning within the EMA.
- h. Affected communities: Members must be infected with HIV or AIDS or an interested community member.
- i. Non-elected community leaders: Members cannot be an elected official, but must be an individual within the EMA who is recognized by members of a specific community to represent the viewpoints of people living with HIV or AIDS within that community.
- j. Medicaid representative: Members must be employed by a Medicaid agency.
- k. Part B: Members must be directly involved with a Part B grant.
- l. Part C: Members must be directly involved with a Part C grant.
- m. Part D: Members must work or be directly involved with women, children, youth, and families living with HIV.
- n. Grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services, AETC, HOPWA, SPNS, Dental Program: Members must work for an agency that administers funding under other federal HIV programs.
- o. Formerly Incarcerated: Representatives of individuals who formerly were federal, state or local prisoners, who were released from the custody of the penal system during the preceding three years, and had HIV disease on the date on which the individuals were released.

3. Not less than 33% of the Council shall be individuals who are receiving HIV-related services from a Part A funded provider, are not officers, employees or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV disease. An individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

B. Membership Category Monitoring

The membership of the Planning Council must reflect the demographic composition of the epidemic of the Eligible Metropolitan Area (EMA). Non-EMA counties that have ten percent or more of the TSA's PLWH population will have two representatives on the Care Council. In addition, the Planning Council shall include representatives of a wide variety of categories as referenced in paragraph (2). To ensure that the Care Council meets the membership requirements of the law, the Care Council administrative staff will monitor the membership of the Care Council as follows:

1. The staff will determine and specify the required representation groups and categories of the Care Council membership (including requirements from the legislation, reflectiveness of the epidemic, and geographic areas of the total service area). This information will be provided to HRSA and the Grantee's office in matrix form. This matrix will include the following information:
 - a. Category: This column reflects the type of membership category an individual can represent. This includes not only the categories listed under paragraph (2), but demographic categories as well.
 - b. Required Percentage: Of the entire membership, this column reflects the percentage of members required in each category.
 - c. Number of Members Required: This column reflects the same information as the required percentage, but translated into total required members rather than percentage.
 - d. Actual Percentage: Of the entire membership, this column represents the percentage of members that are currently (or actually) in each category.

- e. Actual Number of Members: This column reflects the same information as the actual percentage of member column, but translated into total actual members rather than percentage of actual members.
 - f. What We Need: This column reflects the difference between the number of members required column and the actual member column.
- 2. A variety of other matrices are developed to mirror membership representation to the demographics, by organizing according to county and the HIV/AIDS membership.
 - 3. The staff will monitor this listing closely to determine where fulfillment of membership categories is lacking or nonexistent. Please see Section C below, Membership Openings, for the process of filling lacking or nonexistent membership categories.

C. Membership Openings

- 1. There will be two different types of membership openings: a) through annual membership expirations, and b) through ongoing openings created by resignations, illness, excessive absences, and other factors. (If a member has missed three or more meetings, they will be sent a letter of warning. If another absence occurs, their membership will be reviewed by the Care Council administrative staff and the chairperson.) Each type of membership opening will be filled through a different process.
 - a. Annual Membership Expirations: Per the Care Council Operating Procedures, members will serve three-year terms. These terms will be staggered among members to ensure even turnover annually. Membership terms expired on August 31 of each year, with new memberships commencing on September 1. A maximum of six consecutive years of membership may be served. Following two consecutive terms of service, a member must sit out a full year before returning to the Care Council as a voting member. If there is no qualified new applicant for a HRSA-mandated category an exception can be made and a member can serve an additional full term.
 - b. Ongoing Openings: As members resign or are released from membership, the membership categories they occupied will

be reviewed. If existing applications are on file, they will be reviewed to determine whether an existing applicant can fill the open slot. If no existing applicant can fill the existing slot, one of two procedures may take place:

- (1) If the category they are leaving is already well represented per the legal requirements, and the composition of the Care Council is generally well represented per the legal requirements, the Care Council will wait until the annual membership election process to fill that opening.
- (2) If the category they are leaving is a critical category (critical in that a vacancy will mean a population will be left unrepresented per legal requirements, and/or the Care Council membership will be unrepresented in such a way that it may affect a fair decision-making process), the Care Council will advertise for the opening per the same method as utilized in Section III (C)2(b) to fill openings created by annual membership expirations.

2. Process for filling openings created by annual membership expirations.
 - a. In January of each year, the Care Council will review the openings created by annual membership expirations to determine what membership categories will be vacated.
 - b. In January, the recruitment process and vacant positions will be broadly announced to include: advertisements in major county newspapers as well as local community-level publications; local HIV publications; notification to subcontractors; press releases to television and radio stations; and other types of community announcements. Announcements will also indicate time requirements, including deadline for application, conflict of interest disclosure requirements, and HIV disclosure requirements. Specific targeted recruitment will be implemented by staff so as to ensure applications are received for those categories which will be left vacant.

D. Membership Applications

1. Applications will be provided to all interested parties. If an individual has applied in the past but was not appointed, they must

reapply in order to be considered for current membership. Applications will specify the required representation groups and categories of the Care Council membership, open-ended questions to capture information about nominee experience and background, and the scoring criteria for the application. This application will be sent to interested individuals with a brochure identifying the federal designation of the Care Council, its roles and responsibilities, and other pertinent information.

2. A Conflict of Interest Form and a Confidentiality Form will be attached to the application, as well as the current Bylaws. If nominees do not fill out the application section pertaining to conflict of interest or confidentiality, their application will NOT be reviewed nor considered for membership.
3. Completed applications will be submitted to the Care Council administrative staff. In cases where subcontractors collect applications, staff may pick up applications at designated intervals.
4. Applications will be reviewed to determine if other members of an applicant's agency, as it applies to conflict of interest, already sit on the Care Council. Per the Bylaws and Operating Procedures, no two members of one agency may sit on the Care Council, unless the Council and/or staff has determined that the inclusion of an individual who represents the same agency as an existing member is integral to the Care Council planning and decision-making process. If it is determined that two individuals from one agency will sit on the Care Council, one must be a PLWH.
5. Applications will be reviewed by the Care Council staff for completeness. If an application is not complete, the staff will contact the individual for the missing information and/or return the application to the prospective member for completion.
6. Applications will be reviewed by the Care Council staff to determine if the openings created can be filled with the existing applications. If the existing applications have been reviewed and it is determined that the critical categories will be left unrepresented, staff must take additional measures to target and recruit applications from those categories.

E. Membership Elections

1. The Membership Committee will appoint a Member Application Review and Scoring Subcommittee. When the deadline for submitting applications has been reached, the Membership

Subcommittee will assemble to evaluate and score the applications, using the criteria and points identified on the application and scoring sheets provided. Scoring sheets will reflect the majority of points given for the open-ended questions to capture vital information. Additional points will be awarded for those applicants who are part of underserved populations, people living with HIV, or those people who qualify as representatives of the categories delineated in paragraph (2) of the Act.

2. The Membership Subcommittee must consist of at least five (5) current Planning Council members, at least 50% of which are people living with HIV or AIDS.
3. The Membership Subcommittee must be reviewed prior to each application evaluation to ensure representativeness and impartiality. If any member is in violation of the following criteria, the Chairperson will remove that individual from the committee and replace them with an individual who does meet all the specified criteria.
 - a. No subcommittee member can be an applicant.
 - b. No subcommittee member can be employed or serve as an officer of an agency which is represented by an applicant.
 - c. Subcommittee members must be representative of the entire service area.
4. For the purpose of scoring, applications will be separated by county. Applicant's county representation will be determined by county of residence for individuals representing the affected community; county in which the agency has the largest number of clients if agency representation; and district representation if a governmental representative. Membership Subcommittee members each review each application and score according to publicized and explained criteria. Subcommittee member scores for each application are then added to achieve a "grand total" score for that application. A minimum passing score will be required for the applicant to be considered as eligible for membership. A "passing score" will be considered a score of 70% of the maximum points allotted for the application. If it has been determined that gaps in the overall membership exist, additional points may be awarded for certain categorical representations or demographic categories. Which categorical representations or demographic categories will receive additional points and the number of additional points must

be predetermined prior to scoring of the applications. In the case of competition within a county, the applications with the highest scores will be evaluated and ranked according to subjective criteria. Personal interviews will be conducted with new applicants.

5. At this point, one of two events will occur.
 - a. If the committee is unable to score some or all of the applications, or the scores are unacceptable, the committee may elect to:
 - (1) select those applications that met the minimum scoring requirements and place them in certain slots (see b and c); and/or
 - (2) require staff to recruit additional applicants in a timely manner.
 - b. If there is no competition among the slots available (the number of applications equals the number of openings) and the existing applications will allow the Care Council to fill the required representation of categories (including legislatively mandated categories, reflectiveness of the epidemic, and geographic areas from the EMA), the committee may select all applications to recommend to the full Care Council for election and submission to the Hillsborough County Board of County Commissioners for approval and appointment.
 - c. If there is competition among the slots available and the existing applications allow the Care Council to fulfill the required representation of categories, the committee may select those applications which scored highest and place them into the respective categories, ensuring that no category has been left unrepresented.
6. Once the nominees have been selected, the Subcommittee will present the slate and ask for the Care Council's approval of the entire slate.
7. Special consideration will be made for PLWHs and members of underserved populations so that the Care Council composition is as comparable as possible to the demographics of the total service area. The list of recommended members will then be forwarded to Hillsborough County, through the County's Administrative Agency, which is the final appointment authority and who will issue letters of appointment to fulfill and maintain the mandatory representation

categories. Normal terms of office will be three years but may be adjusted to ensure staggered terms and provide continuity from year to year. Those completing their terms may be reappointed through the normal nomination and approval process as outlined above.

8. The target number of Care Council voting members is thirty (30) and may range from 25 to 40. All categorical representations mandated by the Part A legislation, HRSA guidance, State requirements, and these Bylaws and Operating Procedures will be maintained. If any conflicts arise among the above documents, the Part A legislation will take precedence. Openings created by appointed members leaving the Care Council or being removed due to poor attendance or other reasons may be filled through the normal application/nomination and appointment process by the Administrative Agent in close coordination with the Care Council Chairperson, Care Council Administrator, and Membership Subcommittee.

F. Membership Training/Orientation

1. Upon approval of the Care Council, applicants will be notified that they have been recommended to the Hillsborough County Administrative Agency for formal appointment. They will be asked to complete a "Care Council Member Fact Sheet" which will be placed in their file and utilized for HRSA reporting purposes. Once appointed, new members will also be required to fill out an alternate selection form. This is necessary to ensure that the Care Council always has a quorum when voting is necessary at meetings.
2. Once the Care Council has received notification that appointment letters have been received by new members, new members will be formally recognized at the Care Council full meeting. New members will receive a membership manual which includes: the Ryan White Program, Member Roles and Responsibilities, Care Council Bylaws and Operating Procedures (which will include the nomination process) and a Care Council member and committee contact list. In addition, a mandatory orientation will be held for all new members. All new members are required to attend an orientation within ninety days of Care Council membership approval or Care Council membership will be terminated. Additional informational seminars will be held for members on an ongoing basis. Topics include conflict of interest, grievances, member roles and responsibilities, comprehensive planning, needs assessment, and other pertinent topics.

G. Changes in Membership Status

Members are individuals appointed by the Hillsborough County Board of County Commissioners. Members are selected based upon specific criteria, including the HRSA membership category they represent at the time of application as well as the geographical, gender, and racial/ethnic category required to fulfill the Care Council's mandated membership requirement to mirror the demographics of the infected population within the EMA. Thus, a member represents a very specific set of criteria.

1. Members resigning from agency whose service was the basis for the member's HRSA category and member still represents that category: It is because of the specific nature of this appointment that should a member resign from an agency whose type of service/business was the basis for the member to claim representation in one of the mandated categories, the member will retain their membership if the member still claims representation of that category and can substantiate said claim through a written statement to the Chairperson which must be voted on by the full Care Council.

It is important to note that, again, it is the category that is represented on the Care Council, not the agency. Therefore, if a member resigns from an agency, that agency will not be permitted to automatically assume the seat on the Care Council. A representative of that agency may apply for membership and pursue membership through the annual membership and nominations process.

2. Members who no longer represent one or more of the categories upon which their membership was based: Should a member no longer represent one of the categories upon which their membership seat was based (i.e., county representation or HRSA mandated category representation), they must resign their seat on the Care Council unless it is determined that:
 - a. a change in membership category will not adversely affect the overall membership representation of the Care Council, and
 - b. a vote by the full Care Council is held which moves that such member may be reinstated in a different category.

H. Membership Responsibility

Members of the Care Council have the following responsibilities:

1. act as an objective community planner in the best interest of the entire HIV/AIDS community;
2. become familiar with the roles and responsibilities of a Care Council member;
3. chair one Care Council committee, subcommittee and/or ad-hoc committee;
4. attend and actively participate in monthly Care Council meetings and appropriate committee meetings;
5. attend the new member orientation;
6. attend the strategic planning retreat and an additional half-day training retreat;
7. be prepared for meetings, discussions and votes by reading distributed material prior to meetings;
8. participate in objective discussion and voting regarding Care Council issues and agenda items;
9. refrain from voting or participating in discussion when potential conflict of interest arises; and
10. support final majority Care Council votes regardless of individual vote.

I. Chairperson Selection and Responsibility

1. Selection and Term: The Chairperson of the Part A and Part B Care Council is appointed by and serves at the discretion of the CEO of the Part A EMA, who is the Chairperson of the BOCC, acting in consort with the other BOCC members. The Care Council may not be chaired solely by an employee of the grantee. The Membership Committee Chairperson, in coordination with the Care Council Administrator, will present a slate of nominees to the Care Council at least thirty (30) days before elections, which are normally in June. The day the slate is presented, additional nominations may be taken from the floor. The Care Council will vote on the nominees and forward its recommendation for the Care Council Chairperson to the BOCC through the Administrative Agency. The recommendation will then be presented to the BOCC/CEO as an agenda item initiated by the Department of Health and Human Services. If approved, the appointed Chairperson will serve for a two-year term. The term will normally begin on or about September 1. The Care Council Chairperson may be reelected and approved for one additional consecutive two-year term.
2. Duties and Responsibilities: The primary responsibility of the

Chairperson is to ensure the Care Council responsibilities mandated by the CARE Act are accomplished. The Chairperson will also preside over all Care Council meetings, appoint committee chairpersons and committee members with the concurrence of the Care Council when requested, ensure projects and tasks assigned to the Care Council and Care Council Administrator are in accordance with the mandated duties of the Part A Planning Council and the Part B CARE Consortium, and work with the Part A Grantee and the Part B Lead Agency, the State, the Care Council Administrator and staff to fulfill all necessary and appropriate Part A and Part B requirements on behalf of HIV-infected individuals and their families.

3. Expectations and Removal: The appointed Chairperson is expected to conduct the business of the Care Council with impartiality, fairness, and dignity. The Chairperson is expected to attend all meetings of the Care Council and be available for consultation with Grantee and Lead Agency representatives, Federal Grantor representatives, State representatives, the Care Council Administrator, members of the Care Council, and others, as necessary, to fulfill the mandated responsibilities of the Care Council. In addition, the Care Council Chairperson should have the leadership qualities necessary to make a responsible, committed Chairperson, as well as the skills and knowledge necessary to make an effective Chairperson. If the Chairperson is a provider, this individual should have the ability to remain neutral and impartial in acting as Chairperson, by objectively focusing on the purpose of the existence of the Care Council, which is to act in the best interest of the client and the entire HIV community. This individual's participation as Chairperson should make a value-added contribution to the Ryan White Part A and B Care Council. Removal for cause may be recommended to the BOCC by a two-thirds vote of the Care Council membership during a scheduled Care Council meeting, with the item placed on the agenda in advance, recorded in the meeting minutes, and delivered to the Grantee in writing by the Care Council Administrator explaining the reasons for the recommendation.

J. Vice Chairperson

The Care Council will recommend a Vice Chairperson for appointment by Hillsborough County through the Grantee, based on the results of the same Care Council nomination/election process outlined for the Chairperson. Selection and appointment will be confirmed by letter and will be for a two-year term. Should the Chairperson be absent from any

scheduled meeting, the Vice Chairperson will serve as Chairperson. Should the Chairperson resign or be removed by BOCC action, the Vice Chairperson will assume the duties of the Chairperson until the end of the unexpired term. A Vice Chairperson will be elected following procedures specified in the Care Council bylaws at the next Care Council meeting. The Vice Chairperson is subject to the same expectations and removal requirements as the Chairperson.

K. Committees

1. The Care Council may establish committees as required to accomplish its Part A and Part B mandated duties and responsibilities and to perform other necessary work for the good of the Care Council and affected communities.
2. The standing committees of the Care Council shall include (but are not limited to):
 - a. Planning and Evaluation
 - b. Membership, Nominations, Recruitment and Training
 - (1) Membership Application Review Subcommittee
 - (2) Member Mentoring, Development
 - c. Standards, Issues and Operations (SIOC)
 - (1) Grievance Subcommittee
 - d. Resource Prioritization and Allocation Recommendations (RPARC)
 - e. Women, Infants, Children, Youth and Families (WICYF)
 - f. Minority Advocacy
 - g. Health Services Advisory Committee
 - (1) Pharmaceutical Subcommittee
 - (2) Dental
 - h. Client Services
 - (1) Education and Training
 - (2) Client Issues
 - i. Rural Issues
3. Committee Requirements

Each committee, subcommittee and ad-hoc committee must be co-chaired by a member of the governing body. Each committee is responsible for the development and implementation of an annual work plan in accordance with the adopted Care Council Comprehensive Plan. Either the Chair or Co-Chair will participate in chair training within 60 days of election.

All committees of the Care Council should be composed of a minimum of 33% people living with HIV disease, unless otherwise specified.

All newly appointed Care Council members in attendance at the first committee meeting following the September Care Council meeting will be considered voting members of that committee. Subsequently, unless otherwise specified in the descriptions below, any member of the community may become a voting member of a committee after attending two committee meetings and requesting through the Chair of that committee that they be added to the listing of committee members.

Each committee, subcommittee and ad-hoc committee should, when possible, be co-chaired by a person living with HIV or AIDS. The role of this co-chair is: 1) to ensure community participation and leadership in all committees; 2) to assist the chair in carrying out the responsibilities of the committee; and 3) to ensure continuity in committee leadership by carrying out committee chair activities in the temporary absence of the chair. Each co-chair must be a member of the committee and will be elected by a quorum of the committee at a scheduled meeting with advance notice of the agenda.

4. Committee Descriptions, Requirements and Status

a. Planning and Evaluation

This committee provides input to staff regarding components to be included in the annual needs assessment; ensures that the needs assessment is comprehensive and reflects the components required by the legislation, HRSA and the State; and ensures that appropriate populations are represented in data collection within time and resource constraints. This committee is responsible for developing a comprehensive, community plan for the organization and delivery of HIV/AIDS services that is compatible with existing state or local plans regarding the provision of health services to individuals with HIV disease. The committee also develops an implementation plan for the goals, objectives, strategies and evaluations which result from the final plan.

This committee develops program evaluation requirements based on Federal legislature, HRSA guidance and the Comprehensive Plan program goals and objectives. In addition, the committee ensures that requirements are met and reviews results of program

evaluation. It revises program evaluation as needed and seeks to include key indicators or evaluation criteria to measure the extent to which pre-determined goals have been achieved, including cost and effectiveness measures.

- (1) Special Committee Requirements: None
- (2) Subcommittees: None

b. Membership, Nominations, Recruitment and Training

This committee is responsible for understanding the membership process; ensuring that the Care Council adheres to strict legislative membership requirements; ensuring membership application and selection process is effective and administered appropriately; advises governing body in membership issues; works with staff in ensuring appropriate member recruitment, training and orientation, including retreats. A subcommittee of the Membership Committee is responsible for review and scoring of all membership applications. This committee is also responsible for the nomination and election process of the Chairperson and Vice Chairperson.

- (1) Special Committee Requirements: No individual applying for membership to the Care Council may serve as a member of the Application Review and Scoring Subcommittee.
- (2) Subcommittees: Member Application Review and Scoring, Member Mentoring, Development and Training

c. Standards, Issues and Operations (SIOC)

This committee provides monitoring and oversight for the Council. It develops systems for process review; identifies emerging issues for referral to appropriate committees, and continuously reviews the strategic plan to assure compliance with Council goals and objectives. SIOC also identifies, develops and organizes grievance policy and procedures, and as necessary, resolves or recommends means of resolution to the Council.

The SIOC may be convened by one of the following: The Council Chairperson/Vice-Chairperson, the council Administrator, or a majority of voting Council members. The Vice Chairperson will serve as the Chair of SIOC. Decisions resulting from a vote of the committee are final.

Issues which may be addressed by this committee may include: conflict of interest, excessive member absences or assessing the

performance of the Chair or Vice-Chair and then developing recommendations to the full Council concerning possible removal. SIOC may also convene to act on behalf of the Council to respond to emergency Part A or B program or fiscal developments (from Federal, State or local government); to provide time-sensitive, unscheduled program reports for agencies or to respond to provider emergencies requiring immediate service decisions.

The SIOC will not change service category priorities established by the Council as the basis for allocating funds. Nor may it amend the Bylaws, make decisions contrary to the Bylaws or change the Comprehensive Plan's goals or objectives unless approved to do so by the Council.

A quorum of seven members, inclusive of the Chair or Vice-Chair, must be present to convene the SIOC. The composition of the SIOC is as follows:

Chairs of these committees: Planning and Evaluation, Membership, Minority Advocacy, RPARC, WICYF, Client Services, Rural Issues, Health Services Advisory

The Council Chairperson and/or Vice-Chairperson (each with voting privileges except if either are involved in proposed actions)

Two members of the Council representing affected communities. These may be voting or non-voting members.

Other individuals deemed integral to the discussion-at-hand may be called upon to serve ex-officio, as non-voting members.

(1) Special Committee Requirements: In addition to those listed above, for issues related to funding prioritization and allocation, no member may be a Title I or Title II provider. In the case where a committee chair is a provider, the co-chair will be designated as the member of the SIOC for that particular issue.

(2) Subcommittees: Grievance

d. Resource Prioritization and Allocation Recommendations Committee (RPARC)

This committee is responsible for developing recommendations for the Part A and B funding prioritization and allocation process. They work in close coordination with staff to assure that this process reflects the findings of the needs assessment. The

recommendations are then brought to the Council for approval and presented to the Grantee.

The committee also meets at various times throughout the year to re-allocate funds. The committee may also be called on to participate in SIOC issue discussions, which concern funding.

(1) Special Committee Requirements: Each Part A and B agency will be limited to one voting representative. If it is determined that two individuals from one agency will sit on the RPARC, one must be a PLWH. PLWH will comprise 33% of the Committee's voting membership.

(2) Subcommittees: None

e. Women, Infants, Children, Youth and Families (WICYF)

This committee works to ensure the active and effective participation of women and those who represent infants, children, youth and families in the planning and decision-making process of the Council. To accomplish this, the Committee will carefully consider and seek ways to ensure clients' retention in the core medical services, with emphasis on women-centered primary care, and to eliminate or reduce barriers to care (e.g., transportation), to involve appropriate providers, to continuously identify individuals who are under served or not served and to retain these clients in the continuum of care. Finally, the Committee acts as liaison between planning and service provision by working to ensure access and to eliminate barriers to services for women, infants, children, youth and families.

(1) Special Committee Requirements: None

(2) Subcommittees: None

f. Minority Advocacy

This committee ensures that the needs of minority, underserved and underrepresented communities and populations are reflected in the planning and decision-making process of the Council. The committee seeks to increase access to these populations and to increasingly improve their representation and involvement at all levels of the Council, with emphasis on committee participation and Council membership. Finally, the committee acts as a liaison between planning and service provision by working to ensure access and to eliminate barriers to services for minorities, the

underserved and underrepresented populations.

- (1) Special Committee Requirements: None
- (2) Subcommittees: Minority Outreach Pilot Project

g. Health Services Advisory

This committee serves in an advisory capacity to the Council on issues related to primary care, dental care, medications, new treatments, adherence and other clinical issues related to the maintenance and improvement of health. This committee is also directed to work closely with and advise the Rural Issues committee.

- (1) Special Committee Requirements: This committee must include, but is not limited to, health and medical professionals and providers with diverse areas of expertise.
- (2) Subcommittees: Pharmaceutical, Dental

h. Client Services

This committee addresses a variety of issues related to the services which clients receive as a result of Part A and B funding. It ensures that the broadest array of services is provided with the highest possible quality within resource and funding constraints. The committee also seeks to provide clients with updated resource references and to create opportunities in all Council counties for PLWH participation.

- (1) Special Committee Requirements: None
- (2) Subcommittees: Education and Training, Client Issues

i. Rural Issues

This committee ensures that the needs of rural communities and populations are reflected in the planning and decision-making process of the Council and networks to improve the availability and effectiveness of needed services in rural areas. The committee also works to ensure the active and effective participation of rural county clients and agencies and those who represent them in the planning and decision-making process. This committee seeks to educate residents about services; improve rural access to services, including meeting transportation needs of clients and to assure

equitable funding of services. It also acts as a liaison between planning and service provision to ensure access and eliminate barriers to services for rural clients.

- (1) Special Committee Requirements: This committee must include, but is not limited to, representation from Part A and B rural areas as defined by the Council.
- (2) Subcommittees: None

L. Associate Members

The Care Council may appoint Associate Members to the Care Council who will not be considered in complying with the HRSA requirements for membership composition. These members will be required to regularly attend a Committee meeting and will be invited to attend Care Council meetings and retreats. The Associate Members may serve as a pool of alternates for voting members to designate as an alternate. Associate Members will only vote when serving as an alternate for a voting member. Associate Members may be assigned a mentor by the Membership Committee.

V. CONFLICT OF INTEREST

A. From the law (Section 2602(b)(5)):

- 1. The Care Council may not be directly involved in the administration of a grant (under Section 2601(a) - Part A grants to eligible metropolitan areas). 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.
- 2. An individual may serve on the Care Council only if the individual agrees that if the individual has a financial interest in an entity, if the individual is an employee of a public or private entity, or if the individual is a member of a public or private organization, and such entity or organization is seeking amounts from a grant under Section 2601(a), the individual will not, with respect to the purpose for which the entity seeks such amounts, participate (directly or in an advisory capacity) in the process of selecting entities to receive such amounts for such purpose.

- B. All Care Council members must complete and sign, as part of the application process and prior to appointment to the Council, a Conflict of Interest Disclosure Form. This disclosure form certifies the Care Council member has read, understands and supports the conflict of interest objectives of these Bylaws and Operating Procedures. In addition, all Care Council

members shall list all the organizations with which they and/or family members are currently, or have been within the past 12 months, in a staff, consultant, volunteer, officer, board member, or advisor capacity which has received, may seek, or is eligible for funding under Part A or Part B of the Ryan White Program. In addition, clients of an organization which has received, may seek, or is eligible for Part A or Part B funding may optionally disclose any and all organizations of which they are a client.

- C. The goal of the Conflict of Interest Disclosure is to reduce to the absolute minimum the potential for either actual or perceived conflicts of interests in deliberations, votes, or any other activities related to Care Council responsibilities. It also expresses to the greatest extent possible the willingness to leave the special interests of their particular agency behind during Council deliberations and agreement to act only on behalf of the broadly affected HIV community. Council members also agree to base all service priority recommendations and decisions on client needs or gaps in service on their best judgment using the approved Comprehensive Plan for a Continuum of Care and ongoing needs assessment process as the primary guides.
- D. Any member not completing a conflict of interest statement within thirty (30) days of its receipt will be contacted once by the Care Council Chairperson, via certified mail. If a signed disclosure form is not provided within ten (10) days of receipt of said certified letter, the member shall be contacted to determine if there are extenuating circumstances which temporarily prevented them from returning a signed conflict of interest statement. If there are none, the member will be deemed in violation of Care Council Bylaws and Operating Procedures and their membership will be terminated. Upon termination, the Membership Committee will be notified of the vacancy.
- E. To avoid potential conflicts of interest, no two members may represent (receive financial remuneration from or serve as an officer of) the same organization unless the Council and/or staff has determined that the inclusion of an individual who represents the same agency as an existing member is integral to the Care Council planning and decision-making process. If it is determined that two individuals from one agency will sit on the Care Council, then no more than two individuals from one agency will be allowed.

A conflict of interest matrix will be developed by staff, which will provide Care Council members with a list of members and their agency affiliations. Questions about conflicts of interest for any individual Council member can be raised during any meeting. If questions remain regarding a conflict following discussion, the Chairperson will ask for a Council vote as to whether the member in question will have voting privileges on the issue in

question. Specific allegations of deliberate conflict of interest regarding any activities related to the Part A or Part B program will be reviewed by the SIOC, presented to the Care Council, and referred to the appropriate county department for resolution in accordance with current rules and regulations.

- F. The Care Council may also not be directly involved in the administration of a grant under Section 2601(a). Therefore, the Care Council may not designate or be involved in the selection of particular entities as recipients of any amounts provided in the grant.

VI. MEETINGS/ATTENDANCE

- A. The Council will meet at least every two months to fulfill the Care Council's mandated duties or to assist in other HIV program-related tasks. Meetings are open and non-members are welcome, but are not allowed to vote. A transcript of minutes, certified by the chair of the Care Council shall be made available for public inspection within two weeks following each Council meeting. The minutes shall contain a listing of those present; a description of matters discussed and conclusions and/or actions reached; and copies of all reports received, issued or approved by the Care Council. Minutes will be considered for formal adoption by the Care Council at its next regularly scheduled meeting.
- B. Each member must designate, in writing, a voting alternate. The alternate must be designated prior to the meeting at which the alternate will substitute for the member. The designated alternate may vote only in the member's absence. If the member decides to change alternates, he or she must submit a new alternate form in writing.
- C. Staff will keep track of absences of Care Council members at all meetings and report cumulative attendance status monthly. Attendance of the alternate in place of the member for up to three meetings will not constitute a member absence. A member cannot send an alternate more than three times a year; an alternate may not be sent for member orientation or member retreats. Three total absences by the member at regularly scheduled meetings within any 12 month period will result in a review of the member's membership. The Council Chairperson or staff will send a letter inquiring as to the reason for non-attendance and requesting the member to attend the next scheduled meeting. An absence at this meeting is considered sufficient grounds for provisional removal and subsequent replacement recommendation by the Membership Committee to the full Care Council for a vote to retain or dismiss the member. Special considerations will be given with members representing the consumer community. Exemptions may be granted by the Care Council Chair or Membership Chair under special circumstances (i.e. if a member is on official Care Council

business).

- D. A quorum shall be considered present with a 50% +1 person of the appointed Care Council members in attendance. The number of Care Council members shall be the number of current members as of the day of the meeting.

VII. VOTING PROCEDURES

- A. All officially appointed members of the Care Council may vote on any issue brought before the body, unless it has been determined that the member is in conflict of interest with the subject vote (see section V, E). Each member will be allowed to cast only one vote. Alternates designated in writing by the member, prior to the meeting at which the alternate will substitute for the member, may vote in place of the member if the member cannot attend.
- B. Any vote taken by the Care Council where the majority of votes cast equals or exceeds 50% +1 shall be considered action taken. All votes will be hand votes, unless there are greater than two dissenting votes. In that case, a roll call vote will be taken.
- C. No action will be deemed to have been taken by the Care Council unless duly voted upon and passed by the Care Council, Standards and Issues Committee, or declared by the Care Council's Chairperson that a decision by consensus was achieved.

VIII. PROCEDURES FOR COUNCIL MANDATED ACTIVITIES

- A. Needs Assessment: The Part A Grantee is responsible for ensuring that an ongoing needs assessment process is implemented, which facilitates the establishment of priority health and support services to be funded under Part A and Part B. The Care Council, with support from the Care Council Administrator, is responsible to the Grantee for assisting in completing needs assessment activities and preparing needs assessment reports and documents. The needs assessment process should include, but is not limited to, written client interviews, focus groups, a local and national HIV/AIDS environmental analysis, an analysis of all available HIV/AIDS funding streams in the EMA, and a continuum of care resource and services gap analysis. Needs assessment reports and documents will be completed in accordance with Federal Grantor and Grantee requirements.
- B. Establishment of the Health and Support Services Priorities: The Care Council Administrator and the Care Council will, in close coordination with the Grantee, develop, publish, and update the Care Council's yearly work plan, including a schedule of activities with all known decision points, time

lines, and deadlines for accomplishing both mandated duties and Care Council goals and objectives. The work plan will include sufficient detail to track work and milestones, including establishing service priorities to allow the Grantee sufficient time to prepare and submit the Part A and Part B grant proposals (which must include the Care Council's service priorities). To accomplish this, the Resource Prioritization and Allocation Recommendations Committee (RPARC) will convene to review the needs assessment and make recommendations for priorities and allocations which are driven and justified by the needs assessment. These recommendations and the results of the needs assessment will be presented to the Care Council at a publicly announced meeting. The Care Council will vote on the recommendations at this meeting, or will elect to reconvene a maximum of two weeks later to make the final decisions. If the Committee recommendations are not accepted, the Care Council must also ensure that their decisions are driven and justified by the needs assessment. The Care Council will present to the Grantee the detailed list of priority services for the service area, with any allocation recommendations and specific recommendations for sub-priorities or special county-specific requirements.

In the case that the Grantee receives notification of award above level funding, RPARC will be convened in the same manner discussed above. The Care Council's work plan will also allow for sufficient lead time for the Grantee to accomplish the following:

1. To prepare and publish competitive procurement documents;
 2. To establish the appropriate funding levels for each service priority in coordination with the Administrator and appropriate Care Council committees;
 3. To prepare, publish, receive, and evaluate service provider funding applications; and
 4. To negotiate and execute HIV service contracts with selected providers.
- C. Comprehensive Plan: The Care Council's Planning and Evaluation Committee, working directly with the Care Council Administrator, will develop and update the Comprehensive Plan for the organization and delivery of health services. The Care Council will approve the Plan and any changes to it, and will ensure that the Plan includes all available HIV services within the total service area regardless of Title or funding source.
- D. Assessment of Fund Allocations: The Care Council, through its designated committee, working directly with the Care Council Administrator, will develop criteria for and prepare an assessment of the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the total service area.

IX. PART A GRIEVANCE PROCEDURES

The Care Council must develop procedures for addressing grievances with respect to Part A funding (i.e., against the Grantee and/or Care Council), including procedures for submitting grievances that cannot be resolved to binding arbitration.

Grievances that arise pertaining to matters of the Care Council or its bylaws should be addressed in writing first to the chair of the appropriate committee, if unresolved then to the Care Council Chair, thirdly to the Standards, Issues and Operations Committee with final appeal to the Care Council as a whole.

A. Processes which fall under the realm of these grievance procedures.

1. Deviations from an established written priority setting or resource allocation process (e.g., failure to follow established conflict of interest procedures).
2. Deviations from an established written process for any subsequent changes to priorities or allocations.

B. Description of processes listed.

1. The process of establishing priorities.
 - a. Needs assessment is completed.
 - b. A public meeting is held to review the components of the needs assessment.
 - c. The Care Council RPARC convenes to review the comprehensive needs assessment and makes preliminary prioritization recommendations based upon the needs assessment. (The needs assessment is an unbiased process. It is for this reason that any prioritization decisions must be based upon the data presented in the needs assessment.)
 - d. The RPARC meets with the full Council to present the recommendations. This meeting is publicly noticed. The Care Council may accept the RPARC recommendations at this meeting. If the Care Council does not accept the RPARC recommendations, they may vote to reconvene a maximum of two weeks later to vote.
 - e. The Care Council reconvenes a maximum of two weeks later to vote on the recommendations. This meeting is publicly noticed. If the

Care Council does not agree on recommendations, which were presented two weeks earlier, resolution must be achieved at that meeting.

- f. Once the priorities are agreed upon by the Care Council, they are transmitted to the Grantee for use in the Request for Applications and contracting process.

2. Allocating funds to those priorities.

- a. The Care Council will make every effort to distribute the percentage of funds according to the percentage of AIDS and/or HIV cases in the respective county. (That is, if Hillsborough County has 54% of the reported AIDS cases, then the Care Council will make every effort to allocate 54% of the funds to that county.) If the Care Council does not allocate funds according to the respective percentages, they must specify in the minutes of the meeting why they did not. In addition, the decision must be based upon the needs assessment. (For example, a rural county receiving a higher proportion of funds because the needs assessment indicates that a new service must be implemented there.)
- b. The Care Council will allocate percentages of funds to services based upon the last year's allocation and the needs assessment's indication of increased/ decreased need in that area (i.e., if transportation was allocated 5% of the funds last year, and components of the needs assessment indicate a greatly increased need for transportation from last year's needs assessment, then the allocation for transportation may be increased). The amount of increase/decrease will depend upon:

- (1) the percentage increase in need over the year, and the availability of other funding streams to fund that particular service.

C. Who may file a grievance against the Care Council

Individuals or entities directly affected by the outcome of a decision related to Part A funding must be eligible to bring a grievance. Directly affected parties will include:

- 1. Providers eligible to receive Ryan White Part A funding;
- 2. Consumer groups/PLWH coalitions and caucuses;
- 3. Care Council members;
- 4. Grantee.

D. Grievance Process

The Grievance process may be requested from the Ryan White Administrator.

X. Bylaw Revisions

- A. These Bylaws may be amended at any regular or special meeting or the Care Council.
- B. Written notice of the proposed Bylaw changes shall be mailed, faxed or delivered to each voting member at least thirty days prior to the date of the meeting at which such discussion and voting will take place.
- C. Bylaw changes require a two-thirds majority vote of the Care Council voting members present, at which a quorum is present.
- D. Bylaw changes shall be presented to the Care Council through the normal committee approval process.

XI. History

Presented to the Care Council membership on September 1, 1999, at which time these bylaws were passed by vote of the Care Council, at which a quorum was present.

Amended 4/5/2000	Amended 7/3/2002	Amended 7/5/2006
Amended 2/7/2001	Amended 9/4/2002	Amended 6/6/2007
Amended 4/4/2001	Amended 3/5/2003	Amended 12/5/2007
Amended 9/5/2001	Amended 3/2/2005	Amended 12/3/2008
Amended 2/6/2002	Amended 6/1/2005	Amended 5/6/2009
Amended 5/1/2002	Amended 3/1/2006	Amended 9/2/2009