

**THE RYAN WHITE
HIV/AIDS TREATMENT EXTENSION
ACT OF 2009**

**TENNESSEE CONSORTIA
DEVELOPMENT AND TRAINING
MANUAL**



1 MARCH 2010
(Updated March 2016)

RYAN WHITE PART-B CONSORTIA TRAINING MANUAL

**SECTION - I
INTRODUCTION TO THE RYAN WHITE HIV/AIDS
TREATMENT EXTENSION ACT OF 2009**

**SECTION - II
CONSORTIA AND LEAD AGENCY**

**SECTION - III
POLICY AND PROCEDURE DEVELOPMENT**

**SECTION - IV
MEMBERSHIP AND LEADERSHIP
DEVELOPMENT**

**SECTION - V
EFFECTIVE MEETINGS AND COMMITTEES**

**SECTION - VI
COLLABORATIVE COMMUNITY PROBLEM
SOLVING**

**SECTION - VII
STRATEGIC PLANNING**

**SECTION - VIII
NEEDS ASSESSMENT**

SECTION - IX
FUND DISTRIBUTION PROCESS

SECTION - X
MANAGING CONFLICT OF INTEREST

SECTION - XI
EVALUATION PROCESS

SECTION - XII
**GRIEVANCE AND APPEALS PROCESS AND
PROCEDURES**

SECTION - I

INTRODUCTION TO THE RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT OF 2009

The Ryan White HIV/AIDS
Treatment Extension Act of 2009
Introduction

Background.

Ryan White was an Indiana teenager with hemophilia who contracted AIDS through a blood transfusion. He courageously fought AIDS-related discrimination and helped educate the Nation about his disease.

Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White-Ginder fought for his right to attend school, gaining international attention. Ryan was featured on countless television shows and magazine covers and was the subject of a television movie about his life. Ryan White died on April 8, 1990, at the age of 18, just a few months before Congress passed the AIDS bill that bears his name-the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act.

The legislation has been reauthorized four times since; in 1996 and 2000 it was reauthorized as The CARE ACT, in 2006 it was reauthorized and renamed The Ryan White HIV/AIDS Treatment Modernization Act of 2006, and in 2009 it was reauthorized and renamed The Ryan White Treatment Extension Act of 2009.

Intent of the Legislation

- To improve the quality and availability of care for individuals and families with HIV disease.
- To encourage public-private partnerships in planning, developing, and providing care.
- To encourage local decision-making about what care is needed and how funds are used to meet needs.
- To encourage inclusiveness in decision-making, including the involvement of affected populations.
- To define essential health and social services for individuals and families with HIV disease.
- To assure that care and services are provided to people regardless of their ability to pay.
- To assure that localities and states use funds only for services that cannot be paid for through other sources (TENNCARE, MEDICARE, private insurance, or other state / local programs).
- To assist both rural and urban areas.

The Purpose of the Program

The purpose of this program is to provide emergency assistance to localities that are disproportionately affected by the HIV epidemic and to make financial assistance available to states and other public or private nonprofit entities to provide for the development, organization, coordination, and operation of more effective and cost-efficient systems for the delivery of essential services to individuals and families with HIV disease.

The Ryan White Program

The Ryan White Program works with cities, states, and local community-based organization to provide HIV-related services to more than half a million people each year. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

The majority of Ryan White funds support primary medical care and essential support services. A smaller but equally critical portion funds technical assistance, clinical training, and research on innovative models of care.

The Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS. Each is described below.

Part A. Provides emergency assistance to Eligible Metropolitan Areas (EMA) and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic. Presently there are two EMAs in the State of Tennessee, they are Nashville and Memphis.

Part B. Provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated Jurisdictions. The Department of Health is the Part B Grantee for the State of Tennessee. **This document will primarily target Part B issues.**

Part C. Provides comprehensive primary health care in an outpatient setting for people living with HIV disease.

Part D. Provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.

Part F. Provides funds for a variety of programs:

- The Special Projects of National Significance Program grants fund innovative models of care and supports the development of effective delivery systems for HIV care.
- The AIDS Education and Training Centers Program supports a network of 11 regional centers and several National centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.

- The Dental Programs provide additional funding for oral health care for people with HIV.
- The Minority AIDS Initiative provides funding to evaluate and address the disproportionate impact of HIV/AIDS on minority populations.

The Ryan White Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts, as outlined above.

SECTION II

CONSORTIA LEAD AGENCY

Introduction

The purpose of this program is to provide emergency assistance to localities that are disproportionately affected by the HIV epidemic and to make financial assistance available to states and other public or private nonprofit entities to provide for the development, organization, coordination, and operation of more effective and cost-efficient systems for the delivery of essential services to individuals and families with HIV disease.

Service Delivery

Service delivery can be accomplished through direct contracts with the grantee, the grantee can provide direct services and services can be provided through regional consortia.

The State of Tennessee provides service delivery through all three methods.

a. Direct Contracts with Providers

- Centers of Excellence
- Pharmaceutical Support (AIDS Drug Assistance Program)
- Insurance Premium and Co-pay Assistance (Insurance Assistance Program)

b. Direct Service

- Fee For Service Program (Administered in the central office)

c. Consortia delivered services.

Tennessee Consortia Regions

The State of Tennessee has four consortia regions that encompass 79 of the 95 Tennessee counties. The remaining 16 counties are included in the two “Transitional Grant Areas” (TGAs) that are funded by Ryan White Part A. Part A will provide services to these counties. The only exceptions are HDAP and IAP, which Part B will continue to provide to all 95 counties. The four consortia and their inclusive counties are listed below:

West Tennessee Consortium: Hardeman, McNairy, Hardin, Chester, Haywood, Madison, Henderson, Decatur, Crockett, Lauderdale, Dyer, Gibson, Carroll, Benton, Lake, Obion, Weakley and Henry.

Ryan White Community AIDS Partnership of Middle Tennessee: Wayne, Lawrence, Giles, Lincoln, Moore, Coffee, Bedford, Maury, Marshall, Lewis, Perry, Humphreys, Houston, Stewart, Montgomery, Clay, Pickett, Jackson, Overton, Fentress, Putnam, DeKalb, White, Cumberland, Warren and Van Buren.

Southeast Regional Consortium: Franklin, Marion, Polk, Rhea, Hamilton, Bradley, McMinn, Meigs, Bledsoe, Sequatchie and Grundy

East/Upper East Regional Consortium: Monroe, Loudon, Roane, Morgan, Scott, Campbell, Anderson, Knox, Blount, Sevier, Union, Claiborne, Grainger, Hamblen, Jefferson, Cocke, Hancock, Hawkins, Greene, Washington, Unicoi, Carter, Sullivan and Johnson

NOTE: The two Transitional Grant Areas (TGAs) and their associated “Tennessee” counties are listed below:

- A) Memphis TGA: Fayette, Tipton, Shelby

- B) Nashville TGA: Hickman, Williamson, Rutherford, Wilson, Davidson, Cheatham, Dickson, Robertson, Sumner, Trousdale, Macon, Smith, Cannon

Consortium Responsibilities

The membership of the Consortium has responsibilities that relate specifically to the distribution of funds; monitoring of services provided by the funded subcontractors; creation of standards under which services are provided and evaluations of funded programs. In essence, the Consortia are responsible for setting the standards of care from Ryan White funded services being made available in the communities.

The State recognizes the basic underlying principle within Ryan White is that Consortia will take the lead in directing funds for care within the community. It is also important to accept that, within mandates of both HRSA and Tennessee’s contractual process, certain requirements must be held as standard operating procedures to ensure that all obligations are met. Therefore, the State has attempted to identify various responsibilities of Consortia and set parameters under which each Consortium must operate, without actually determining how each Consortium will conduct business.

- It is the responsibility of the Consortium to maintain a multi-variant, on-going needs assessment and to ensure that the results of that assessment are reported to the State on at least an annual basis.
- It is the responsibility of the Consortium to develop a formal system of tracking unmet needs within the community and to include these needs within the regional needs assessment.
- It is the responsibility of the Consortium to develop a written policy on how the regional needs assessment will be prioritized, and how the funding process relates to those priorities.
- It is the responsibility of the Consortium to develop a Conflict of Interest policy.
- It is the responsibility of the Consortium to develop a policy relating to confidentiality.

- It is the responsibility of the Consortium to develop a Grievance Policy. .
- It is the responsibility of the Consortium to develop standards for case management practice (medical and psychosocial) under which all Consortium-funded case managers will be evaluated. These standards must include the minimum standards developed by the Ryan White Services Program.
- It is the responsibility of the Consortium to communicate to each agency under subcontract for Ryan White funding the policies on verification of client HIV status and the definition of “family” as it relates to Ryan White funded programs. (The definition of “family” is included as Attachment N.)
- It is the responsibility of the Consortium to develop formal standards for all remaining services and/or positions funded through Consortium, under which evaluations will be based.
- It is the responsibility of the Consortium to develop a written plan that will outline and detail the coordination of all funded services within the region.
- It is the responsibility of the Consortium to develop a formal selection process for all potential subcontractors.
- It is the responsibility of the Consortium to develop a formal evaluation process for use with each subcontractor that will include procedures and methods to be used in the evaluation.
- It is the responsibility of the Consortium to develop a formal regional budget based upon the allocation of local Ryan White funds.
- It is the responsibility of the Consortium to develop a formal “subcontractor checklist” for all funded agencies that will include the following:
- It is the responsibility of the Consortium to develop Bylaws.

Proof of Incorporation; recent audit or financial statement; general liability insurance; personnel policies of the agency; a formal job description for all (Consortium) funded positions; a client grievance policy; demonstrated collaboration with other service providers; an internal quality and assurance program (and a copy of the funded program’s goals and objectives for Ryan White funds); plans to evaluate the cost effectiveness of the funded program; data to indicate the percentage of women, infants, children, youth and families being served through the Ryan White funded component, and specific standards/units of service through which each funded program will be evaluated.

Lead Agency

Beginning in 2017, the State requires a single Lead Agency to administer the four (4) Ryan White Part B Consortia. The Lead Agency is required to be a government agency or an incorporated community organization. The Lead Agency is responsible for receiving and disbursing Ryan White Consortia funds from the State, maintaining records and invoices, using standard accounting practices, coordinating federal and state data reporting requirements, and as necessary, arranging for fiscal audits. Once the Consortium completes a needs assessment and prioritizes the services to be funded, the Lead Agency shall establish a subcontract with service providers approved by the Consortium and implement a subcontractor invoice and monitoring system. An agency to be named / selected will serve as The Lead Agency for the four (4) Consortia Regions in Tennessee.

Responsibilities of the Lead Agency

Listed below are a number of considerations required for a Lead Agency.

- The Lead Agency will have demonstrated experience with generally accepted accounting principles, as evidenced by audit reports, appropriate records and financial management-information systems.
- The Lead Agency will not be a recipient of Ryan White direct service funds through the regional Consortia. The Lead Agency will assume the role of Administrative Agency for fee for service or multiple vendor client service plans (i.e. Dental Services Plan).
- The Lead Agency will sign a formal contract on behalf of the four (4) regional Consortia with the State of Tennessee and as such, will adhere to the regulations and requirements of that contract.
- The Lead Agency will sign formal subcontracts with service providers that are identified by the regional Consortium as being recipients of local Ryan White funds (after approval has been received from the State of Tennessee).
- The Lead Agency will be responsible for receiving invoices from subcontractors that have been awarded funds through the regional Consortium.
- The Lead Agency will be responsible for invoicing the State of Tennessee for services performed by the identified subcontractors.
- The Lead Agency will be responsible for reimbursing subcontractors with funds received from the State.
- The Lead Agency will be responsible for submitting regular (quarterly) programmatic and financial reports to the State, and as required, to the Consortium; including In Kind or match contribution(s).

- If applicable, the Lead Agency will be responsible for employing, supervising and providing office space for the Consortium staff.
- The Lead Agency will keep the State of Tennessee apprised of all regional Consortium and RAC meetings, membership lists, committee membership lists, minutes of meetings and other items of business (relating to Ryan White and care/prevention collaboration) within the regional Consortium. The State needs this information to fulfill its requirements under the law. Membership lists should contain name of member and contact information. Changes to ANY of the above need to be sent to the State within two (2) weeks of the change.
- The Lead Agency will be responsible for ensuring that all subcontractors are familiar with the CAREWare Data Collection, used to collect demographic and service related data on all clients receiving Ryan White funded services. An electronic submission of reports is required quarterly by the State. Each agency is required to follow the schedule that has been provided from the State. Reporting is to be done by every agency funded through Consortia and Minority AIDS Initiative Project funds.
- The Lead Agency is responsible for maintaining all Consortium meeting files.
- The Lead Agency is responsible for organizing all Consortium mailings.
- The Lead Agency is responsible (to the State) for monitoring all regional subcontractors and conducting monitoring visits no less than two times per year.
- The Lead Agency is responsible for negotiating with the State the manner and the amount of costs it will require to operate as a Lead Agency.
- The Lead Agency is responsible for submitting to the State, a formal Consortium budget based upon Ryan White funds allocated to the region. This budget should include funding categories (based upon prioritized needs defined within the analysis of the needs assessment) and amounts intended to be awarded within each category. This budget should also include categories and caps on funding.
- The Lead Agency will be responsible for ensuring that services to women, infants, children, youth and families provided by Ryan White funds fall within the ratio of women, infants, children and youth to the total HIV/AIDS population within the Consortium region. This will involve the collection of data for the State to use in determining if the required percentage of the State award is used to provide services for this population. The amount required (percentage) is updated annually and provided by the Health Resources and Services Administration.

- The Lead Agency will be responsible for reporting to the State any programmatic or funding irregularities that pertain to the operation of the regional Consortium under the Ryan White Program.

Upon reviewing the above guidelines, it becomes very evident that the responsibilities of both the Lead Agency and the Consortium are extensive. It is imperative that the Lead Agency and the regional Consortium clearly define their respective responsibilities and create a written agreement that specifically details exactly what is required and expected, and to provide the State a copy of that written agreement. The items listed above, especially as they relate to the State, are items that must be included in the overall roles of both the Lead Agency and the Consortium.

Primary / Major Consortia Activities

- 1. Conducting / developing annual Needs Assessment.**
- 2. Plan for Coordinated Services**
- 3. Funding Mechanism**
- 4. Implementation Plan**
- 5. Oversight & Monitoring of:**
 - a. Service Providers**
 - b. Lead Agent**
- 6. Evaluation of:**
 - a. Consortium Process**
 - b. Quality of Services Provided**

Consortia Activities
Requirements Worksheet.

Task	Date Completed
Establish 'Conflict of Interest Policy	
Conduct Needs Assessment	
Prioritize Services Based on Needs Assessment	
Plan Coordination of Services	
Budget According to Services Selected	
Develop Funding Procedures / Mechanism	
Develop Subcontractor Selection Process	
Select Subcontractors	
Develop Grievance Policy	
Develop subcontractor / Fiduciary Agent Monitoring / Oversight Process	
Ensure that Women, Infants, Children and Youth amounts are included.	
Develop Bylaws	
Develop Comprehensive Plan	
Develop Evaluation Process for Consortium & Quality of services	
Develop an Implementation Plan	
Develop Process for Tracking Unmet Needs	

How do we get there from here?

There are some key questions that must be addressed
and decisions that must be made.

Functional Operational Decisions

1. Where do we start?

Key initial decisions should be made about the mission or purpose of the Consortium, how decisions will be made, basic initial structure and how the Ryan White funds will be handled. However, it is critical that all members understand that the Consortium development process is an evolving process. Policies and procedures can and (most likely) will change over time. As the Consortium grows and develops the procedures to implement the full intent of the legislation, policies and procedures must be flexible enough to change. Getting a basic framework in place is the first step. Spending excessive amounts of time “second guessing” any possible contingency and developing comprehensive policies and procedures to meet any future problem will not only result in frustration on the part of members, but will delay the Consortium’s ability to move quickly to the tasks at hand: a needs assessment, a fund distribution process, development of a comprehensive service plan, contacting with service providers and a process for evaluating the Consortium and subcontractor performances. Don’t fall into the “What If.” trap in the early development stages of the Consortium.

2. What is the Consortium’s mission and / or purpose?

Obviously, the reason for convening the Ryan White Part B Consortium in the first place is to provide a mechanism for distribution of federal fluids aid provide direct client services to people infected and affected by HIV/AIDS. If the Consortium wishes to expand their mission beyond this, then the mission statement should include any additional purposes, such as:

- Soliciting additional sources of funding.
- Providing the mechanism for collaboration between the local HIV Task Force, the Education & Prevention Community Planning Group, state HIV planning entities and any additional advisory councils relative to the mission of the Consortium
- Becoming the HIV/AIDS “United Way” - a foundation for raising and distributing funds to service providers.
- Educating the community about HIV/AIDS.
- Being the “umbrella” organization for all HIV/AIDS planning in the community.
- Serving as an advisory body to local government agencies.

3. How will decisions be made?

- Majority vote
- Smaller committees
- Group consensus
- Roberts' Rules
- Recommendations by subcommittees to the body as a whole
- A combination of above

4. How will each entity be represented in decision making?

- One person, one vote
- One agency, one vote
- One constituency, one vote

Ample time should be allowed for this discussion. If the Consortium decides to have one agency, one vote, for example, the Public Health Department is not one agency and representation should be encouraged from various agencies in Public Health - Alcohol/Drug, TB & Infectious Diseases, Housing Authority, etc. Additionally, how are volunteers and Board Members from an agency categorized? What if someone volunteers at more than one agency or sits on more than one Board? If the Consortium decides on one constituency, one vote - will "seats" be set aside for constituencies based on demographic representation in the community (i.e. if 40% of the general population is Latino/Latina, will 40% of the membership "seats" be designated for Latino/Latina representation?)

5. Is there a limit on the number of members?

The intent of the Ryan White Legislation is to include everyone affected and infected by HIV, from both the public and private sectors, in the collaborative process of developing a community plan for the delivering of HIV services along the full continuum of care. At the same time, the Consortium must complete very specific tasks and functions. It is very difficult to have productive meetings with one hundred people seated at the table. Therefore, the need for Consortium productivity must be carefully balanced against the mandate of the legislation to include all perspectives in the process.

Consortia representing large areas with high numbers of representatives may wish to create a structure where the bulk of the work needing to be completed is in the hands of smaller groups (such as a Board of Directors and Committees) with reporting of activities at quarterly meeting of all the members. Obviously, this structure must take into account the need to carefully delineate decision-making authority of all components (i.e. what decisions do the general members make and what decisions does the Board of Directors make?).

A decision to limit the number of members on the Consortium should be made only after a structure is proposed that includes making sure all perspectives relative to HIV in the community are represented (i.e. designated seats for each perspective) and incorporates venues to ensure regular communication between the larger community and the Consortium (i.e. regular public hearings, townhall meetings, public comment at Consortium meetings, etc.)

6. What is the process for appealing Consortium decisions?

- Grievance Committee
- Leadership position / Chair / Co-Chairs
- Ad-hoc committee
- Subcommittee of a standing committee
- Consortium as committee of the whole

7. Who will handle the Consortium's funding? (Fiscal Agent, Fiduciary Agent, Lead Agency) In the State of Tennessee, each Consortium has a Lead Agency.

- County Health Department
- Community-based private agency
- Nonmember agency
- Incorporated, for-profit agency

8. How should the Lead Agency be selected?

- Vote of entire Consortium membership
- Recommendation of the State, Ryan White Program Office
- Selection / Interview / Nominating Committee
- Executive Body / Committee of Consortium

9. What should be the criteria for selection?

The Lead Agency should be “the organization within the Consortium with the most experience with the identified population and types of services needed”. If this is a criteria selected by the Consortium, then how can conflict of interest be avoided? Fiscal Agents must meet the following criteria:

- A track record in human service delivery and contract for service delivery.
- Demonstrated experience with generally accepted accounting principles, based on audit reports and appropriate records, etc.
- Sufficient cash reserves for 60-90 days of Consortium service delivery.

- Legal status (incorporated. etc.)
- Experience in program management.

Public entities chosen as Fiscal Agents are governed by legal procedures and must secure specific approvals from the Boards of Supervisors for all contracts and subcontracts.

10. What are the Fiscal Agent / Fiduciary Agent / Lead Agency’s role and responsibilities as they pertain to the Consortium?

- Signing subcontracts on behalf of the Consortium.
- Signing a contract with the State on behalf of the Consortium.
- Receiving invoices from subcontractors.
- Invoicing the State for services performed.
- Reimbursing subcontractors with funds received from State.
- Submitting financial reports on a regular basis to the Consortium and the State Ryan White Program Office.
- Employ, manage and house Consortium staff, if required.
- Donate Consortium staffing personnel.
- Maintain Consortium files (could include all documents, minutes, etc.)
- Consortium mailings (minutes, meeting announcements, etc.)
- Provide staff to take meeting & committee meeting minutes.
- Monitor subcontractors.

Each Consortium and Lead Agency should clearly define responsibilities. Clarity on this relationship and the roles and responsibilities of each, will provide for a much healthier working relationship.

11. What percentage of the Consortium’s Part B funds will be spent on administration, accounting, reporting and program oversight, planning and evaluation?

The State Ryan White Part B Program Office will provide this information. Administrative costs will not exceed 10% of the total award. The State Program Office, Fiscal Section, will provide the details of what exactly can be charged as Administrative and what can be charged as Program Costs. The Consortium will need to decide what percentage is appropriate as part of the negotiation with the Lead Agency. A Consortium administrative budget should be developed either as part of the Lead Agency budget or in addition to the Lead Agency budget.

12. Who will do the contract / agreement / Letter of Understanding / Memorandum of Understanding delineating these roles and responsibilities between the Consortium and the Lead Agency?

- Executive Committee
- Officer(s)
- Lead Agency
- Legal Counsel
- Combination of some or all of the above

13. Will staff or Board Members of the Lead Agency be allowed to serve as Consortium Officers?

There are three distinct entities participating in the local-level Ryan White Part B process: the Consortium, the Lead Agency and the Service Provider(s). Maintaining the integrity of the Consortium's decision-making process requires careful discussion about the roles and responsibilities of the Lead Agency in their fiduciary capacity. To maintain a true check and balance relative to the finances of the Consortium, many Consortia do not have Lead Agency staff or Board Members in officer positions. Some do not allow these Lead Agency representatives to Sit as voting members of the Consortium. Any not-for-profit organization which has undergone an outside financial audit knows that accepted financial procedures require a clear separation between the person who authorizes a payment, the person who writes the check and the person who keeps the financial records. The clear separation of financial authority for different actions needs to be clearly defined by the Consortium as part of the negotiation process with the Lead Agency.

14. How will the Lead Agency performance be evaluated?

- Regular reports to the Consortium by Lead Agency
- Evaluation Committee develops and implements Evaluation Process
- Questionnaire filled out by Consortium members
- Committee of financial experts not attached to Consortium evaluates performance.
- Criteria for evaluation included in Memorandum of Understanding between Lead Agency and Consortium

15. Who is responsible for evaluating the Lead Agency's performance?

- Executive Committee / Officers
- Oversight / Monitoring / Evaluation Committee
- Committee convened with people not attached to Consortium

SECTION - III

POLICY AND PROCEDURE DEVELOPMENT

Consortia Policies and Procedures

Every Consortium should have policies and procedures which have been developed and approved by the entire Consortium. Every member of a Consortium should have a copy of all policies and procedures. While policies and procedures will vary from Consortium to Consortium, every Consortium needs to ask key questions relative to the Consortiums functions and task completion. Throughout the life of a Consortium, decisions are being made at even meeting. These decisions need to be recorded and distributed to the general membership. Essentially, all key decisions made relative to the functioning of the Consortium are the Consortium's policies and procedures. Going back over Consortium minutes and pulling out all key decisions is a good place to begin when developing a new Policies and Procedures Manual. The following identifies the major areas of policy and procedure development and lists key questions which need to be discussed and decided upon by the Consortium membership. The answers to these questions are the Consortium's policies and procedures.

1. What are the key points to consider when developing policies and procedures?

a. General Key Questions:

- Will the Consortium have formal by-laws?
- What is the role of the Consortium?
- What are the responsibilities of the Consortium?
- How will the Consortium's performance be evaluated?

b. Membership Key Questions:

- What is the composition of the membership?
- Will there be a limit on the number of members?
- How will members be selected?
- How will members get the right to vote?
(Example: a member must attend three consecutive meetings before voting.)
- Will there be a policy regarding status of an entity's number of votes'.
(Example: one agency, one vote)
- What is the process for removing members?
- Are there criteria for continuing membership?
(Example: A member cannot miss more than four consecutive Consortium meetings to keep active status or all members must participate in a committee to retain active status.)
- Will members be required to sign a commitment statement?
- What is the member grievance or complain process?

c. Meeting Key Questions:

- Are there attendance requirements?
- What is the decision-making process?
- Who will chair meetings?
- Who will take meeting minutes?
- Is there a quorum requirement?
- How will meetings be announced? When will meetings be held?
- Will there be provisions at meetings for the special needs of targeted populations?
(For example: signers for hearing challenged, wheelchair accessibility, etc)
- Are there meeting wound rules?

d. Officers and / or Board Members Key Questions:

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

e. Committee Structure Key Questions:

- What standing committees will be created?
- Are any ad-hoc committees needed?
- What will be the roles and responsibilities of each committee?
- How will committee members be selected?
- What authority will committees have to act independently?
- What authority will committee members have to act independently?
- How can committee members be removed?
- How will the performance of committee members be evaluated?

f. Lead Agency Key Questions:

- What are the roles and responsibilities of the Consortium's lead agency?
- What will be in the document (contract / memorandum of understanding) between the Consortium and the lead agency?
- Who will negotiate the contract?
- What is the relationship of the lead agency to the Consortium?
- What authority does the lead agency have to act independently?
- How will the lead agency's performance be evaluated?

g. Fund Distribution Key Questions:

- What process will be used to distribute the Consortium's funds?
- How will the availability of the funds be announced to potential service providers?
- What will be the guidelines or criteria for selecting service providers?
- Who will select the service providers?
- How will conflict of interest be avoided?
- What is the funding appeals process for service providers who apply?

h. Subcontractors Key Questions:

- What are the roles and responsibilities of the Consortium's subcontractors?
- Who will negotiate the subcontracts?
- What is the relationship of the subcontractors to the Consortium?
- What is the authority of subcontractors to act independently relative to Consortium funds they receive?
- What are the standards of care for case management (and all service provided with Ryan White funds?)
- Will a quality assurance or quality improvement program be required of subcontractors?
- What is the process for evaluating the performance of subcontractors?

i. Policies and Procedures Key Questions:

- What is the conflict of interest policy and process?
- What is the confidentiality policy?
- What policies and processes govern conflict resolution?

2. What will a typical Policies and Procedures Manual include?

- By-Laws.
- Consortium's Mission Statement.
- Consortium's current Strategic Plan.
- Membership policies and procedures.
- Committee policies and procedures.
- Job descriptions for all officers, board members, general members and committee members.
- Copies of a contracts, letters of agreement, memorandums of understanding with subcontractors and the lead agency.
- Meeting rules and regulations.
- All definitions.
- Confidentiality policy.
- Conflict of interest policy and procedure.
- Conflict resolution policies, processes and procedures.
- Fund distribution process.
- Any other policies and procedures relative to a Consortium's role in the community.

3. Who should develop the Consortium's policies and procedures?

- The Consortium as a whole.
- Committee.
- Subcommittee.
- Legal counsel.
- Leadership.
- A combination of above.

4. How will the Consortium participate in the ongoing development of operating policies and procedures?

- Members may introduce policies and procedures in motion form at general Consortium meetings.
- Policies and Procedures Committee writes all draft policies and procedures for final approval by Consortium.
- Committees introduce policies / procedures for Consortium approval relative to committee's roles and responsibilities.
- A combination of above.

5. How will the Consortium's policies and procedures be distributed to members?

- In Consortium meeting minutes.
- Policies & Procedures Binder (new policies / procedures are added after approval).
- Mailed quarterly or as updated.
- Provided at Consortium meetings.

6. How rigidly will policies and procedures be enforced? I

The Consortium as a whole must agree to enforce its own policies and procedures. While one or two people may be assigned to monitor compliance, the responsibility for the effective functioning of a group by agreeing to "play by the rules" rests with every single Consortium member. The Consortium will set its own culture or "tone" by whether or not its own policies and procedures are enforced. Members should be encouraged to speak up if they feel that policies and procedures are being ignored by the membership. Either the policy or procedure needs to be reconsidered because it is not being used / no longer applies or a general consensus needs to be reached about how to enforce policies and procedures. This should include specific actions that will result when Consortium policies / procedures are disregarded.

7. Who is responsible for assuring compliance with policies and procedures?

- Chair, Co-Chair, President.
- Officers.
- Committee Chairs.
- Executive Committee.
- Policies & Procedures Committee.
- Facilitator.
- All Consortium members.

8. Where will the Consortium's records be kept?

- Lead Agency office.
- Staff office (if applicable).
- Chair / President's office or home.
- Secretary office or home.
- Shared office space within some community based organization.
- Local Health Department.

Grievance / Appeals Processes

There are three types of grievance or appeals which may occur relative to the Consortium and its decisions:

- (1) Consortium member grievance,
- (2) Client complaint/grievance and
- (3) Agency appeal after the funding process.

1. What is a “Consortium Member Grievance”?

Consortium members may have a grievance / problem / concern relative to the activities of the Consortium which they feel is not being addressed during the regular meeting or committee process of the Consortium. Consortium member grievances are confined to responsibilities of the Consortium. This process should not be used to address concerns or problems with a specific service provider’s performance, a client problem, problems with the local health jurisdictions, concern regarding activities of the state program office, etc. There are seven areas of activity which represent the “outcome” of the entire Consortium process. The general meeting and committee processes support these outcomes. The specific activities of the Consortium are:

- a. Needs Assessment
- b. Prioritization of needs dollars to service priorities
- c. Plan for Coordinated Services
- d. Implementation Plan
- e. Funding Mechanism
- f. Oversight & Monitoring of
 - Service Providers funded by Consortium
 - Lead Agency
- g. Evaluation of:
 - Consortium process
 - Quality of services funded

A Consortium member grievance may be relative to any of these activities and the operational processes developed to produce these activities the meeting process, the membership process, the leadership development & selection, committee development and responsibilities, policies & procedure development, etc.

What does a “Consortium Member Grievance” process look like? A typical grievance or complaint process includes the following steps:

- Written grievance or complaint is mailed to the Consortium’s principal leader such as the chairperson, president or selected committee chairperson.

- The person in receipt of the written grievance should acknowledge receipt of the complaint in writing within a specified number of days.
- The principal leader or his / her designee meets with the complainant with the goal of alleviating concerns and rectifying the situation for mutual satisfaction.
- If a resolution of the grievance cannot be obtained by the principal leader, a membership grievance committee can be convened to conduct an investigation of the issues, hold a hearing and develop a solution. The membership grievance committee is sometimes composed of community leaders not formally attached to the Consortium or Consortium-funded services. Potential non-members include attorneys, judges, and professional mediators.
- The decision of the membership grievance committee can be final, or a recommendation can be given to the membership of the Consortium for a vote.

2. What is a ‘Client Complaint Grievance’?

The Consortium should avoid getting involved between a service provider and its clients in any disputes or grievances. How a service provider handles client complaints and how frequently clients complain about a service provider should be included in the evaluation of a service provider’s performance and will be reflected in the Consortium’s decisions about which service providers to fund each year.

The Ryan White Part B Consortium is responsible for prioritizing the client service needs in a community, developing a coordinated implementation plan to meet those needs and directing Ryan White Part B funds to service providers who will provide the services necessary to meet the needs in the community’. The Consortium is not a direct service provider. The Consortium funds service providers. As such, the Consortium should require that, at a minimum, its funded service providers meet these criteria: (a) incorporation as a legal, business entity, (b) adequate liability insurance, (c) written personnel policies and (d) a written client grievance complaint process within the service provider structure. As a funder, the Consortium should not be tempted to “micro-manage its service providers. The Consortium is responsible for developing a community-wide response to HIV/AIDS and needs to maintain an objective unbiased perspective about the full continuum of services provided locally. The Consortium can, and should, expect their funded service providers to meet certain standards of care. The Consortium monitors and provides oversight of the services provided by its funded service providers. Further, the Consortium is responsible for evaluating the quality of services it funds. The standards of quality care expected (and the indicators of how to measure those standards) should be included in the contract between the Lead Agency and the service provider. One standard of care should be “Client Satisfaction”. Indicators of this standard could be “number of client complaints” or quality rating of specific services by clients. Therefore, it is important to get input and feedback from clients about the quality of services they are receiving. This is an appropriate function of the Consortium. Resolving the actual complaints / grievances is the responsibility of the agency providing the services.

3. What is an “Agency appeal” after the funding process?

Any agency/organization, which meets the criteria for funding, may appeal funding and / or reallocation decisions of Consortium. The appeal must be based on one of the following:

- a. Agency did not receive information made available to other agencies;
- b. Agency has additional information that might make for a more informed decision;
- c. Allegation of bias, fraud, or misuse of federal funds on the part of the Consortium;
- d. Violation of federal or state guidelines;
- e. Violation of the Consortium By-Laws.

NOTE: Dissatisfaction with level of funding is not a basis for appeal.

Potential providers / non-funded providers may have a grievance / problem / concern relative to the funding decisions procedures of the Consortium.

What does an “Agency Appeal / Grievance” process look like? A typical grievance or complaint process includes the following steps:

- Written grievance or complaint is mailed to the Consortium’s principal leader such as the chairperson, president or selected committee chairperson.
- The person in receipt of the written grievance should acknowledge receipt of the complaint in writing within a specified number of days.
- The principal leader or his / her designee meets with the complainant with the goal of alleviating concerns and rectifying the situation for mutual satisfaction.
- If a resolution of the grievance cannot be obtained by the principal leader, a special appeals / grievance committee can be appointed and convened to conduct an investigation of the issues, hold a hearing and develop a solution. The appeals / grievance committee is sometimes composed of community leaders not formally attached to the Consortium or Consortium-funded services. Potential non-members include attorneys, judges, and professional mediators.
- The finding and recommendations of the grievance committee may be presented to:
 - a. The Executive Committee for final decision or
 - b. Consortium Chair for final decision or
 - c. The Consortium Membership for final decision or
 - d. All or any combination of the above.

SECTION - IV

MEMBERSHIP AND LEADERSHIP DEVELOPMENT

Membership Recruitment & Maintenance

Introduction

Central to the Ryan White, Part B Consortia process are the Consortia members. In addition to providing a collaborative private/public partnership and developing a coordinated provider response to HIV/AIDS, the Consortia process promotes community involvement, which is essential to the development and implementation of a plan which provides quality, cost-effective direct client services to people infected and affected by HIV/AIDS. Recruiting and maintaining members must be a top priority of all Consortia.

If there is a “magic recipe” for membership recruitment and maintenance, it is quite simply: The better the Consortium is organized and operated, the easier it is to recruit new members and the easier it is to maintain current members. If the Consortium’s mission is clearly defined, the Consortium’s policies and procedures documented and agreed upon by all members, the strategies and tasks necessary to complete the mission are developed and undertaken by the members, and the committee structure such that all participants understand their roles and responsibilities, then the Consortium members will feel that they are making a worthy contribution to something that matters to them and will feel that their participation is producing something they can take pride in. Even the way meetings are run will keep or drive away members. Everything in this manual is geared towards one goal: efficient and effective Consortia with strong, participatory membership.

An example of how the Consortia process affects membership is the case of one Consortium in California which decided to target their fairly sizeable Native American population for membership recruitment. One member of the Consortium was an honorary member of the local Tribal Council (He was a County Supervisor and not Native American) This member spent about six months talking about HIV and the Part B Consortium with members of the Tribal Council. After much discussion, the elders finally decided to send two representatives to the Consortium. After one meeting, they did not return. It turned out that the way the meetings were run was so foreign to the two representatives that they felt too uncomfortable to return. Native American culture uses a consensus process with lots and lots of time (over months or even years) to reach any major decisions. The speed with which the Consortium was making critical funding and need priority decisions by using a majority vote process was anathema to the Native Americans in attendance. Now the Consortium is very careful so begin its critical decision-making process 6 months before the final decision is required, they include agenda time in every meeting to simply discuss the key issues (even if the final decision isn’t required for another 6 months) and they hold more public forums town-hall meetings where everyone can discuss the issues that will eventually result in their funding decisions and there are members of the Consortium who are Native American.

Before a Consortium embarks upon a recruitment plan for new members, they should evaluate and review their own procedures and policies and ask:

- a. “Is our Consortium run in such a way that new members will feel welcome?”
- b. “Will new members understand what we are trying to accomplish?”
- c. “Will new members feel comfortable participating in meetings?”

- d. “Will new members clearly understand what needs to be done and how to get actively involved?”

How will members be recruited?

- a. Direct mailings to other organizations mailing lists & current members’ own personal mailing lists.
- b. Targeted contact where Consortium members agree to call up potential members from targeted groups and work with them to become members. This may include a type of mentoring” or “buddy” program where the members agree to pick-up potential members and drive them to meetings, work with them to help them understand the process and do whatever it takes to help someone become involved. Consortia members should be sensitive to the special of needs of many targeted populations. This could include providing transportation, child care, signers for the hearing challenged, special presentations for those with visual problems, reading of all printed materials for those with varying degrees of literacy levels, and meetings held in various locations and at various times.
- c. Collaborative community networking. Consortium members should attend other organization’s meetings and promote membership on the Consortium in their public venues or where speakers are allowed. Some Consortia are developing “Speakers Bureaus. To not only educate about HIV/AIDS and the Consortium funded services, but to advertise/promote Consortium membership.
- d. Newspapers, newsletters. Consortium meetings should be regularly advertised in local newspapers and member organization’s newsletters.
- e. Flyers, brochures. Distributing flyers or brochures at various locations is certainly one technique to promote the Consortium but has seen little direct success when used as the only recruitment technique. When used in conjunction with some of the other techniques, it can be an effective tool for promoting the Consortium membership but is used most widely to promote the Consortium funded services. Flyers and brochures should, also, be translated into all the major language groups of the targeted populations for both services and Consortium presentation.

How do non-members become members (criteria for membership)?

- a. Application process
- b. Appointment by Consortium
- c. Invitation to join
- d. Attendance at multiple consecutive meetings
- e. By volunteering
- f. Signing a commitment statement

- g. Meeting specific criteria determined by the Consortium
 - Agreement with mission of Consortium
 - Represent targeted populations
 - Represent targeted agencies
 - Recommended by other Consortium members
 - Experience with HIV/AIDS

What are the requirements to maintain membership?

- a. Committee participation
- b. Regular attendance at full Consortium meetings
- c. Can't have more than an agreed upon number of unexcused absences from Consortium meetings
- d. Participation in special projects
- e. Fundraising commitment
- f. Membership dues

Are there different types of participatory membership?

- a. Advisory members (non-voting)
- b. Members who are in the process of completing requirements for full membership (i.e. attending a certain number of meetings)
- c. Members (non-voting) from Consortium-funded service providers (to avoid conflict of interest issues)

How will new members be oriented?

- a. Regular orientation meetings
- b. One-on-one (mentor/buddy system)
- c. Mailing them a new-member orientation package or binder

Who will do new member orientations?

- a. Individual members who volunteer to do orientation
- b. Mentor/buddy
- c. Staff
- d. Membership Committee members

- e. Officer(s)
- f. Committee convened to do

Who will develop and maintain the new member packages or binders?

- a. Membership Committee
- b. Executive Committee
- c. Committee convened to do
- d. Staff
- e. Secretary or other Officer

Will there be continuing education/training for all members?

- a. Consortium Strategic Planning Retreats
- b. Trust Building
- c. Team Building
- d. Conflict Resolution
- e. Mission/Issues/Functions
- f. Facilitation/Meeting Management
- g. Agenda Development
- h. Membership Development/Maintenance
- i. Leadership Development
- j. Collaborative Community Problem-Solving
- k. Effective Use of Committees
- i. Effective Communication Skills
- j. Diversity Development/Competence

How can members be removed?

After membership criteria have been developed, the Consortium should then develop a specific process to remove members who do not continue to meet the membership criteria or who violate the By-Laws, Policies & Procedures or Rules of the Consortium. In an effort to avoid requests for removal that are based solely on personality conflict, the Consortium should develop a process that is as fair and impartial as possible. Members cannot be removed if there are no clear, articulated membership requirements. You cannot remove members for violation of rules they did not know about. A Membership Recall Policy should incorporate the following elements (similar to personnel policies in most organizations):

- a. Written notification of violation(s) to member. This should include actions necessary to correct violations and a time frame within which the corrective action must occur. This is usually handled by the Executive Committee or Officers of the Consortium.
- b. Meeting between member and Executive Committee or Officers to attempt to mediate a solution that provides for the needs of the member and the Consortium.
- c. If corrective action does not occur or if the member refuses to attempt to find a solution with the Executive Committee or Officers, mediation/conflict resolution can be attempted with an outside expert facilitating.
- d. If all attempts to mediate a solution fail, a motion to remove a member can be introduced before the full membership with complete written documentation of all steps taken to mediate the situation. Usually, membership removal requires a two-thirds vote of the members of The Consortium.
- e. The member should be allowed to appeal via the member grievance process of the Consortium..
- f. Some Consortia use the member grievance process for all complaints, including complaints relative to a member's removal.

How will the Consortium solicit the input of members and non- members?

- a. Surveys, questionnaires
- b. Interviews
- c. Public hearings
- d. Focus groups
- e. To meetings
- f. Committees
- g. Public testimony/input time at every Consortium meeting.
- h. Random public sampling (via telephone or "Person on the street").
- i. Self-addressed, stamped "Opinion cards" distributed widely and mailed back to the Consortium.
- j. Radio talk show - call-in format.

What is the Consortium's process for member grievances/complaints?

- a. Written grievance/complaint mailed to (Chair, Co-Chairs, President of the Board, Executive Committee, Membership Committee).
- b. Person(s) in receipt of written grievance should respond in writing within a specified number of days.

- c. If a resolution of the member grievance cannot be obtained by the Executive Committee or Officers, a Member Grievance Committee can be convened to conduct an investigation of the issues, hold a hearing and develop a solution
- d. The decision of the Membership Grievance Committee can be final, or a recommendation can be given by the Membership Grievance Committee to the full membership of the Consortium. Asking the full Consortium to make the final decision in a member grievance can be very difficult and may require a lengthy re-debate of the findings of the Membership Grievance Committee.
- e. The Membership Grievance Committee (usually ad-hoc) is sometimes composed of community leaders/members not attached in any way to the Consortium or Consortium-funded service providers. Some Consortia use members of their local United Way Board of Directors in this function (only if United Way is not the Consortium's Lead Agency).

Statement of Individual
Consortium Member's Responsibilities

I _____ do hereby commit to:

General Expectations

1. Know the Consortium's mission, purpose, programs and services. Continually work to develop and implement strategies, goals, policies and procedures that promote the Consortium's mission.
2. Work to attract new members who can make significant contributions to the work of the Consortium and reflect the diversity of the community and the HIV/AIDS epidemic.
3. Fulfill commitments made, undertake special assignments willingly and consider serving in leadership positions.
4. Avoid prejudiced judgments on the basis of information received from individuals and urge those with grievances to follow established policies and procedures for grievances within the Consortium. (All matters of potential significance should be called to the attention of the Consortium's leadership)
5. Stay informed and follow the trends in the HIV/AIDS epidemic.
6. Bring a sense of humor to the Consortium's deliberations.

Meetings

1. Prepare for and participate in Consortium meetings and committee meetings.
2. Ask timely and substantive questions at Consortium and committee meetings consistent with my conscience and convictions, while supporting the majority decision on issues decided by the Consortium.
3. Maintain confidentiality of the Consortium's executive sessions and speak for the Consortium only when authorized to do so.
4. Suggest agenda items periodically for Consortium and committee meetings to ensure that significant policy-related matters are addressed.

Avoiding Conflicts

1. Serve the HIV/AIDS community as a whole rather than only serving a special interest group, constituency or service provider. (It is very important that all the various perspectives of the HIV/AIDS epidemic be represented and participate in discussions. Ultimately, all Consortium members need to make final decisions for the good of the entire community.)
2. Avoid even the appearance of a conflict of interest that might embarrass the Consortium and jeopardize the credibility of the funds allocation process, and disclose any possible conflicts to the Consortium in a timely fashion.
3. Maintain independence and objectivity and do what a sense of fairness, ethics, and personal integrity dictate even though not necessarily obliged to do so by law, regulation, or custom.
4. Never accept (or offer) favors or gifts from (or to) anyone who is funded by the Consortium or does business with the Consortium.

Fiduciary Responsibilities

1. Exercise prudence with the Consortium's decisions regarding allocation of the Ryan White Part B funds. I understand that we are the stewards of these public funds and our decisions about how to spend them must be made in a fair, impartial, and informed way.
2. Faithfully read and understand the Consortium's financial statements and budgets and otherwise help the Consortium fulfill its fiduciary responsibility.

Further, I personally commit to:

(For example: accomplish a specific task, sit on certain committees, take responsibility for certain functions of the Consortium, take a leadership role, etc.)

Signed _____ Date:

Leadership Development

Consortia Leadership

Introduction

Selection of leadership for the Consortium is one of the most important decisions the members of a Consortium can make. There are general guidelines (expectations, if you will) that can guide the membership in their selection process. A Consortium can expect its leaders to:

- Provide leadership to the members in expediting the goals of the Consortium.
- Guide the Consortium in fulfilling its stated roles.
- Chair Consortium meetings effectively, assuring adequate discussion of all issues, but keeping the meeting moving.
- Utilize the Consortium members' time effectively.
- Supervise standing committee chairpersons.
- Represent the Consortium in important matters that affect it.
- Develop Consortium members to assume future leadership roles.
- Enhance the Consortium's image in the community.
- Be a role model as demonstrated by the way they represent the Consortium.
- Maintain a sense of humor.

Leadership positions in the Consortium.

- a. Chair
- b. Co-Chairs
- c. President
- d. Officers
- e. Executive Committee
- f. Steering Committee
- g. Board of Directors

Establish limitations to authority & responsibility of leadership.

- a. Limited terms of office
- b. Spokesperson only
- c. Liaison between Consortium and others
- d. Recall procedure

Selection of leadership role(s).

- a. By nomination and majority vote of entire Consortium.
- b. By volunteers.
- c. Rotating positions.
- d. Nomination/Selection Committee.
- e. Committees/groups representing local communities or counties name representatives.
- f. Combination of above.

Other issues

- 1. Should there be a policy which ensures that people with HIV/AIDS and targeted special populations have access to leadership positions?
- 2. Will representatives of agencies receiving Part B funds be allowed to serve in leadership positions?
- 3. If there is a Steering Committee, Executive Committee or Board of Directors, how will full membership representation be assured?
- 4. If there is a Steering Committee, Executive Committee or Board of Directors, what kinds of decisions will they be allowed to make vs. the decisions the full Consortium will make?
- 5. Who will develop the Job Descriptions for each position?
 - a. Officers
 - b. Executive Committee
 - c. Committee Chairs
 - d. Policies & Procedures Committee
 - e. By-Laws Committee
 - f. Special ad-hoc committee
- 6. What accountability is there regarding leadership & completion of tasks?
 - a. Executive Committee
 - b. Full Consortium review (verbally or with an evaluation tool/questionnaire)
 - c. Included in Consortium's peer review process
 - d. Fiscal Agent/fiduciary Agent/Lead Agency

SECTION - V

EFFECTIVE MEETINGS AND COMMITTEES

Effective Meetings

Your group can not be any more effective than your meeting process. To have effective meetings, consider the following:

(1) Use a facilitator.

A facilitator's role is to guide discussion without participating in the content of the issues under discussion. The Chair can serve as a facilitator, or someone else in the group. If the Chair is responsible for parliamentary procedure, it is very difficult to chair a meeting, facilitate the discussion and keep track of time. Using a facilitator will complement the Chair's ability to run an effective meeting. A facilitator also helps make sure that everyone has had an opportunity to speak and encourages those attendees who are not actively participating to speak up. Using a facilitator helps diminish domination of the meeting by a few participants. The facilitator should be someone respected for their skill in helping others express their opinions, for their ability to respond to group process, and for their personal integrity/fairness/even-handedness/coolness under fire/ability to be strong when needed.

(2) Use a recorder.

A recorder's role is to note major points on flip charts posted on the wall, so participants can tell at a glance the major points covered during the discussion as well as the current topic or focus under consideration. The facilitator can point to these charts to focus attention and to summarize actions and agreements at the end of the discussion or meeting. The secretary or person taking minutes can use these charts to check for accuracy of notes taken and reports made.

(3) Keep track of policy decisions & action items.

The recorder should keep a separate sheet of paper which lists all final decisions that have been made by the group - whether it's a policy decision or an action item. This will be a list of any commitments made by individuals or subcommittees/committees. Included should be a complete list of who agreed to do what by when. (Who, What, By When) This list should be at the top of the minutes printed and distributed after the meeting. At the beginning of the next meeting, the facilitator can use the list to review the action items and policy decisions from the previous meeting to ensure consistency, refresh participant's memories of previous decisions and promote follow-through.

(4) Prepare the agenda in advance.

The agenda should be pre-circulated. The agenda should be very clear in stating what you hope to accomplish by the end of the meeting. The agenda should list in order every item or activity you plan to cover, with approximate times indicated for each agenda item. Post the agenda on a flip chart during the meeting. At the beginning of the meeting, the facilitator should allow time for the group to review the agenda and suggest changes that the group may agree to. During the meeting, if any changes must be made, the facilitator should negotiate them with the group; that includes changes to the approximated times.

(5) Insist that your meetings start and end on time!

You can encourage group members to participate more actively if they know that the meeting will start at the appointed time, and that it will not run over the appointed ending time.

(6) Summarize each meeting at the end.

At the end of each meeting, it is useful for the facilitator to summarize all agreements and decisions made by the group. Take a few minutes at the end of the meeting to check-in with group members about what they liked about the meeting, and what they would like to see changed in the meeting process the next time. This serves as a learning tool for the group and helps them learn together how to improve the effective use of their time.

(7) Develop ground rules.

The group should have a set of agreed-upon ground rules for what behavior is appropriate during meetings. It is important to get everyone's agreement that the ground rules developed are reasonable and that everyone is willing to live by them. They should be posted on flip chart paper at every meeting, and can be changed as needed and agreed to by the group. It is the job of the facilitator, as well as every member of the group, to notice when others are not living up to the ground rules and point that out in a non-evaluating and non-threatening way. Here are some examples of ground rules:

- Respectful engagement (even in the most bitter of debates)
- One person speaks at a time
- Side conversations must happen outside the meeting room
- No personal attacks
- Let the speaker finish a thought
- Do not repeat a point already made by someone
- Have fun

Brainstorming these is fun and allows the group to have a role in formatting their own time together. Ground rules allow for group 'buy-in to the meeting process and helps participants own their responsibility in the meeting process.

(8) Agree on the meeting process.

Robert's Rules is the most widely-used parliamentary process used by most groups. However, the group as a whole must either agree to use Robert's Rules exactly as they are printed or they must agree to their own modified Rules of Order. Robert's Rules is designed to provide a guideline to parliamentary procedure but they, also, clearly state that each group has its own process and its own intended meeting outcome. Many groups use a modified Robert Rules with customized Rules of Order designed to meet the specific culture of the organization. This only works if: (a) everyone agrees to the rules and (b) the rules are written down and distributed to everyone.

(9) Design an agenda format and stick to it.

The road map' to a successful meeting is the agenda. Developing agendas takes practice and experience, but is critical since a meeting can fall apart with a poorly developed agenda. One example of an agenda is:

- (a) Open with a review of the agenda, anticipated outcomes, ground rules and introductions, if appropriate.
- (b) Review action items and policy decisions from last meeting.
- (c) Conduct new business.
- (d) Summarize all actions and policy decisions made during the meeting
- (e) Close with a quick review of the major agreements/decisions/commitments made during the meeting and with a process review.

As with any process, these suggestions are intended to provide guidelines only. Each group must develop its own process. The key is taking the time to regularly evaluate how effective your meetings are. You shouldn't have to wait until the symptoms of an ineffective meeting process make themselves known. Symptoms of ineffective meetings include: divisiveness, lack of participation, membership falling off, inability to accomplish tasks of organization, a feeling of time being wasted, and the stagnation of an organization. Use of a formal, structured, agreed-upon meeting process with regular evaluation of your own process &ill ensure much more effective meetings.

Consortia Committees

Introduction

Committees are appointed, elected or drafted, for a purpose. They have an assignment to complete within a specified time. Committees have jobs to do - recruiting membership for the Consortium, developing policies and procedures, providing monitoring/oversight of subcontractors, developing and performing an on-going needs assessment, developing community public relations and communication, working with the Fiscal Agent/Fiduciary Agent/Lead Agency or providing executive oversight. Committees help move the business of the Consortium along in a much more effective and efficient manner than if all discussion, background work and development were done by the full Consortium. Committees can accomplish a great deal of work with smaller numbers of people, bringing recommendations back to the Consortium for final decisions.

One requirement for improving the work of committees is that the purpose of the committee should be clearly defined. The Consortium should define the purpose of the committee, spell out its job, and its responsibilities and duties. The committee should then develop its own (1) Mission Statement, (2) Strategies for accomplishing the Mission, and (3) Tasks and timelines. Additionally, every committee should have a Job Description for its members.

The Consortium is also responsible for defining the committee's limits, the time span for which it is appointed, how far it is supposed to go and where it is expected to stop. The Consortium, as a whole, must decide how much authority is invested in a committee and then resist the temptation to re-do" the committee work at the Consortium meeting by re-discussing all components of a committee recommendation, thus duplicating the discussion which happened at the committee level.

Any one committee may do its work in a number of ways. At committee meetings, the members plan jointly. They all take part in committee discussions and decisions. But they may actually do the work by individual assignment, sub-committees, teams or pairs, or by combinations of these either during or between meetings. It is not necessary, and probably not desirable, to have the whole committee write an RFP (Request for Proposal), write a report or compose a letter. Individuals or teams may compose questionnaires, conduct surveys, compile and analyze answers and figures, make telephone calls, draft policies and/or procedures, etc.

The Ryan White Part B Consortia have very specific tasks that need to be accomplished. Committees are developed based on these tasks. Each Consortium needs to assess what needs to be accomplished and develop committees that complement the completion of these tasks.

Committees that need to be developed.

(These are just some ideas based on what Consortia have developed):

- a. Executive - usually composed of Officers and Committee Chairs. Provides leadership, Consortium oversight, committee oversight, and can have varying degrees of decision making authority. The Executive Committee usually meets between Consortium meetings and can be authorized to take certain actions on behalf of the Consortium should the need arise in the intervals between Consortium meetings.
- b. Needs Assessment - handles developing the needs assessment plan, tools and for collecting data for on-going reporting of unmet needs.
- c. Client Services - responsible for developing draft service delivery plan and can be responsible for tracking status of client services in community.
- d. Membership - develops plan for recruiting new members, develops and implements new member orientation presentation and package, can be responsible for mentoring new members.
- e. Grants / Allocation - reviews RFP's, conducts interviews with agencies seeking funding, ensures that the funding recommendations are based on the latest needs assessment.
- f. Financial - works with Fiscal Agent/Fiduciary Agent/Lead Agency to keep track of funds, responsible for making sure financial reports are prepared and distributed to Consortium members.
- g. Policies & Procedures - develops draft policies and procedures for the Consortium membership, maintains the Policies & Procedures Manual, ensures that every member has copies of all policies & procedures after they have been approved. May be responsible for Parliamentary Procedure during meetings (if the Consortium has decided to use Parliamentary Procedure for its meeting process).
- h. Bylaws - responsible for developing Bylaws, maintaining the By laws, presenting purposed changes to the Consortium.
- j. Fund Raising Development - if the Consortium has decided to do fund raising, this committee develops a fund-raising plan and can either directly implement the plan or convene ad-hoc subcommittees to actually do the different fund-raising tasks.
- k. Membership Grievance - usually an ad-hoc committee convened when a member files a grievance. This committee can investigate the complaint or grievance, make recommendations to the full Consortium or act as the final arbitrator in resolving the grievance.
- l. Appeals - also usually an ad-hoc committee convened as part of the fluid distribution process. This committee handles service provider appeals relating to applications for funding.

- m. Monitoring/Oversight - responsible for providing oversight of both the Fiscal Agent/Fiduciary Agent/Lead Agent activities and the activities of the subcontractors. Can be responsible for developing the Quality Assurance/Quality Improvement Plan for Consortium which is incorporated into the contracts with subcontractors. Some Consortia have assigned individual members from this committee to be the personal representative to each service provider, to expedite clear communication, deal with issues and concerns that need to come back to the Consortium, do site-visits and submit regular reports on the service provider's activities relative to the Part B subcontract.
- n. Consortium Evaluation - responsible for developing the process to evaluate the performance of the Consortium, could use peer review techniques or design a process using input from outside the Consortium membership.

The following methods can be used to select committee members.

- a. Appointment by Consortium
- b. Election by Consortium
- c. Volunteers
- d. Election by current committee members

Building Committees

Why Have Committees?

Committees are appointed, elected or drafted, for a purpose. They have an assignment to complete within a specified time. Committees have jobs to do - recruiting membership for the Consortium, developing policies and procedures, providing monitoring/oversight of contractors, developing and performing an on-going needs assessment, developing community public relations and communication, working with the fiscal agent or providing executive oversight.

One requirement for improving the work of committees that demands so much of our time and energy, and on which we depend for so much important work, is that "the purpose of the committee should be clearly defined". The Consortium should define the purpose of the committee, spell out its job, its responsibilities and duties. The committee should then develop its own (1) goals, (2) objectives and (3) timelines. The Consortium is also responsible for defining the committee limits, the time span for which it is appointed, how far it is supposed to go and where it is expected to stop. The Consortium, as a whole, must decide how much authority is invested in a committee and then resist the temptation to "re-do" the committee work at the Consortium meeting by re-discussing all components of a committee recommendation, thus duplicating the discussion which happened at the committee level.

The Committee At Work.

Committees are set up to do specific jobs for the Consortium as a whole. A committee can reflect or reproduce all the nonproductive issues/problems of the Consortium - or develop nonproductive issues/problems of its own - unless its assignment is clearly defined, its membership includes the necessary individuals, and unless its organization and operation are democratic.

Any one committee may do its work in a number of ways. At committee meetings, the members plan jointly. They all take part in committee discussions and decisions.

But they may actually do the work by individual assignments, subcommittees, teams, or pairs, or by combinations of these either during or between meetings. It is not necessary, and probably not desirable, to have the whole committee write an RFP, write a report or compose a letter. Individuals or teams may compose questionnaires, conduct surveys, compile and analyze answers and figures, make phone calls, etc.

Often there is a tendency for the committee chair to take on too many individual assignments her/himself, instead of sharing the work and the leadership.

The accompanying Committee Check List gives some important guides for effective committee operations.

Committee Check List.

1. Is the place of meeting comfortable, accessible, and attractive?
2. Does the committee understand its assignment?
3. Is the agenda carefully planned and thoughtfully worked out by the whole committee?
4. Do the members transact their business in an expeditious manner?
5. Does the committee have representation of differences of viewpoint and diversity of belief?
6. Is there healthy competition of ideas?
7. Do the members feel they really belong are “a part of,” and think of it as “their” committee?
8. Is the committee responsible in that it is willing to be accountable to the Consortium?
9. Does the committee spread its work assignments?
10. Can the committee make constructive use of conflict, opposition or criticism?
11. Is the committee flexible and adaptable?
12. Does the committee obtain the facts, study and analyze them, make decisions as a result of full discussion and then take appropriate action?
13. Do the members feel that time is used wisely and sense real achievement?

14. Do the meetings start and stop on time? (A Committee Work Record chart can be used as an aid, by the chair and the entire committee, to develop a picture of committee assignments and work progress. It can also help the committee see which members, if any are being overlooked and not permitted or required, to participate as fully as they should.)

Members Have Responsibility, Too.

A committee is more than a collection of individuals. Whether around a conference table or a kitchen table, over a period of time committee members must learn to work together as a group.

For a committee to function effectively, the members must accept responsibility. The next time that you say, "That was a poor committee meeting," perhaps you should ask, "What did I do to try to make it better?"

It might be well for your Consortium to consider a code of committee member responsibility. For just as chairs are too often pushed into leadership jobs with such arguments as: "There's nothing to it," and "it won't take much time," so people are pushed into accepting committee membership assignments when the committee task is not one they are comfortable with or do not enjoy. Many Consortia are requiring committee membership as a requirement of Consortia membership. It is important that people accept committee assignments where they have something to offer, are comfortable with the other members and committee duties, and have the time and energy to do the job. Consortia must be especially sensitive to the physical realities of the members with HIV. There is always something that someone can do, even if they don't have the energy to attend meetings. These members may be perfectly willing to make phone calls from their home, write reports, or just provide much-needed advice and reality-checks about the affected communities.

A member has as much responsibility as the chair for the success of a committee.

"Do I just go to a committee meeting as I might go to the movies or on an excursion"? Of course not. When I work on a committee I am..

- Exercising my right and my responsibility for democratic self expression.
- Sharing in doing a task that needs to be done and can be done better by a group
- Giving of my ideas, my opinions, my feelings, my convictions with reference to the task.
- Getting helpful ideas from others who are likewise focusing on the job to be done.
- Testing my ideas against the varying experience of others.
- Learning the necessity of give and take as the discussion develops.
- Carrying responsibility in a thoughtful manner in behalf of the whole group.
- Thinking out-loud and developing my thoughts in the company of others.
- Creating a common unity of purpose and understanding.

- Deciding upon the best course of action.”

To carry out these responsibilities well a committee member needs certain knowledge, attitudes and abilities. Answers to the following questions may give you clues as to where the qualifications for committee membership can be strengthened:

Committee Member Check List.

1. Am I familiar with and sympathetic toward the aims and methods of the Consortium which created the committee?
2. Can I express myself easily and clearly and enjoy the give and take of exchanging ideas with others?
3. Do I have reasonably good focus, a sense of direction and a sense of timing, plus a willingness to stick to the task at hand?
4. Am I receptive, open-minded and able to learn and to receive stimulation from others?
5. Do I have vision and perspective which enables me to see the present in terms of the future?
6. Am I fundamentally operative and seeking after agreement and unity?
7. Am I able to arrive at decisions and face their implications?

To be effective, committee members should be able to attend meetings regularly. They should seek to understand the committee assignments and discussions and should share the responsibility of sticking to the subject and trying to understand and use the ideas of other members. They should help in reaching committee decisions, in committee action and in following up the final disposition of its work. Committee members should also evaluate their own contributions to the committee and share the responsibility for evaluating the work of the committee as a whole.

Facilitation Roles and Responsibilities.

1. Develop Ground Rules.
2. Give everyone a chance to speak.
3. Encourage quiet people to contribute.
4. Keep one or two people from dominating.
5. Keep your eye on the clock
6. Control distractions.
7. Watch “tone/mood” of group.
8. End the meeting on a high note.

Principles of Presentation

1. The purpose of presenting is to persuade.
2. Perceptions are more powerful than facts.
3. People are inundated with data.
4. People forget fast.
5. Effective presentations are balanced and satisfy four basic criteria:
 - They are attention-getting
 - They are meaningful
 - They are memorable
 - They are activating

Presentation Components

- Know subject well / Do your homework
- Know your audience
- Outline your presentation
- Develop the narrative
- Design supplemental materials (audiovisuals, handouts)
- Tell audience what you are going to say, say it, tell them what you said:
 - Introduction
 - Body of Presentation
 - Summary
- Reinforce familiar ideas
- Link personal experiences to those of your listeners
- Stick to the purpose of your presentation

Speaking Skills

1. SMILE SMILE SMILE
2. Speak clearly and slowly (articulate)
3. Make eye contact
4. Engage the group/audience
5. Use examples audience can relate to
6. Project confidence
7. Be enthusiastic

8. TALK to your audience
9. Never read from a script or your notes
10. Never point at people
11. Know your objective well & stick to it
12. Respect your audience
13. Watch “nervous” physical activities/distractions
 - playing with clothing
 - jingling coins in pocket
 - tossing hair off face
 - putting on or taking off glasses
 - making vocalized pauses “uh”
 - waving your hands without a reason
 - shuffling your feet
 - rustling your papers or notes

Good public speakers understand these six basic rules

1. They know when to talk and when not to.
2. They talk about things that interest others.
3. They use simple, everyday language.
4. They talk without pomposity.
5. They gesture naturally.
6. They maintain eye contact.

Good Books to Read:

Make Presentations with Confidence, Vivian Buchan, Barron’s Educational Series. Inc.1991.

Public Speaking Made Easy, Thomas Montalbo, Melvin Powers Wilshire Book Company. 1994.

How to Present Like a Pro (Getting People to See Things Your Way) Lani Arredondo McGraw-Hill, Inc. 1991.

SECTION - VI

COLLABORATIVE COMMUNITY PROBLEM SOLVING

Collaborative Community

Problem-Solving

Introduction

Before we begin to look at problem-solving in the collaborative environment as it relates to the public and private response to HIV/AIDS at the community level, we need to define “collaboration” relative to the Ryan White Part B Consortia.

The following is taken from “Community Collaboration Manual” published by The National Assembly of National Voluntary Health and Social Welfare Organizations.

What is Collaboration?

Collaboration is the process by which several agencies or organizations make a formal, sustained commitment to work together to accomplish a common mission. Collaboration requires a commitment to participate in shared decision-making, and allocation of resources related to activities responding to mutually identified needs.

Collaboration implies a structure by which organizational representatives decide how to plan and act together. Generally, by-laws or other written materials or procedures will be helpful.

Collaboration implies a style of work in which agencies and organizations deliberately decide to do things together as a whole, rather than as individuals acting on their own initiative.

Collaboration implies a sense of community in which members see themselves as complementary and mutually supportive contributors to the whole community and not as competitors.

Each collaboration is unique in its characteristics and structure, but there are some factors identified as unique to successful collaborations. Collaborations have:

1. a clearly defined mission or purpose which is mutually agreed upon by participants;
2. active involvement of participants in the establishment of goals, objectives, and activities;
3. clearly defined operating procedures and a clear definition of members’ roles;
4. a communication system, which includes regular information sharing and planned discussion of interagency competition, vested interests, and turf issues; and
5. a sense of “common ground” where participants find a common agenda and feel the collaboration is their enterprise.

As they work together, collaboration members will make decisions about:

1. What kinds of services will be provided?
2. Which organizations will be included for membership?
3. The structure of the collaboration.
4. The focus of the collaboration - whether to emphasize capacity building for members to enhance their service to the community; or community action/advocacy, or both.
5. How to provide resources to operate the collaboration.

Why Collaborate?

Collaborations provide opportunities to rethink concepts of how organizations within a community relate to each other and can respond to the growing needs of their members and the community, often in the face of scarce resources.

Collaborations Can Help Communities:

1. identify gaps in current services and cooperate to fill the gaps;
2. expand available services by cooperative programming and joint fundraising or grant programs;
3. provide better services to clients through inter-agency communication about client needs, referral programs, and client case management;
4. develop a greater understanding of client and community needs by seeing the whole picture;
5. share similar concerns while being enriched by diverse perspectives that different members from varied backgrounds bring to the collaboration;
6. reduce interagency conflicts and tensions by squarely addressing issues of competition and "turf";
7. improve communication with organizations within the community and, through those organizations, to larger segments of the community;
8. mobilize action to affect needed changes through collective advocacy,
9. achieve greater visibility with decision-makers, the media and the community;
10. enhance staff skill levels by sharing information and organ joint naming programs;
11. conserve resources by avoiding unnecessary duplication of services; and
12. decrease costs through collective buying programs and other collective cost containment opportunities.

Seven Keys to Successful Collaborations

1. Shared Vision

Collaboration means that participants are willing to act together to meet a mutually identified need and that they believe the collaboration is useful. It also implies that the participants are willing to trust each other is carrying out the mission of the collaboration, while understanding that each participant may bring a different agenda to the collaboration. Developing a shared vision starts with understanding these different agendas and finding ways to meet the needs of the participants whenever possible. The process continues with the participants coming to consensus around the definition of the need or problem, and developing a mission statement that guides the group in its decision-making and its activities. The founding participants must collectively discuss and support the final mission statement. New participants must understand the vision of the collaboration and support the mission.

2. Skilled Leadership

Collaborations usually begin with a small group of interested individuals brought together by a catalyst event or by common needs or values. All participants in this initial group have a stake in leadership, and in the outcomes. As the collaboration groups, new participants need to feel a sense of responsibility for the success of the group, even if they choose not to take a leadership role.

As the group further evolves, however, new leaders need to be cultivated to ensure that a few individuals are not over-burdened and are not perceived as too controlling or monopolizing. Continuity and orderly transitions of leadership are essential.

Listed below are some characteristics and skills that good collaboration leaders might possess:

1. ability to guide the group toward the collaborations goals, while seeking to include and explore all points of view.
2. comfort with consensus building, and small group process;
3. respect in the community and knowledge about the issues the collaboration will address;
4. skill to negotiate turf issues;
5. belief in the process of collaboration;
6. knowledge about the community and organizations in the community;
7. skill and persuasiveness in oral and written communication; and
8. time to commit to leadership.

3. Process Orientation

While collaborations live by their results, the process of collaborating is itself an end worth pursuing.

Attention always needs to be focused on the process of including people in the shared decision-making of the collaboration. Many groups strive for consensus. This ensures the opportunity for all participants to have input and gives minority opinions a full hearing.

Since participants always “come to the table” with their own agendas, it is important to maintain the focus on the agreed upon mission, while simultaneously striving to meet the participants’ needs.

Some form of conflict is natural as various parties engage in collaborative efforts, Change brings about a certain degree of discomfort, and disagreements over turf. The key is to manage the conflict and channel it into useful solutions. When conflict occurs, it must be addressed sensitively, using effective communication and listening skills.

4. Cultural Diversity

The collaboration must be open to the richness that comes from including members of different cultural, racial, ethnic, and income groups. It must recognize the commonality of all human beings while treasuring the unique aspects that various cultures bring. Understanding differences in language, customs, and values is vital.

If there were no differences among groups, life would be less exciting - and there would be little need for collaborations. Members of each culture need to examine their own assumptions about other cultures and act to correct misunderstandings. Collaborations provide the “common ground” for this to occur. Participants need to devote the necessary time and energy to ensuring that they communicate clearly with members of other cultural groups. Often the effort needed to communicate successfully with someone from another culture results in a new perspective on the topic and creative solutions to problems.

5. Membership-Driven Agenda

Groups join collaborations to meet organizational needs. Participants must acknowledge and clarify their needs, to allow as many individual needs to be met as possible. People need to feel important and included. On-going assessment on how well the collaboration is meeting the needs of members, enhances the viability of the group.

All participants should contribute resources to the collaboration. These resources may be time, space, contacts, in-kind resources, or financial resources. When members contribute resources, their sense of ownership in the collaboration is increased. But there should be a balance in the relative level of contributions from various participants. Sometimes, organizations that contribute large amounts of resources accrue a disproportionate amount of power. While this is sometimes unavoidable, it can prevent other members from feeling included.

6. Multiple Sectors

Successful collaborations seek to include as many segments of the community as are compatible with the mission of the collaboration. Collaborations exist to represent certain viewpoints or stands on issues, or they seek to bring together organizations in a particular field of endeavor.

Collaborations who attempt to mobilize an entire community around an issue or set of issues find that it is important to be as inclusive as possible. Organizations and communities not likely to be represented need to be brought into the process. One of the strengths of collaborations is that they bring together different segments of the community around a particular need or concern and attempt to forge a new style of working together

Strength comes from the diversity of the collaboration. Encouraging as much diversity as appropriate for the collaboration is important. Diversity can result in creativity, increased understanding and communication and enhanced political clout in the community. However, tokenism should be avoided. The group must be open to authentically involving all members in the process.

7. Accountability

Collaborations exist to achieve certain specified results and outcomes. The process of developing a shared vision with appropriate goals and objectives should aim toward these clearly stated results. Accountability means specifying results anticipated at the outset, and then monitoring progress on a continuous basis so midcourse corrections can be made. An evaluation of collaboration efforts and results should be planned from the outset to help collaborators decide how various efforts should be modified, expanded or dropped.

Possible Barriers to a Collaboration

Barriers arise from:

- negative past experiences with collaborative efforts in the community
- difficult past or current relationships among member organizations
- competition and turf issues among members
- personality conflicts between representatives of member organizations
- racial or cultural polarization in the community
- differing community norms and values about cooperation

Preventive Strategies to Minimize Barriers

1. Keep the commitment and activities clearly defined. Move through each stage of developing the collaboration only when members are ready.
2. Make clear communication a priority. Communicate with all members regularly and avoid assuming that all members are informed on collaboration business.
3. Spend time getting to know each other. Schedule time for information sharing and team building on a regular basis.
4. When new members join, make an extra effort to help them understand the collaboration process and how to “tap in”. People who are new often remember the little acts of courtesy and hospitality that helped them feel welcomed.
5. Encourage members to be “up front” about their needs. Set up win-win situations so that members’ needs can be met whenever possible.
6. Don’t avoid turf issues and hidden agendas. Encourage negotiation and communication among member organizations that are in conflict. Bring in outside experts if necessary.
7. Develop clear roles for members and leaders. Develop written statements that document commitments expected of participants.
8. Plan activities that are fun. Celebrate the accomplishments of the collaboration. Recognize the contributions of the members and reward their accomplishments. Also, recognize the successes of the members and member agencies even when not directly related to collaboration business.

Ten Most Common Problems of Collaboration

1. Loss of direction or focus.
2. Loss of leadership or struggles for leadership.
3. The “Founding-Member-Syndrome.”
4. Unequal involvement and recognition of members.
5. Poor planning efforts.
6. Negative publicity.
7. Failure of planned projects.
8. Burn out or unrealistic demands on members.
9. Bureaucratic structure.
10. Turf battles and competition.

SECTION - VII

STRATEGIC PLANNING

Strategic Planning

Introduction

Strategic Planning is the process of determining what an organization intends to be in the future and how it will get there. Planning toward a future for the organization and determining the best path to reach that future are the essential components of strategic planning. Strategic planning is long-range planning, usually a three to five year plan. Operational planning (short-range) is the annual planning around objectives, program plans and budgets. Operational plans should complement the strategic plan in that the operational plan will develop the smaller increments of movement on an annual basis which serve to move the organization toward the vision of the strategic plan

There are three major forces in strategic planning:

1. The mission - what the organization intends to accomplish
2. Opportunities and Threats - what is needed and what is feasible
3. Strengths and Weaknesses - what are you capable of doing

The strategic plan attempts to find where these three forces overlap. Key questions need to be answered in the strategic plan: “Is the mission clear? Does the mission fit with what’s needed and feasible? Does the organization have the capabilities and resources to do what’s needed? Does the organization have the ability and incentive to make the necessary course corrections as changes in the environment happen?”

Developing A Strategic Plan

Step #1 Get Organized

1. Decide whether to develop a strategic plan
2. Get commitment
3. Determine if outside help is needed
4. Outline a planning process that fits
5. Form a planning team

Step #2 Do a Situation Analysis

1. History and present situation
2. Mission
3. Opportunities and Threats
4. Strengths and Weaknesses

5. Critical issues for the future

Step #3 Develop a Strategy

1. Select a planning approach
 - Scenario approach
 - Critical issues approach
 - Goal approach
2. Identify and evaluate alternatives
3. Develop strategy

Step #4 Draft and Refine the Plan

1. Agree on format
2. Develop a first draft
3. Refine the plan
4. Adopt the plan

Step #5 Implement the Plan

1. Implement the Plan
2. Monitor performance
3. Take corrective action
4. Update the plan

Figures 1 and 2 are examples of Strategic Planning Processes for a small / medium and a large organization. The other templates are samples of tools that can be used in the development of a Strategic Plan.

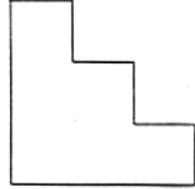
Figure-1: Strategic Planning Process.
Community Health Center

Steps	Responsible
1. Get agreement on planning steps.	Executive director Board chair Consultant
<i>Meeting 1 (5-hour meeting with board and key staff):</i>	
2. Orient board and staff to strategic planning.	Consultant
3. Do situation analysis: History and present situation Mission Opportunities and threats Strengths and weaknesses Critical issues for the future	Participants Consultant
4. Form board/staff team to complete the plan.	Board chair Executive director
5. Summarize situation analysis (between meetings).	Executive director Consultant
<i>Meeting 2 (2 hours):</i>	
6. Develop scenarios for the future (scenario approach): Develop scenarios. Note areas of agreement and choices.	Planning team Consultant
7. Summarize scenarios and choices (between meetings).	Executive director Consultant
8. Gather information to test feasibility of scenarios (between meetings).	Executive director
<i>Meeting 3 (2 hours):</i>	
9. Evaluate scenarios (e.g., fit with mission, fit with needs, financial feasibility). Select the best scenario.	Planning team Consultant
10. Develop first draft of strategic plan. Include sections on mission, services, staffing, finances, facilities, and implementation (between meetings).	Executive director Consultant
<i>Meeting 4 (2 hours):</i>	
11. Review first draft. Note suggested improvements.	Planning team Consultant
12. Revise first draft (between meetings).	Executive director Consultant
Review, adopt, and implement plan:	
13. Review second draft with Board Staff 2-3 outsiders Note reactions and suggestions for improvement.	Board chair Executive director Executive director
14. Review reactions and make needed revisions; prepare final draft.	Planning team Consultant
15. Adopt plan.	Board
16. Implement plan. Review progress every 6 months. Update plan yearly.	Executive director Board
Total meeting time, including review sessions: 18-20 hours. Time to develop plan: 3 months.	

Figure-2 Strategic Planning Process
Large Human Services Organization

Steps	Responsible
1. Preparation	
a. Get agreement on planning steps.	Executive director Board chair
b. Review planning process with: Board Key staff Make needed adjustments.	Executive director
c. Gather information for retreat regarding: National, state, local trends Local service needs	Executive director Staff Outside experts
2. Situation Analysis/Future Emphasis	
At a 1 1/2-day board retreat:	
a. Do situation analysis: History and present situation Opportunities and threats National, state and local trends Service needs Other Strengths and weaknesses Critical issues for the future	Board Executive director
b. Redefine the organization's mission and emphasis for the future: Mission Service emphasis Financial guidelines	Board Executive director
c. Summarize results (after retreat).	Executive director
3. Review Sessions	
a. Review retreat summary with key staff. Get reactions and suggested revisions.	Executive director
b. Review staff comments with board. Make needed revisions in mission and emphasis statement.	Executive director
4. Division Concept Papers	
a. Develop concept papers for each division (twelve hours of team meetings for each division): Do situation analysis: mission, opportunities and threats, strengths and weaknesses, critical issues. Outline division strategy. Draft concept papers. Sections include division mission, service plans, starting plans, financial plans.	Division directors
b. Review division concept papers with: Key staff Board	Executive director Division directors
c. Resolve critical issues across divisions (e.g., service levels, finances, etc.).	Executive director Division directors
5. Strategic Plan	
a. Draft strategic plans for: Total organization Each division (revise concept papers)	Executive director Division directors
b. Review drafts of strategic plans. Resolve any remaining critical issues. Revise plans as needed.	Executive director
c. Approve strategic plan.	Board
6. Implementation	
a. Implement plans. Review progress every 6 months.	Executive director Division directors
b. Update total organization and division plans yearly.	Board chair Executive director Division directors
Total meeting time: 60 hours. Time to develop plan: 9 months.	

Opportunities and Threats



Include items

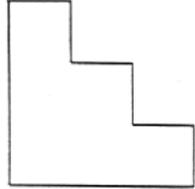
- 1) List the major opportunities (O) and threats (T) that you believe your organization will face in the next 2-5 years that will determine whether it succeeds or fails.
- 2) Worksheets 5a and b may be useful if you wish to do a more detailed analysis of your customers or competition.

If you combine your responses with those of other planning team members, then identify the 4-6 opportunities or threats that are most critical to your organization's future success.

Clients, customers, stakeholders	Competitors and allies	Social, cultural, economic, political, or technological forces

5a

Clients, Customer, and Stakeholder Needs



Instructions

- 1) List the needs of present or potential "customers" that your organization might address. Note ideas for how your organization might meet those needs.
- 2) List the significant groups who have a stake in what you do (for example: funders, contractors, regulators, supporters). Note how you might meet their needs.
- 3) Transfer major opportunities and threats to the "clients, customers, stakeholders" column of Worksheet 5.

Clients, customers, users Describe existing, or possible new, target groups	Their needs	Ways to meet those needs
Other stakeholders List group or person	Their needs	Ways to meet those needs

Competitors and Allies

Instruction

- 1) List present and possible new competitors, what you compete for, then note your organization's relative advantages or disadvantages (price, image, quality, etc.).
- 2) List possible allies and how you might team up with each organization, person or group (e.g., joint program, merger, trade association).
- 3) Transfer major opportunities or threats to the "competitors and allies" column of Worksheet 5.

Competitors	Compete for	Your relative advantages	Your relative disadvantages
Existing			
New			
Allies		How might you team up?	

Strengths and Weaknesses

Instructions

- 1) List the major strengths and weaknesses of your organization as it faces the future.
- 2) Combine your responses with those of other planning team members. Note which strengths and weaknesses will be most critical to your organization's future success.

Strengths and assets

Weaknesses and liabilities

Worksheet #3
Strategic Planning
Strategies to Overcome Barriers

Strategy #1: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Strategy #2: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Strategy #3: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Worksheet #3
Strategic Planning/AIDS/HIV Continuum
Opportunities and Threats

(Instructions: First, list responses to the following three categories. Second, put an "O" for opportunity or a "T" for threat next to each response. Finally, identify the top 3 Threats and the top 3 Opportunities by placing the number 1, 2 or 3 next to the "O" or "T" already written.)

Clients and Stakeholders

Competitors and Allies

Social, cultural, economic, political or technological forces

Worksheet #4
Strategic Planning/AIDS/HIV Continuum
Strengths & Weaknesses

(Instructions: First, list all strengths and weaknesses below. Second, identify the top 3 Strengths and the top 3 Weaknesses by placing the numbers 1, 2, or 3 next to the item.)

Strengths or Assets

Weaknesses or Liabilities

Worksheet #5
Strategic Planning/AIDS/HIV Continuum
Strategies to Overcome Barriers

Strategy #1: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Strategy #2: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Strategy #3: _____

<i>Task</i>	<i>Who</i>	<i>By When</i>
1. _____		
2. _____		
3. _____		

Worksheet #6
Strategic Planning
Goals and Objectives

Definitions: **Goals** are generally broad, qualitative statements which describe the general intent of the organization's activities. **Objectives** put goals into operation by providing a set of outcomes, usually one to five per goal, which are quantitative (measurable) and time-limited (to be accomplished within a specified time period.)

Goal: _____

Objective #1: _____

Objective #2: _____

Objective #3: _____

Goal: _____

Objective #1: _____

Objective #2: _____

Objective #3: _____

Goal: _____

Objective #1: _____

Objective #2: _____

Objective #3: _____

SECTION - VIII

NEEDS ASSESSMENT

Needs Assessment

Introduction

The purpose of the Ryan White Part B Consortium is to decide how best to use its Part B allocation to meet the needs of people with HIV/AIDS and their families living in the local community. As stewards of public funds, the members of the Consortium are obliged to develop a responsible, fair and equitable process for the distribution and monitoring of funds. The major activities of the Consortium provide the basis for making the funding decision.

The specific activities which help the Consortium make the most responsible funding decisions are:

1. Needs Assessment
2. Prioritization of needs and budgeting dollars to service priorities
3. Strategic plan for community to include how services will be coordinated
4. Funding mechanism
5. Oversight and monitoring of service providers funded by the Consortium to include an evaluation of the quality of services provided
6. Evaluation of Consortium processes

The needs assessment sets the stage for the planning process by identifying needs in the community, services available to meet the needs, and gaps between needs and services. The needs assessment can also be a meaningless exercise if not planned carefully. All too often Consortia develop very extensive, sophisticated needs assessment tools and methodology, spending great amounts of money and time, only to find that the results do not assist them in achieving their purpose as a Ryan White Part B Consortium, allocating Part B dollars to best meet the needs of their community. Consortia should avoid getting bogged down in a needs assessment. There is a tendency to look to the needs assessment to provide the “magic formula” that will give the Consortium an exact answer on how best to allocate its funds. The needs assessment is one of six activities which assist the Consortium in developing an informed, professional, and responsible plan. The needs assessment is one of numerous tools which assist the Consortium. Ultimately, the resulting data from the needs assessment, as it relates to the Ryan White Part B Consortia process, must provide the Consortium with a list of the prioritized needs of people affected and infected with HIV/AIDS in their community.

Needs Assessment Steps

1. Determine the Approach

- a. Whose needs will you assess (target population)?
 - Clients
 - Families
 - Service Providers (including medical providers)
 - General community
 - All of the above

- b. What programs and services will you assess?
 - Case Management services
 - Emergency programs
 - Home based care programs
 - AIDS Drug assistance programs
 - Housing programs
 - All of the above

- c. What aspects of services and program areas will you assess?
 - Access to services
 - Program policies
 - Governmental policies
 - Interagency collaboration
 - Quality of HIV/AIDS interventions
 - Funding patterns
 - All of the above

Develop a Timetable and Budget

1. Decide on the total length of the project, start-up and completion dates. Also decide on specific activities to be completed by certain times - project milestones.
2. Determine financial and volunteer resources available for the needs assessment and develop a budget incorporating both. The budget will help define the scope and methods used for the needs assessment.
3. Determine who will be responsible for completing the project:
 - A Needs Assessment Committee
 - Consortium Staff
 - Outside Consultant
 - Governmental employees (state or local health jurisdiction)
 - Collaboration between staff from CBO's and local health departments and state Ryan White Program Office

Establish a Process for Community Involvement

1. Who will be involved in the planning process?
 - Key leaders
 - Members of target population(s)
 - Service recipients
 - Service providers
 - All of the above
2. How will we involve the community in planning and implementing the Needs Assessment?
 - Advisory Committee(s)
 - Working Group/Committee
 - Needs Assessment Oversight Committee

Methods

1. Standard Protocol for Initial Needs Assessment Data Collection Basis for a Community HIV/AIDS Needs Assessment Process U.S. Public Health Service, Health Resources and Services Administration, Bureau of Health Resource Development, Division of HIV/ AIDS Services, June 13, 1994.
2. Surveys/Questionnaires
3. Structured Groups/Interviews
 - Focus Groups

- Community Forums
- Public Hearings
- Interviews with target populations
- Nominal Groups
- Delphi Groups

Develop a Data Collection Instrument

1. Develop questionnaires
 - Analyze demand for services/programs
 - Identify existing resources and services
 - Assess client satisfaction with services/programs
 - Elicite opinions of key informants
 - Determine knowledge, attitudes, beliefs, and behaviors of target population(s)
2. Develop questions and protocols for structured groups and interviews

Determine an Outcome

1. Prepare a report to communicate results. The report should:
 - Give general background on why the needs assessment was conducted
 - State the Goals
 - Describe the Methods
 - Present Results
 - Discuss implications of the findings
 - Make recommendations for action
 - Explore need for further investigation
2. Useful tools to help present findings:
 - Executive Summary
 - Pie charts/bar graphs
 - Oral presentations
3. The report should contain, but is not limited to, the following specific information:
 - Epidemiology of HIV/AIDS for the community and target population
 - Descriptive profile of the community and target population
 - Identified barriers to existing program/service utilization

Methodology

Method (1): Social and Health Indicator Analysis

Social and health indicators are aggregate statistical measures that depict significant aspects of a social situation and the health status of the population in the community. This objective information is useful in both describing the current health status of communities and as an indirect measure of the effectiveness of the current service delivery system.

The social and health indicator analysis method collects, compiles, and analyzes statistics to present a snapshot of health status and to make inferences of need. When combined with information about service utilization, it can shed light on patterns of usage and the relationship of these patterns and health status.

Method (2): Social Area Surveys

Surveys provide a means for finding out information about a community or target population, service providers, and other groups. Data can be collected on a wide variety of topics related to HIV/AIDS health and support services by conducting specific surveys among a representative cross section of clients and among service providers. Given the proper guidelines and appropriate questionnaires, surveys can generally be conducted quite easily. One does not necessarily need to be an expert researcher to conduct a good survey and to obtain valuable results.

Areas of investigation:

- a. Analyzing demand for services/programs
- b. Identifying and assessing existing services and resources
- c. Assessing client satisfaction with current services/programs
- d. Assessing staff satisfaction with current services/programs
- e. Eliciting opinions of key informants

All surveys have similar basic elements, from development and production of the questionnaires, to collection and analysis of the data, to communication of the results. However, where they differ primarily is in the specific methods for collecting data. The three major types of survey methodology generally used in conducting needs assessment are (1) Mail questionnaires, (2) telephone interviews and (3) face-to-face interviews. Deciding the manner in which the client and provider questionnaires will be administered within each Consortium region will depend largely on the type of information being collected, the time available, and the personnel resources. Questionnaires need to be designed to accommodate whatever approaches are most feasible in the region. The use of open-ended and complex questions should be kept to a minimum as analysis of the data from these instruments is quite labor intensive. Instead, open-ended questions should form the basis for the structured discussion groups, which are an important part of the protocol for conducting needs assessments.

Method (3): Structured Groups

Structured groups generate qualitative information that can supplement or enhance the more quantitative data obtained from social and health indicator analysis and social area surveys. Individuals are selected to come together in a group setting to discuss the needs of the target population. Group involvement and understanding of the pertinent health issues are important requirements of the representatives. The four types of structured groups typically used for needs assessments are focus groups, nominal groups, Delphi panels, and community forums.

It is important that local planning groups, and/or a person designated as the project planner, be selected to assume primary responsibility for ensuring that the structured groups are conducted according to specific guidelines and that all tasks are completed. No matter which structured group approach a region chooses to utilize, the following overall process is will be necessary to successfully complete the planning and implementation of this component.

- a. Define the Purpose of the Project - define the purpose of conducting the group, with a view of what decisions will be made on the basis of this research.
- b. Set Objectives - decide the specific information that will be collected so that the research is directed toward meeting set objectives.
- c. Design the Project - design the logistics of the project. For example, who will comprise the group, where and when will the groups be held, will incentives be used, etc.
- d. Prepare the Group - schedule the groups, design and test questions, and prepare for a discussion guide.
- e. Conduct the Group - follow group specific guidelines.
- f. Results of the Group Process - report findings, analyze results, make-conclusions/recommendations.

A general rule of structured groups is to continue conducting group sessions until no new ideas are generated. This usually occurs after three or four group sessions. If information from people of different backgrounds is of particular importance to the research, these subgroups should be identified and three or four groups should be conducted for each subgroup. It is best to use more than one type of group to discuss most research questions. The makeup of the groups should be as homogenous as possible to reduce variations in responses based on social, intellectual, lifestyle, or demographic differences. In addition, individuals with similar backgrounds may be more likely to relate better to one another, thus enhancing the group discussion. If conducting more than one group is not possible, then heterogeneity in the group members is desirable to capture the diversity of opinions that generally surround the discussion topics.

The following are some general guidelines for designing the questions that will be used, and for the manner in which the discussion should be facilitated.

- a. Move From General to More Specific - Start with a general/broad question to get the group warmed up and comfortable.

- b. Use Open-Ended Questions - Don't ask "yes" or "no" questions, collect information with a minimum of direction to the respondent.
- c. What? Why? How? - Questions phrased in this way will elicit more detailed and informative responses.
- d. Follow-Up With Probes and Clarifications - If an initial response is too general, urge the respondent to be more specific and complete.
- e. Know When You Have a Specific Answer - Descriptions such as nice, friendly, terrible, etc. are vague and require further clarification to understand the actual experience.
- f. Avoid Leading Questions - Do not ask questions that suggest a certain answer, leading to a conclusion.
- g. Pretest Questions Whenever Possible - Questions should follow in a logical order and be easily understood by the target audience.

The success of the structured group process depends largely on the skills of the group facilitator. This individual must have good interpersonal communication skills and be able to quickly establish rapport and gain the confidence of the participants. He or she must have a friendly but assertive demeanor, be patient but maintain control of the discussion, be unbiased and non-judgmental, and be skilled at taking notes that very closely reflect what is said (or know how to use someone else as a recorder). The facilitator should assure the participants that all opinions are welcome, that nothing is trivial, and that all information shared with the group will remain confidential. A discussion guide which addresses any procedural issues, outlines the purpose of the group, and lists the basic questions should be developed before the groups are conducted. This guide should be designed to assist the facilitator in introducing and focusing on the topic or topics, and should be used to ensure that groups are conducted in a consistent manner.

While the facilitator could be affiliated with the Consortium, it is highly recommended that a non-aligned facilitator who is perceived as objective should moderate the session, particularly if sensitive or potentially threatening questions are to be discussed. If possible, facilitators should be of similar background to the participants. This is not always possible, especially when using a diversity of groups, since it is preferable that the same facilitator should be used for all groups. If using multiple facilitators, all facilitators should receive joint orientation and training to ensure that the different groups follow consistent procedures.

SECTION - IX

FUND DISTRIBUTION PROCESS

Fund Distribution Processes

The sole purpose of the Ryan White Part B Consortium is to decide how best to use their Part B allocation to meet the needs of people with HIV/AIDS and their families in the local community. As stewards of public funds, the members of the Consortium must develop a process which is as professional and responsible as possible. The major activities of the Consortium support this one decision, made once a year: the funding decision.

The specific activities which help the Consortium make responsible funding decisions are:

- a. Needs Assessment
- b. Prioritization of needs/budgeting dollars to service priorities
- c. Plan for Coordinated Services
- d. Implementation Plan
- e. Funding Mechanism
- f. Oversight & Monitoring of:
 - Service Providers funded by Consortium
 - Lead Agency
- g. Evaluation of
 - Consortium process
 - Quality of services funded

There are six steps to a community-wide Needs Assessment.

Step I: Determine the Approach

- a. Whose needs will you assess (target population)?
 - Clients
 - Families
 - Service Providers (including medical providers)
 - General community
 - All of the above
- b. What programs and services will you assess?
 - Case Management services
 - Emergency programs

- Home based care programs
 - AIDS Drug assistance programs
 - Housing programs
 - All of the above
- c. What aspects of services and program areas will you assess?
- Access to services
 - Program policies
 - Governmental policies
 - Interagency collaboration
 - Quality of HIV/AIDS interventions
 - Funding patterns
 - All of the above

Step 2: Develop a Timetable

- a. Decide on the total length of the project, start-up and completion dates. Also decide specific activities to be completed by certain times - project milestones.
- b. Determine who will be responsible for completing the project:
- A Needs Assessment Committee
 - Consortium Staff
 - Outside Consultant
 - Governmental employees (state or local health jurisdiction)
 - Collaboration between staff from CBO's and local health jurisdiction and state office of AIDS

Step 3: Establish a Process for Community Involvement

- a. Who will we involve in the planning process?
- Key leaders
 - Members of target population(s)
 - Service recipients
 - Service providers
 - All of the above
- b. How will we involve the community in planning and implementing the Needs Assessment?
- Advisory Committee(s)

- Working Group/Committee
- Needs Assessment Oversight Committee

Step: 4 Select the Methods

- a. Standard Protocol for Initial Needs Assessment Data Collection:
Basis for a Community HIV Needs Assessment Process
U.S. Public Health Service, Health Resources and Services
Administration, Bureau of Health Resource Development, Division of
HIV- Services, June 13, 1994.
- b. Surveys/Questionnaires
- c. Structured Groups/Interviews
 - Focus Groups
 - Community Forums
 - Public Hearings
 - Interviews with target populations

Step 5: Design a Data Collection Instrument

- a. Develop questionnaires/surveys
 - Analyze demand for services/programs
 - Identify existing resources and services
 - Assess client satisfaction with services/programs
 - Elicit opinions of key informants
 - Determine knowledge, attitudes, beliefs, and behaviors of target population(s)
- b. Develop questions and protocols for structured groups and interviews

Step 6: Determine an Outcome

- a. Prepare a report to communicate results. The report should:
 - Give general background on why the needs assessment was conducted
 - State the Goals
 - Describe the Methods
 - Present Results
 - Discuss implications of the findings
 - Make recommendations for action

- Explore need for further investigation
- b. Useful tools to help present findings:
 - Executive Summary
 - Pie charts/bar graphs
 - Oral presentations
- c. The report should contain, but is not limited to, the following specific information:
 - Epidemiology of HIV/AIDS for the community and target population
 - Descriptive profile of the community and target population
 - Identified barriers to existing program/service utilization

What types of fund distribution processes are there?

a. Letter of Intent

Consortium publishes the services required, the monies available for each service and requests Letters of Intent from prospective providers. This initial screening or precursor to the application process helps the Consortium determine who and how many agencies are interested. In the smaller counties with very few providers, this step may be unduly cumbersome and unnecessary. In these smaller areas, some Consortia have modified the “Letter of Intent” to include a brief proposal and budget as the whole application process.

b. Request for Proposal (RFP)

This is a competitive process. This process should be open, clearly defined and clearly structured. The Consortium publishes specifically what services are requested and what money is approved for the service. The proposal from prospective service providers must specifically state how the agency will perform the service required and for how much money.

c. Request for Application (REA)

This is a competitive process. The Consortium publishes specifically what services are required. The prospective service provider applies to perform the services and then negotiates a budget with the Consortium. This process allows the Consortium to focus on quality and amount of services provided. This process also allows for more flexibility/creativity in the response from prospective service providers and allows the Consortium more flexibility than pre-determining exactly how much a service will cost (the traditional REP process)

d. Invitation for Bid (IFB)

This is a competitive process. An IFB should say, Here is exactly what we want. How much will you charge us? In that an IFB sets forth the specific requirements of the Consortium, the evaluation of which agency will provide the services consists of

determining those providers who meet the specified requirements. For each specific requirement, a basis “Yes” or “No” answer is required. There is no “fully”, “barely”, “almost”, or “exceeded” level of evaluation. The selection process is then the identification of that provider who meets the specifications at the lowest monetary level, and who is not relieved from his/her bid due to mistake, fraud, etc.

e. Sole Source

When there is only one provider of a specific service in the community, there is no need to do a competitive process. The Consortium negotiates with the only source to provide the service required. The Consortium must still develop criteria for granting these dollars and would need to carefully provide justification that this is indeed the sole source in the community. The following factors should be used to determine that the costs are justified: (1) Cost information in sufficient detail to support and justify the contract, (2) Cost information for similar services, differences should be noted and explained, and (3) Special factors affecting the cost under this contract.

How will the availability of funds be announced to potential service providers?

- a. Announcement in local newspapers
- b. Targeted mailing from phone book or Consortium mailing list
- c. Mailing to known service providers
- d. PSAS on local radio
- e. Announcement flyers/brochures distributed by Consortium members to clients, family members, community leaders, Chamber of Commerce, etc.

What will be the guidelines or criteria for selecting service providers?

- a. Incorporation as legal business entity
- b. Current audited financial statements
- c. History of providing required services
- d. Personnel policies
- e. Client grievance policy
- f. Relevancy to the Consortium’s priority areas of funding, based on needs assessment
- g. Capability to provide services
- h. Demonstration of cooperation and collaboration with other related providers in community
- i. Project purpose, measurable outcomes, methods, evaluation
- j. Access to target population
- k. HIV/AIDS service delivery experience

- l. Cost
- m. Other sources of funding

After criteria are selected, points or a percentage should be attached to each criteria so that the reviewers can then score each application based on how well they meet each criteria. (For example: Target Population 20 points; Project purpose, outcomes, methods and evaluation = 30 points; Applicant Capability = 20 points; Cooperation and Collaboration 20 points and Budget = 10 points. Minimum passing score = 70 points)

Who will select service providers?

- a. Review Committee composed of community members not attached to Consortium or any proposed service providers.
- b. Members of Board from another agency such as United Way, Red Cross. etc. - if they have no attachment to Consortium process or proposed service providers.
- c. Members of Consortium NOT in conflict of interest.

Some Consortia use an outside Review Committee to score the applications only. The final decision regarding how much to fund eligible providers is made by the members of the Consortium who are not in conflict of interest to the funding process.

What is the funding appeals process for service providers who apply?

Criteria for Appeal For example:

Any agency/organization, which meets the criteria for funding, may appeal funding and/or reallocation decisions of the Consortium. The appeal must be based on one of the following: a) agency did not receive information made available to other agencies; b) agency has additional information that might make for a more informed decision; c) allegation of bias, fraud, or misuse of federal funds on the part of the Consortium; d) violation of federal or state guidelines; e) violation of Consortium by-laws.

Dissatisfaction with level of funding is not a basis for appeal.

SECTION - X

MANAGING CONFLICT OF INTEREST

Managing Conflict of Interest

Introduction

This document is meant to provide a framework to identify the characteristics and problems of conflict of interest issues, and to suggest strategies for solving or avoiding them in the future. Additionally, this document offers recommendations to improve a Councils/Consortia's operation by recommending viable processes for avoiding or resolving the many challenges this issue can pose.

As one Council stresses in its Bylaws, the ultimate objective for developing definitive policy around conflict of interest is [keep] the Council focused on directing funds to meet the need of individuals affected by the HIV/AIDS epidemic in the most expeditious manner possible. The same principle motivated the Division of HIV Sciences to prepare this document -

Information from the following sources was used in the development of this report:

- 1992 Title I Supplemental Funds grant applications of all current Eligible Metropolitan Areas,
- Bylaws of Planning Councils,
- Reports of MESA External Grant Review Committees,
- Quarterly Progress Reports submitted by grantees, and
- Site Visit Reports prepared by HRSA staff members.

Discussions with Project Office and members of several Planning Councils were also valuable sources of information.

The conflict of interest challenge.

By stipulating that the membership of Councils' Consortia include individuals or organizational representatives with direct personal or professional expertise related to HIV services, Congress built the conflict of interest challenge into the legislation, and thus, into the heart of state and local implementation of the Ryan White Program. Identifying and accepting conflict of interest as an ongoing challenge inherent in the legislation should hasten acknowledgement of the responsibility of the Planning Council to manage it.

Acknowledging that the challenge is present and that it can never be totally eliminated is also the preliminary steps to avoiding problems. Recognizing that the challenge can be and has been successfully managed by a broad array of organizations is the next step.

Regardless of the extent to which a Council strives to make policy or otherwise "legislate" solutions to the conflict of interest challenge, personal responsibility of individual Council/Consortia members plays a central role in how successfully managed it is. Policy guidelines must be in place to facilitate management of the situation, but

training/orientation must also be offered so that the member is cognizant of the implications of her/his actions. One Council has also sought to address this issue by having members appointed not as representatives of specific agencies, but as members of the public with a recognized expertise.

In confronting the challenge several Councils have incorporated a definition of a Conflict of Interest in their Bylaws, including those listed below.

1. A Conflict of Interest occurs when an appointed public official knowingly takes action or makes a statement intended to influence the conduct of the public body of which she/he is a member in such a way as to confer any financial benefit or the member, family member(s), or on any organization in which she/he is an employee or has a significant interest.
2. Conflict of interest is defined as a direct or fiduciary interest, which includes, with limitation, ownership, employment, contractual, creditor, or consultative relationship to, or Board or staff membership in, an entity (including any such interest that existed at any time during the twelve months preceding the vote). with respect to which a vote is to be taken.”
3. A planning council member who also serves as a director, trustee, or salaried employee, or otherwise materially benefits from association with any agency which may seek funds from the planning council is deemed to have an ‘interest’ in said agency or agencies.”

Areas in which a conflict of interest challenge has emerged include:

- the relationship of Council members to the service provider organizations and to the administrative organization,
- selection of service priorities,
- the allocation of funds (within the process and with regard to the selection of sole—source providers), and
- the evaluation of provider organizations and the administrative organization.

What to do when a conflict of interest arises.

Most councils require that a member with a conflict of interest abstain from votes that relate to the source of the conflict. While this will logically be a key outcome of any council’s policy, it should be pointed out that this should be the final, and not the only, response. Believing that a conflict of interest concern should never be avoided, the Division of HIV Services has formulated the following procedural options. These options are applicable prior to having a council member abstain from a vote, and include:

- charging a standing committee of the council with the responsibility of reviewing all conflict of interest concerns,
- authorizing any member of the council to make a request for review of a perceived conflict of interest,

- defining the process of review in writing, establishing timelines so that any review is undertaken in an expeditious manner,
- establishing policies which stipulate that a member may be removed from the council and all of its committees, advisory boards, etc. when it is determined that the member knowingly attempted to influence the council or refuses to cooperate in a conflict of interest review.

Policy and preventive recommendations.

The following nine recommendations are based on measures that are reported to have worked for certain councils. They are meant to offer guidance on a complex and difficult topic, but should not be construed as policy of the Division of HIV Services. If adopted at the local level, they should be clearly identified as local policies.

1. Know and adhere to local, county and state statutes governing issues related to conflict of interest. Many states and localities have elaborate regulations governing this issue. Much time and energy could be saved by providing each council member with a copy of the regulations, or a summary of them. Counsel for the designated Chief Elected Official (CEO) could serve as the provider of this information.
2. Seek, maintain and document legal advice. Here again, the CEO office could (and should) play a leading role. The perception of a conflict of interest can have a great deal of influence on a council and cause as much damage as a real conflict of interest. This factor combined with the inherent and ever present tension written into the legislation make it essential to arrange continual access to legal counsel. One designated CEO assigned an Assistant County Attorney to be present at all meetings (of the planning council) to provide opinions as to legal issues which might arise.
3. Strive to achieve an openness in and accessibility to all decision making processes beyond that required by local, state or federal regulations. Several Councils have developed sophisticated methods for communicating with the many organizations and constituencies impacted by the council's work. This effort appears to mitigate against the perception of a closed and secretive club-like atmosphere.
4. Amend Planning Council Bylaws. Clear and explicit language in this document is an essential tool in the effort to manage the conflict of interest challenge. Bylaws that simply state that conflicts of interest will not be tolerated, or that require members to announce their conflict, are inadequate. Efficient and fair management of this issue requires language that provides clear guidance. Responsibility for responding to conflict of interest issues should be assigned to one of the council's permanent/standing committees.
5. Implement training mandated for all council members that includes thorough explanation of the conflict of interest challenge. Such a session could be incorporated into existing orientation programs for new council members or offer annually during a scheduled council meeting. The CEO's office, or county/city

attorney's office, could provide assistance in developing the content for such a session.

6. Utilize a Conflict of Interest Disclosure Form. Completed forms should be kept updated and on file in the councils office and available for public inspection.
7. Establish External Review Committees. Several councils have already begun utilizing committees comprised of consumers of HIV services, clinical providers and others who are not members of the council, to provide the initial assessment of potential providers of services. Employing a consensus model of decision making may further strengthen the committee's recommendations. The council then accepts or rejects the recommendations of the External Review Committee. Maintaining a culturally diverse, qualified pool of potential committee members becomes the responsibility of the designated council committee.

The creation of an External Review Committee must not, however, preclude council members from participating in "discussions or debates about community needs, service priorities, allocation of funds to broad service categories, and the processes for and the results of evaluation of service effectiveness?"

8. Facilitate access to proposals by members of the Planning Council. Conflict of interest policy must not obstruct a council member's work. Therefore, a clearly defined process will assure fair and equal access to proposals. The key elements of this process are:
 - the request to read proposals be made in writing at least twenty-four hours in advance,
 - the review take place at a location established by the council, preferably the council's office,
 - the council member be required to review all proposals in the category of interest, and
 - a log of the date, members name and proposals reviewed be maintained by the council staff and be available for public inspection.
9. Authorize a standing committee to review all conflict of interest concerns, and establish and disseminate written policies governing the work of this committee.

Conclusion

One Council reported that it is known as,

a place anyone is welcome to come and work and be significantly involved in vigorous, open debate. This very openness and inclusiveness is the mechanism by which the potential conflict of interest, inherent in the Ryan White Program's definition of council, is mitigated. Decisions and policies are made jointly by a large and representative group of people, whose primary interest is to assure that high quality, effective HIV services are delivered efficiently to the people most in need of them.

Having committed council members who represent the diverse and varied communities affected and infected by the HIV epidemic is both mandated by the legislation and seen by the Division of HIV Services as absolutely essential to identifying unmet need and determining community priorities. These “givens” mean that every Planning Council or Consortia will encounter conflicts of interest, making it critical that they establish policies for handling conflicts of interest (real and perceived) to strengthen trust and confidence in the body by every member. These policies will also expedite resolution of the concern and minimize the debilitating organizational and individual stress this issue can cause. The alternatives, an absence of policy or lack of its consistent application will multiply problems and hinder the council’s functioning

Sample Bylaws Language

Section 1: Definition of Conflict of Interest

Conflict of interest occurs when an appointed and voting members of the Planning Council has a direct or fiduciary interest, (which includes ownership; employment; contractual, creditor, or consultative relationship to; or board or staff membership in) an organization (including any such interest that existed at any time during the twelve months preceding her this appointment), with which the HIV Health Services Planning Council has a direct, financial and/or recognized relationship.

Section 2: Definition of Member

The rules contained in this section apply to all members, members of committees, task forces and technical advisory groups, staff members, contractors and consultants to the council, all of whom shall be referred to as Council members for the purpose of this section.

Section 3: Application of Regulations

Members shall be provided with copies of, and shall abide by local, county and state regulations governing conflict of interest.

Section 4: Oversight Responsibility

A standing/permanent committee of the Council shall be authorized to formulate council policy, review all concerns, and make recommendations to the full council regarding conflict of interest issues.

The members of this committee shall be appointed by the Council Co-Chair(s) and serve at her/his pleasure.

All Council members are encouraged to identify conflict of interest, or request a review of a potential conflict of interest of another member.

Section 5: Disclosure Form

All members must sign, upon appointment to the council, a Conflict of Interest Disclosure Form which shall be formulated by the authorized committee and approved by the full Council.

The completed Disclosure Forms shall be kept on file at the council's office and made available for public inspection.

Council members shall review and update their Disclosure Forms on a semi-annual basis, or as otherwise precipitated by a change in employment, board service, consultative relationship, or other status.

Section 6: Determination of Conflict

All concerns regarding conflict of interest shall be recorded in the councils meeting minutes and referred to the authorized committee for review. The full council shall take, based on the recommendations of the committee, whatever actions it deems appropriate and are in compliance with standing council regulations.

Section 7: Participation and Voting

In the event of a conflict of interest and/or during the period of review of said conflict of interest, member(s) may participate in the discussion of the matter in conflict/question but shall abstain from voting on that matter.

Section 8: Termination

A member shall be terminated from service on the council and any of its committees or task forces for refusing to cooperate in a conflict of interest review, or when it is determined that she/he knowingly took action(s) intended to influence the conduct of the council in a manner as defined in these Bylaws.

Sample Disclosure Form.

The _____ Planning Council has members who are professionally or personally affiliated with organizations that have, or may request or receive funds authorized under Part B of the Ryan White Program. Because of the potential for conflict of interest, this Disclosure Form has been adopted by the ___ Planning Council and must be completed by all current and future members and candidates for membership of the council.

By my signature below, I certify that;

1. I have read, understand and support Section (s) _____ Conflict of Interest of the Planning Council’s Bylaws.

2. I and/or a family member am/are (or have/has been within the past twelve months) serve(d) in a staff, consultant, officer, board member, or advisor capacity with the following organization(s) which has/have received, may seek or is/are eligible for funding under Part B of the Ryan White Program:

Organization:

Title: _____ Period of Affiliation: _____

(Please attach additional pages if necessary)

Council Member: _____

Signature: _____

Date: _____

Date Form Received by the Planning Council: _____

SECTION - XI

EVALUATION PROCESS

Evaluation Process

Consortia Evaluation

Introduction

Evaluating the performance of the Consortium is the first step in evaluating the overall impact of HIV/AIDS programs in a community since the Consortium is responsible for developing a community-wide service plan and for funding the service providers who implement the plan. There are two different elements in the Consortium structure which should be incorporated into the Consortium evaluation: (1) internal process and (2) outcomes. These two elements of evaluation can also be directly correlated to evaluation of the efficiency and effectiveness of the Consortium's performance.

Efficiency can be measured by evaluating criteria relative to operations procedures, organizational development/structure and internal processes. (Example: How meetings are run, members' understanding of mission, working relationships between member agencies, etc.)

Effectiveness can be measured by evaluating criteria relative to outcomes and product. (Example: Strategic plan implementation, quality of services offered through funded service providers, duplication of services, etc.)

Evaluation refers to judging the merit of something by comparing it against some yardstick. The first thing the Consortium must do is develop the "yardstick". Standards of measurement (criteria) guide the evaluation so that the Consortium can measure its actual performance or outcome against the standards it set. Quite specifically, the Consortium should develop a set of goals and objectives and then assign measurements (standards) to the objectives. Goals are generally broad, qualitative statements which describe the general intent of the Consortium activities. Objectives put goals into operation by providing a set of outcomes, usually one to five per goal, which are quantitative (measurable) and time-limited (to be accomplished within a specified time period.)

Example 1:

Goal: Consortium membership will reflect the racial diversity of the community.

Objective: Consortium members from the African American community.

Standard: Since 45% of the affected & infected community is African American, 45% of the Consortium membership should be African American.

Example 2:

Goal: Informed, active members on the Consortium.

Objective: The Consortium members will receive copies of all relevant materials in a timely fashion.

Standard: 90% of members felt that they received copies of all relevant materials in a timely fashion.

Evaluation Process Development

1. Establish an Evaluation Committee (either ad hoc or standing)
2. Develop goals, objectives and standards
3. Consortium membership approves goals, objectives and standards
4. Establish procedures for evaluation

Instrument:

- Questionnaire
- Meetings
- Focus group
- Evaluators from outside the Consortium membership
- Interviews

Population:

- Consortium members
 - Fiscal agent/lead agency
 - Service providers
 - Clients/family
 - General community
5. Determine constraints and resistances and develop a plan to deal with
 - Individual member's resistance
 - Financial resources
 - Timeline
 - Individual resources (people available to do evaluation)
 - Political issues inside and outside the Consortium
 - Sensitivity to structure and how Consortium operates
 6. Develop an Evaluation Schedule
 7. Implement the Evaluation Plan
 8. Disseminate and use the information obtained

**Example
Evaluation Questionnaire**

Rating Your Ryan White Part B Consortium

Instructions: Each Consortium member should fill out this questionnaire anonymously. After the results are compiled, any statements that received a majority of respondents “Strongly Agreeing” or “Strongly Disagreeing” are areas that the Consortium should focus on either because they are doing a great job in that area and should acknowledge this or because the statement represents a problem area which, should be addressed by the Consortium.

Consortium Characteristics

How the Consortium Rates
Strongly Agree - Strongly Disagree

1. The Consortium is made up of effective individuals who supplement one another’s talents and expertise.	1	2	3	4	5
---	---	---	---	---	---

2. The Consortium does not represent the perspectives that should be consulted as part of developing an HIV/AIDS service delivery plan in the local community..	1	2	3	4	5
---	---	---	---	---	---

3. The Consortium is large enough to carry out the necessary responsibilities but not so large that nothing gets done at meetings.	1	2	3	4	5
--	---	---	---	---	---

4. The basic operational structure of the Consortium (Officers, Committees, Lead Agency, State Office, Service Providers, and staff, is clear.	1	2	3	4	5
--	---	---	---	---	---

5. There is an effective working relationship between the Consortium members, Officers, Lead Agency, State Office of AIDS, Service Providers and staff.

1 2 3 4 5

6. The members of the Consortium understand the mission of the Consortium and how that mission is achieved by their work.

1 2 3 4 5

7. Consortium members have a feeling of social ease and rapport with one another.

1 2 3 4 5

8. Each member of the Consortium feels involved and interested in the work of the Consortium.

1 2 3 4 5

9. The Consortium has formulated specific strategies/goals to guide its work.

1 2 3 4 5

10. Decisions on policy are made with consideration by all members of the Consortium.

1 2 3 4 5

11. The Consortium has established and maintains effective community relationships.

1 2 3 4 5

12. The Consortium members have a sense of progress and accomplishment in their work on the Consortium.

1 2 3 4 5

13. The Consortium meetings are productive, informative and rewarding to attend.

1 2 3 4 5

14. The Consortium committees don't seem to do very much.

1 2 3 4 5

15. The Consortium's process used to decide who is funded each year is fair and impartial.

1 2 3 4 5

16. The Consortium's decisions about which services to fund do not accurately reflect the needs in the community.

1 2 3 4 5

17. The Consortium members receive copies of all relevant material (meeting minutes, By-Laws, policies & procedures, needs assessment results, reports from service providers/lead agency, financial reports, etc.).

1 2 3 4 5

Evaluating the Quality of Service Delivery

Oversight/Monitoring/Evaluation

Introduction

There are three evaluation procedures which need to be developed and implemented by each Ryan White Part B Consortium. The fourth procedure involves the individual service providers funded by the Consortium. The Consortium needs to evaluate: (1) its own performance, (2) the performance of its fiscal agent and (3) the performance of the service providers funded by the Consortium relative to the contract with each service provider. Each service provider funded by the Consortium should, also, have an ongoing, internal evaluation procedure called a Quality Assurance or Quality Improvement Plan. The Consortium, fiscal agent and service providers are all part of the collaboration necessary to deliver quality services to clients in the local community. The performance of any one of these entities directly impacts the performance of the other two. If a fiscal agent is not reimbursing the service provider in a timely fashion, the ability of the service provider to deliver services can be jeopardized. If the Consortium is not conducting a good needs assessment, funds may not be directed at the areas of greatest need. If the service provider doesn't monitor its own performance, it could be providing poor services and not even realize it. That service provider could lose funding and its ability to continue providing services when its services are perceived as substandard by funders.

The following information will help the Consortium to develop a collaborative approach to oversight/monitoring/evaluation with the ultimate goal of providing the best possible quality of services for people affected and infected with HIV/AIDS in the local community.

I. Evaluating the Consortium

Evaluating the performance of the Consortium is the first step in evaluating the overall impact of HIV/AIDS programs in a community since the Consortium is responsible for developing a community-wide service plan and for funding the service providers who implement the plan. There are two different elements in the Consortium structure which should be incorporated into the Consortium evaluation: (1) internal process and (2) outcomes. These two elements of evaluation can also be directly correlated to evaluation of the efficiency and effectiveness of the Consortium's performance.

Efficiency can be measured by evaluating criteria relative to operations procedures, organizational development/structure and internal processes. (Example: How meetings are run, members' understanding of mission, working relationships between member agencies, etc.)

Effectiveness can be measured by evaluating criteria relative to outcomes and product. (Example: Strategic plan implementation, quality of services offered through funded service providers, duplication of services, etc.)

Evaluation refers to judging the merit of something by comparing it against some yardstick. The first thing the Consortium must do is develop the “yardstick”. Standards of measurement (criteria) guide the evaluation so that the Consortium can measure its actual performance or outcome against the standards it set. Quite specifically, the Consortium should develop a set of goals and objectives and then assign measurements (standards) to the objectives. Goals are generally broad, qualitative statements which describe the general intent of the Consortium’s activities. Objectives put goals into operation by providing a set of outcomes, usually one to five per goal, which are quantitative (measurable) and time-limited (to be accomplished within a specified time period.)

Example 1:

Goal: Consortium membership will reflect the racial diversity of the community

Objective: Consortium members from the African American community.

Standard: Since 45% of the affected & infected community is African American, 45% of the Consortium membership should be African American.

Example 2:

Goal: Informed, active members on the Consortium.

Objective: The Consortium members will receive copies of all relevant materials in a timely fashion.

Standard: 90% of members felt that they received copies of all relevant material in a timely fashion.

Consortium Evaluation Process Development

1. Establish an Evaluation Committee (either ad hoc or standing)
2. Develop goals, objectives and standards
3. Consortium membership approves goals, objectives and standards
4. Establish procedures for evaluation

Instrument:

- Questionnaire
- Meetings
- Focus group
- Evaluators from outside the Consortium membership
- Interviews

Population:

- Consortium members
- Fiscal agent/lead agency
- Service providers
- Clients/families
- General community

5. Determine constraints and resistances and develop a plan to deal with

- Individual member's resistance
- Financial resources
- Timeline
- Individual resources (people available to do evaluation)
- Political issues inside and outside the Consortium
- Sensitivity to structure and how Consortium operates

6. Develop an Evaluation Schedule

7. Implement the Evaluation Plan

8. Disseminate and Use the information obtained

II. Evaluating the Fiscal Agent

The Fiscal Agent is selected by the Consortium to manage its money. The Fiscal Agent also signs all contracts (with the State and with the subcontractors) since the Consortium is not, in most cases, an incorporated legal entity with the ability to enter into contractual relationships with other entities. The Fiscal Agent holds the legal liability for the decisions and actions of the Consortium. It is, obviously, in the best interests of the Consortium that all of these types of evaluating performance are developed and implemented.

The following criteria should be considered when selecting a Fiscal Agent:

1. A commitment to HIV/AIDS issues
2. Fiscal-management experience
3. Cash-flow reserves
4. Experience of accountability to a wide array of organizations and funders
5. Ability to collect, store and retrieve data about services
6. Incorporated business (could be for-profit or not-for-profit)
7. History of sound financial practices

The Consortium and its Fiscal Agent should clearly define their respective responsibilities. Clarity about their relationship will make for a healthier working relationship and deflect problems and misunderstandings. The Consortium must also define how the Fiscal Agent will be compensated for its services.

The Consortium's officers, executive committee or legal counsel, or the Fiscal Agent itself, may assume the responsibility for writing a contract, agreement or letter of understanding or memorandum of understanding delineating the roles and responsibilities of the Consortium and the Fiscal Agent.

Any or all of the following duties may be assumed by the Fiscal Agent in the written agreement:

1. Signing subcontracts on behalf of the Consortium
2. Signing a contract with the State on behalf of the Consortium
3. Receiving invoices from subcontractors
4. Invoicing the State for services performed
5. Reimbursing subcontractors with funds received from the State
6. Submitting regular programmatic and financial reports to the Consortium and the State
7. Employing, supervising and providing office space for Consortium staff
8. Maintaining Consortium files
9. Organizing Consortium mailings and paying for production, postage, etc.
10. Monitoring subcontractors

The Consortium should regularly evaluate the performance of the Fiscal Agent.

Clear criteria for evaluation should be spelled out in the memorandum of understanding between the two. The evaluation can take the form of:

1. Regular reports to the Consortium by the Fiscal Agent
2. An evaluation process developed and implemented by a Consortium committee
3. A questionnaire or report card filled out by the Consortium members
4. A performance evaluation by a committee of financial experts not affiliated with the Consortium

III. Evaluating the Service Providers Funded by the Consortium

The Consortium awards contracts to perform services to organizations and agencies (subcontractors). A contract is developed and signed between the Fiscal Agent and the subcontractors. A further letter of agreement, memorandum of understanding or written agreement should be developed that clearly slates the relationship between the Consortium and its subcontractors.

The following guidelines or criteria should be used to select service providers:

1. Incorporation as a legal business entity
2. Current audited financial statements
3. Has general liability insurance (usually \$1 million)
4. A history of providing pertinent services
5. Personnel policies
6. Client grievance policy
7. Relevance to the Consortium's priorities based on the needs assessment
8. Capacity to provide services
9. Demonstrated cooperation and collaboration with other providers
10. Clearly articulated and quantifiable methods of evaluation (Quality Assurance/Improvement Plan implemented)
11. Established access to target population
12. HIV/AIDS service-delivery experience
13. Cost-effectiveness
14. Other sources of funding

Subcontract Monitoring Plan

The Consortium needs to develop a "Subcontract Monitoring Plan" which should be included in the initial RFP process at the very beginning of the funding cycle. Specific components of the Subcontractor Monitoring Plan should include:

1. Goals, Indicators (criteria) and Standards of Contract Performance
2. Developing a Monitoring Committee or Team
3. Developing activities of Monitoring Committee or Team
4. Developing methods of collecting data and information
5. Implementation of Subcontractor Monitoring Plan

Goals, Indicators (criteria) and Standards of Contract Performance

Goals: Program functions which are essential for compliance with contract performance requirements.

Indicators: An element of the program considered necessary to reach a stated goal and which is believed to demonstrate contract compliance.

Standard: Desired and achievable level of performance of indicator, against which actual performance is measured.

Example:

Goal: The delivery of quality psycho-social case management services.

Indicator: Case plan developed for each client which includes medical history, physical assessment, financial and psychosocial evaluation.

Standard: 95% of case plans contain all 4 components.

Indicator: Evaluation criteria in subcontractor's Quality Improvement plan are being met.

Standard: 75% of evaluation criteria are being met.

Indicator: Clients are satisfied with case management services they have received.

Standard: 90% of clients surveyed indicate a 75% approval rating or higher.

Goal: Sound fiscal management of Consortium awarded funds.

Indicator: Fiscal reports are prepared and forwarded to the Consortium and Fiscal Agent by the 15th of each month.

Standard: 100% of fiscal reports are received by the Consortium and Fiscal Agent by the 15th of each month.

Indicator: Expenditures reflect actual work performed.

Standard: Subcontractors' accounting process that shows how expenditures are invoiced and, when sampled, shows 100% accuracy.

Monitoring Committee or Team

The Monitoring Committee or Team should be composed of people who do not have a vested interest or are in conflict of interest with any subcontractors being evaluated. Some Consortia choose to include people from outside the Consortium process to sit on this committee (i.e. people from other community based organizations which do not provide any subcontracted services, people from the Boards of Directors of other agencies such as United Way, business leaders from Chamber of Commerce, professionals from related fields, etc.)

The activities of the Monitoring Committee, which will help them determine if the goals of the Consortium relative to contract compliance are being met, can include:

1. Chart review
2. Client satisfaction survey/interviews
3. Agency staff interviews
4. Survey of professionals who work with agency
5. Peer review survey
6. Consortium member survey
7. Fiscal Agent survey
8. General site visit

The Consortium needs to design a Subcontractor Monitoring Plan that not only assures contract compliance but encourages the subcontractor to work closely with the Consortium to help improve the overall quality of service delivery in the community. Subcontractor monitoring should never be punitive in nature. The quality of services delivered in a community under Ryan White Part B are the responsibility of everyone involved in the process. As such, everyone is equally accountable. If there is a problem with the quality of services being delivered in a community, the Consortium, the fiscal agent and the service provider all bear equal responsibility and, in the eyes of the general community, are equally at fault. Therefore, it is especially important that the Consortium develop evaluation methodologies and processes that are collaborative in nature and encourage everyone to participate as team mates in the process. Further, the evaluation processes should be viewed as opportunities for improvement, not punitive, divisive activities that penalize people.

Definition of a Culturally Competent Service Delivery System

It is inherently dangerous for a system to fail to acknowledge its tendency to ignore the cultural relevance of service delivery. It is equally dangerous not to correct the problem by failing to make efforts to change. Cultural competence goes far beyond just employing ethnic representatives of the client population. A culturally competent system of care acknowledges and incorporates at all levels, the importance of culture, the assessment of cross cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adoption of services to meet culturally unique needs.

The very thought of a system being able to accomplish these seems quite idealistic. Therefore it is important to understand cultural competence as a developmental process and a goal toward which agencies can strive. To illustrate this process, let's look at a "culturally competence continuum" with six possibilities, from destructive to proficient. The characteristics are briefly explained here:

Cultural Destructiveness:

This, the negative end of the continuum, represents attitudes, policies, and practices destructive to a culture and consequently to the individuals within it. One example is Aid to Families With Dependent Children (AFDC). This system, disguised as help, has literally destroyed a large segment of black family life. Women have been forced to lie, prostitute, wed and sell their children to a system before they can get the help they need. Foster care also caused the unnecessary removal from their families of hundreds of black children, placing them in the homes of white families without consideration for the cultural implications of these placements. This has been endured by Native Americans as well, and the impact on their future generations will be astounding. Wherever a system subjects people to dehumanizing or sub-humanizing treatment in the name of providing a service, cultural destructiveness is at work.

Cultural Incapacity:

At this point the system does not intentionally seek to be culturally destructive, but rather lacks the capacity to help minority clients or communities. The notion of racial superiority is at work and discrimination and segregation are in full practice. People of color are the victims of racist policies and stereotyping perpetuated out of ignorance and unrealistic fear. They are given the message that they are not welcomed or valued, and that expectations of them are lowered.

Cultural Blindness:

Here the system functions with an expressed philosophy of being unbiased. Indeed, it sees the world through rose-colored glasses, a world of what ought to be, given that all things are equal. Thus, services are rendered virtually useless, since they ignore cultural strengths, encourages assimilation, and blame the victim for their problems. The mental health system has long been guilty of these practices, as only recently have there been efforts to understand the cultural needs of clients. However, many of these efforts have been dictated by funding and we can see the casualties mount as funds dwindle.

Cultural Pie-Competence:

Movement toward the positive end of the scale occurs when the agency realizes its weaknesses in serving minorities attempts to improve its services to a specific population. There is a desire to deliver quality services and a commitment to civil rights. It engages the community's cry for improved services by asking, "What can I do?" The shortcomings at this level are visible in 1) a false sense of accomplishment as if the fulfillment of one goal meets the obligation to the community; 2) failure that results in the reluctance to try again; 3) tokenism in the hiring of minority staff who may also lack appropriate cultural training. Lack of information on what is possible and how to proceed restrains cultural competence.

Cultural Competence:

Agencies are characterized as being culturally competent when they can: accept and respect difference; continue self-assessment regarding culture; pay careful attention to the dynamics of difference; continue expansion of cultural knowledge and resources; and make adaptations to service models in order to better meet the needs of minority populations. Culturally competent agencies take seriously the hiring of minority staff and unbiased employees. They consult with the community regarding service provisions and delivery. They commit to cross-cultural training as well as to policies that enhance services to diverse clientele.

Cultural Proficiency:

This is the positive end of the continuum and is characterized by holding all cultures in high esteem. Culturally proficient agencies advocate cultural competence throughout the system and improved relations between cultures by: conducting research that adds to the knowledge base; developing approaches based on culture; publishing and disseminating the results of demonstration projects; and, hiring staff who are specialists in culturally competent practice.

Positive movement along the continuum results from factors of attitude, policy and practice at every level of an agency; at all levels board members, policy makers, administrators, practitioners, and consumers must participate in the process.

**SERVICE DEFINITIONS
FOR THE
PART B CARE CONSORTIA PROGRAM**

1. CORE MEDICAL SERVICES

Outpatient/Ambulatory Medical Care (health services)

Outpatient/Ambulatory Medical Care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight.

Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ Ambulatory medical care*.**

Medical Care/Case Management Services:

Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Dental Care Service:

Diagnostic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners. includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

AIDS Drug Assistance Program (ADAP treatments)

State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

AIDS Pharmaceutical Assistance (local)

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

Health Insurance Premium & Cost Sharing Assistance:

Health Insurance Premium & Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home Health Care Services:

Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Hospice Services:

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Mental Health Services:

Psychological and psychiatric treatment and counseling, including behavior change counseling, individual and group counseling, provided by a mental health professional licensed or authorized within the state, including physicians, psychologists, clinical nurse specialists, social workers, and counselors.

Substance Abuse Services (Outpatient)

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Medical Nutrition Therapy:

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Home and Community-based Health Services:

Home and Community-based Health Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Home Health Care:

Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Early Intervention Services (EIS)

Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

2. SUPPORT SERVICES:

Non-Medical Case Management Services:

Being that both *Traditional Case Management* and *Medical Care Management* are case management activities and are funded through the same source as separate entities, it is important to define *Case Management* and clearly distinguish the function of each entity.

Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

(Note)

Non-Medical Case Management differs from Medical Case Management in that Non-Medical Case Management supports the more traditional social needs of the patient, i.e., housing, financial assistance, support groups, etc. whereas Medical Case / Care Management focuses on access and coordination of outpatient medical care,

Medical Transportation Services:

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Referral for Health Care / Supportive Service:

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Child Care Services:

Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. **NOTE:** This does not include child care while a client is at work.

Pediatric Developmental Assessment and Early Intervention Services:

Pediatric developmental assessment and early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

Emergency Financial Assistance:

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

Food Bank/Home-Delivered Meals:

Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health Education/Risk Reduction:

Health education/risk reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Housing Services:

Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Note: In Tennessee, Housing Services are provided through HOPWA.

Legal Services:

Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics Services:

Linguistics services include the provision of interpretation and translation services.

Outreach Services:

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency Planning:

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial Support Services:

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Rehabilitation services:

Rehabilitation services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Respite Care:

Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Treatment Adherence Counseling:

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

STANDARDS OF CARE PROCEDURES

Introduction

The Ryan White Part B Consortia are comprised of providers and community members whose intent is to improve the quality and availability of care to individuals and families with HIV disease. Additionally the Consortia will encourage collaboration and inclusiveness in the definition and financial support of essential services, and in building community partnerships to more effectively respond to the HIV epidemic.

Purpose of Standards

Standards of Care are developed and implemented to determine the degree of excellence attained in the implementation of services to Ryan White Part B Consortia target populations. A well designed procedure provides accountability for the cost and quality of client services. The first step in developing standards is clarification of values. The values of Ryan White Part B Consortia regarding client services are these:

- Access for all eligible clients
- Provider sensitivity to HIV/AIDS issues as they impact the lives of individuals and families
- High quality professional services provided to all clients who request them
- Client-driven services
- Full range of services offered to every client
- Provider involvement in community activities that will strengthen services to affected individuals and families.

Role of Consortium in Monitoring Quality Assurance

A distinction needs to be made between Standards of Care required by the Part B Consortium and Quality Assurance Standards required by agencies providing care: The primary focus of Consortium Standards of Care is on oversight of contracting agencies and general community responsiveness to client-needs. In contrast agencies providing care to clients in home nursing, case management, or therapy, are required to have their own Quality Assurance Protocols and a process of QA implementation and problem-correction. The professional staff of each project has the responsibility to set standards for their own practice and to be accountable for the achievement of those standards.

As the funding agency, the Part B Consortium will request copies of Quality Assurance Protocols from every contracting provider. Additionally, as part of annual site visits, Quality Assurance material will be reviewed, response to problems evaluated, adequate use of QA procedures evaluated. The Standards of Care Will be made available to all prospective contractors as part of the RFP process. Contractors who wish to comment on the standards may do so through the Consortium.

The Consortium and its Fiscal Agent have the final authority and responsibility for assuring that services are provided according to Consortium goals, and that they are provided according to program requirements of State and Federal agencies.

Definitions:

Standards of Care Procedures. Procedures are tools to further a process that will assure the delivery of quality care to clients. The process includes collection of data about relevant activities of the service provider, comparison of the data to expected standards of performance, and implementation of corrective action when the performance falls below expected standards.

Standards. The standard is the desired and achievable level of performance of indicator, against which performance is measured.

Indicator. An element of service delivery considered necessary to reach a stated goal, and which is believed to demonstrate quality service.

Method. The way indicators are matched against standards.

Implementation of Standards of Care

Provider Contracts.

It is vitally important that all providers who contract with the Part B Consortium are aware of the expectations of quality and accountability. Therefore, agreements about Standards of Care are included in the RFP process. The Consortium will evaluate the Quality Assurance Programs of all contracting providers. All contracting providers will sign an agreement with the Consortium agreeing to Consortium oversight.

Quarterly Reports / Implementation Plans.

Quarterly reports will be used to monitor provider progress toward goals established at the time of contracting. These reports will contain data that will highlight success in reaching target populations, in providing level of services expected, and status of funding in relation to remaining quarters.

Site Visits.

Site visits will be conducted at the discretion of the Consortium, but at a minimum of two times during the duration of the contract. At this time, a Site Visit Checklist will be completed.

Client Satisfaction Surveys.

The Consortium will conduct Client Satisfaction Surveys with the cooperation of service providers, at least annually. Responses from clients will be returned directly to the Consortium and reviewed. Results will be shared with providers within 30 days of the survey. Problem areas will be addressed and corrective action plans developed. Areas of excellence will also be noted and made available to provider staff.

Corrective Action Plan.

At any time that contractors are found to be out of compliance with a Standard, a written plan will be submitted to the Consortium and reviewed by the appropriate staff and subcommittee. At the discretion of the Consortium, problem areas may be re-visited quarterly (or more often) until there is assurance of compliance.

Access and Confidentiality.

The Consortium authorized members will have access to records for the purpose of monitoring these Standards of Care for any client whose services are paid for with Part B Ryan White funds. All documents created as part of implementing these Standards of Care Procedures are considered confidential and are maintained in compliance with the Consortium confidentiality policy. At no time will minutes, records, reports include the name of clients.

Clients Rights.

All contracting providers will agree by contract to inform clients of the full range of services to which they may be entitled and for which Ryan White Part B may provide financial support. This information is to include alternate providers of all services. All clients must be informed that Consortium authorized staff may have access to their records. All contracting providers will agree by contract to include the Consortium in their grievance policy. Clients will be informed of the contractual relationship of the provider with the Consortium and clients will be informed that if their grievance is not managed to their satisfaction at the provider level, they may bring their grievance to the Consortium..

Minimum Standards for Contractors.

All individuals or entities who contract with Ryan White Part B Consortium will:

- For those applicants claiming incorporation or non-profit status, appropriate documentation from the Secretary of State must be submitted.
- All providers will have liability insurance.
- All Board governed applicants must provide Director's and Officer's Insurance.
- All providers must provide written personnel policies including job descriptions, licensing requirements, and performance standards.
- All providers must have written policies regarding Equal Opportunity, Affirmative Action, and Nondiscrimination in Services, Benefits, and Facilities.
- Providers must have a written client grievance policy which includes recourse to the Consortium.
- Providers must have Quality Assurance Standards and Practices.

STANDARDS OF CARE FOR SERVICE CATEGORIES

**TENNESSEE'S RYAN WHITE
PART B CONSORTIUM**

STANDARDS OF CARE

UNIVERSAL STANDARDS OF CARE

These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B. The Ryan White Part B Grantee and/or staff of the Contract Administrator will review agency documentation to ensure that these standards are being met.

GENERAL

1. Every client is treated with respect, dignity and compassion.
2. Promote autonomy and informed participation in care
3. Subcontractors/providers demonstrate a willingness to provide services to all affected communities.
4. Subcontractors/providers demonstrate cultural sensitivity must have a plan for providing language translation services and assistance for clients who are visually or hearing impaired, when necessary.
5. Coordinate services with collateral care providers to ensure efficient service delivery and optimal client services and avoid duplication of services, as appropriate.
6. Involve the client's caregivers, as appropriate and with client consent, in supporting client's optimal well being.
7. Within existing resources, ensure that services are available and accessible to all individuals in need of and eligible for services.
8. Provider is licensed and accredited by appropriate local, state and/or federal agencies if applicable.
9. Offer services in a safe, timely, reliable, and cost-efficient manner

CONFIDENTIALITY

1. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable local, state and federal law.
2. Subcontractor/provider has in place a policy addressing client confidentiality. Clients are informed of this policy and confirm their understanding of the policy.
3. Subcontractor/provider will have a system of safeguarding client information (written, verbal, electronic).
4. The provider shall have an "Authorization for the Release of Confidential Information" form, signed by the client prior to the release of any information about the client, as required by state and federal laws including but not limited to the Health Insurance Portability and Accountability Act.

STAFF

1. Staff receives annual training and is knowledgeable regarding HIV/AIDS and the affected community.
2. Staff members will have a clear understanding of their job description and

responsibilities.

3. The staff shall be appropriately certified or licensed as required by the state or local government for the provision of services.
4. There are written personnel and agency policies, including a formal complaint procedure for staff.
5. A job performance evaluation is conducted regularly for each Ryan White Part B funded position.

OPERATIONS/FACILITY

1. Subcontractor/provider demonstrates compliance with physical and programmatic accessibility requirements designated by the Americans with Disabilities Act (ADA).
2. Facility meets the applicable Occupational Safety and Health Administration (OSHA) requirements.
3. Service delivery hours will accommodate target populations.

The subcontractor/provider shall maintain a safe environment for provision of services. This shall include adopting a written policy to refuse services to clients who:

- Threaten physical abuse to staff or other clients;
- Are being verbally or physically abusive of to staff or other clients;
- Engage in sexual harassment of staff or other clients; or
- Possess illegal substances or weapons while accessing services.

ELIGIBILITY

- **Ryan White Eligibility**

1. Providers must document that those clients receiving services are eligible for Ryan White: 1) have HIV/AIDS; 2) have a household income, which does not exceed 300% of the Federal Poverty Level and 3) are a resident of the state.
2. There must be documentation that clients have been properly screened for other service resources as appropriate **to verify that Ryan White is payer of last resort.**
3. Documentation of Ryan White eligibility updated every six (6) months.
4. When presenting for services, client will be informed of the eligibility requirements for services, either in writing or verbally, in a manner that he or she is able to understand.
5. Services are made available to any individual who meets program eligibility requirements subject to the availability of funding and if the client abides by the rules of behavior established by each subcontractor/provider.

***NOTE:** In instances where the person served is a person affected by HIV, such as caregivers, partners, family and friends, verification of HIV status of the infected person is required when available.*

- **Service Specific Eligibility**

1. Service providers/agencies must have written eligibility policy/standards, consistent with the eligibility requirements of the funding source(s) in the service area, that define who is eligible for the service and must follow those policies/standards.
2. If applicable, reason for ineligibility for program must be documented in the client's record. If applicable, eligibility for each specific service is included in standards of care for that service.

REFERRAL

1. Demonstrate a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of HIV-related services to facilitate referral
2. A current list of provider agencies that provide services by referral is maintained and updated. .
3. Subcontractors/providers make appropriate referrals to collateral services when clients have additional service needs beyond the scope of Part B services.
4. Provision of all Ryan White Part B funded services and referrals are documented.

CLIENT EDUCATION

1. The subcontractor/provider shall have an agency plan for each funded service for conducting client education, including education on HIV/AIDS, HIV transmission and role and importance of HIV medical care (including assessment of whether the person has seen their HIV medical doctor at least two times within the last year), medications (including assessment of medication adherence) and oral health.

CLIENT RIGHTS

1. The subcontractor/provider shall inform all clients of their rights, obligations, and realistic expectations of service.
2. No client shall be discriminated against with regard to race, color, religion, age, gender, gender identity, marital status, political affiliation, national origin, sexual orientation, or disability.
3. The subcontractor/provider shall have a formal complaint procedure. Clients are informed of this policy and confirm their understanding of the policy.
4. The subcontractor/provider has written policy and procedures to ensure that any incidents of abuse, neglect, or exploitation of clients by a subcontractor/provider are reported to the proper authorities.

CLIENT SURVEY

1. A client survey must be conducted on a yearly basis, including a measure of satisfaction.
2. Subcontractors/providers must encourage input from consumers (and, as appropriate, caregivers) in service design and delivery through a mechanism chosen by the agency.
3. There must be evidence that the results of customer surveys have been incorporated into the subcontractors/provider's plans and objectives.
4. The subcontractor/agency will have a procedure for internal review and evaluation Continuous Quality Improvement.

QUALITY MANAGEMENT

1. Grantees must develop a quality management/improvement plan in accordance with Part B Grantee requirements, including a procedure for internal review and evaluation. .

MEDICAL TRANSPORTATION SERVICES

A. DEFINITION:

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. **Medical transportation is used to provide transportation to eligible Ryan White clients to core medical services and support services.**

Medical transportation services fund the provision of:

- Transportation passes (public transportation passes). This service provides reduced fare transportation passes to eligible clients with HIV/AIDS and their caregivers attending core medical service appointments. This includes two-way and one-way passes.
- Agency based transportation (van, transporter, etc.). This service provides free transportation to and from core medical services for eligible clients with HIV/AIDS and their caregivers, in vehicles 1) operated directly by the service provider or 2) through a subcontract with a provider of transportation services.
- Mileage reimbursement (private transportation, staff transportation, voucher, etc.). This service provides reimbursement for the cost of mileage for eligible clients with HIV/AIDS and their caregivers, appropriate staff persons and volunteer drivers assisting clients attending core medical service appointments. Gas vouchers to participating gas stations are an acceptable form of mileage reimbursement.
- Taxicab reimbursement (voucher, invoice, etc.). This service provides reimbursement for the cost of each qualifying taxicab ride for eligible clients with HIV/AIDS and their caregiver attending core medical service appointments.

B. PURPOSE:

Offer services in a safe, timely, reliable, and cost-efficient manner that facilitates access to core medical services for clients and their caregivers.

C. ELIGIBILITY:

Clients receiving transportation passes must be documented as having been properly screened for other transportation resources as appropriate. While clients qualify for other funding sources for transportation, they will not be eligible for Ryan White Part B funding for this service

MILEAGE REIBURSEMENT-Additional Requirement:

- To qualify for mileage reimbursement, the client must demonstrate, if needed, that a caregiver provided transportation assistance.
- To qualify for mileage reimbursement, non-clients must: 1) be an eligible staff person and/or unpaid volunteer of the agency and 2) have proof of the appropriate insurance and other liability issues either personally or through

agency coverage

TAXICAB REIMBURSEMENT-Additional Requirement:

- To qualify for reimbursement for taxicab transportation, the client must: 1) have a medical emergency or severely inclement weather which prohibits the use of other transportation sources and/or 2) no available public transportation or other resource.

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Reassessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards.
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of this service.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client

- c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
 - f. Abuse of services, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client’s case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

K. STAFF REQUIREMENTS

ALL	Are soundly coordinated and administered by qualified persons with designated specific administrative and program responsibilities Provide services by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency
Passes	Administered by or coordinated through appropriately trained and supervised staff and/or volunteers.
Agency Based	Coordinated and administered by qualified persons with designated specific administrative and program responsibilities. Provided by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency.

Mileage Reimbursement	NA
Taxi	This service may be administered by or coordinated through appropriately trained and supervised staff and/or volunteers.

- ▶ SUPERVISION:
- ▶ TRAINING:

L. MISC. REQUIREMENTS:

ALL	Demonstrate coordination with transportation agencies and services, TennCare Special Transportation and other existing transportation programs to avoid duplication of services.
Agency Based	<p>Provided in combination with core services to clients of Ryan White Part B funded programs.</p> <p>They must be in compliance with all state regulations regarding transportation including driver's license; appropriate insurance and other liability issues; and/or any applicable state regulations.</p>
Mileage Reimbursement	Mileage will be reimbursed at no more than the current state rate. Provider agencies may state their own rate as long as Ryan White funded reimbursement does not exceed the current state rate.

M. UNITS OF SERVICE FOR REPORTING:

Passes	Units of service need to be reported by dollar amount of vouchers issued, i.e., \$1=1 unit of service, so \$5 voucher = 5 units of service. Providers must report monthly activity according to the dollar amount of the voucher issued, the number of vouchers, and the number of clients served.
Agency Based	Monthly reporting for this service will be on the basis of one-way trips, i.e., one round trip to medical appointment and home = 2 units of service. Providers must report monthly activity according to the number of one-way trips and the number of clients served
Mileage Reimbursement	Monthly activity reporting for this service will be on the basis of one-way trips i.e., one round trip to medical appointment and home = 2 units of service.
Taxi	Monthly reporting for this service will be on the basis of one-way trips, i.e., one round trip to medical appointment and home = 2 units of service. Providers must report monthly activity according to the number of one-way trips and the number of clients served.

FOOD BANK AND HOME DELIVERED MEALS

A. DEFINITION:

Food bank and home delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. This includes vouchers to purchase food.

Food Bank/Home Delivered Meal services fund the provision of:

- **Food Bank.** A food bank is a central distribution center within an agency's catchments area or home delivery providing groceries for indigent clients with HIV/AIDS and their families. The food is distributed in cartons or bags of assorted products to Ryan White clients.
- **Food Vouchers.** This service provides certificates or cards, which may be exchanged for food at cooperating supermarkets, or meals at clinics or social service agencies.
- **Home Delivered Meals.** This service provides nutritionally balanced home delivered meals for clients with HIV/AIDS who are indigent, disabled or homebound, and/or who cannot shop for or prepare (or have others shop for or prepare) their own food. This includes the provision of both frozen and hot meals
- **Non-Food Products.** This service provides reimbursement for the cost of non-food products, such as personal hygiene products, to be provided to eligible individuals through food and commodity distribution programs. Ryan White Part B funds **may not be used** for household appliances, household products, car care products, pet foods or products, or baby care items (e.g., diapers, formula, layette items, etc.). Personal care kits must be provided from the agency's central distribution center.

B. PURPOSE:

The purpose of Food Bank and Home Delivered Meals is to provide the nutrition and personal and home hygiene items to enhance a person's health status.

C. ELIGIBILITY:

1. Providers must document that those clients receiving services have been properly screened for other community resources as appropriate by the primary case manager.

Food Vouchers

2. Documentation that clients have applied for food stamps, if eligible.

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Reassessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of this service.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.

6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
 - f. Abuse of services, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

MENTAL HEALTH SERVICES

A. DEFINITION:

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

B. PURPOSE:

The purpose of mental health services is to address and stabilize mental health issues so that a person is able to engage in and maintain participation in HIV medical care.

C. ELIGIBILITY:

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility as described in universal standards of care and as described in each service area.
7. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.

- a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
8. A record of the intake process must be kept and if determined eligible, a client file is created.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

CLIENT ASSESSMENT REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) The facility must ensure that the following assessments are completed prior to the development of the Individual Program Plan:
 - a. Assessment of current functioning according to presenting problem including a history of the presenting problem:
 - b. Basic medical history and information:
 - c. A six-month history of prescribed medications, frequently used over-the-counter medications and alcohol and other drugs; and
 - d. A history of prior mental health and alcohol and drug treatment episodes.

F. REASSESSMENT

Reassessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment must occur at the time the IPP is revised.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have

an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

INDIVIDUAL PROGRAM PLAN REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) An Individual Program Plan must be developed for each client which is based on an initial history and ongoing assessment and which is completed within thirty (30) days of admission. Documentation of the Individual Program Plan must include the following:
 - a. The client's name;
 - b. The date of development of the IPP;
 - c. Specified client problems in the IPP which are to be addressed within the particular service/program component;
 - d. Client goals which are related to specified problems identified in the IPP and which are to be addressed by the particular service/program component;
 - e. Interventions addressing goals in the IPP;
 - f. The signatures of the appropriate staff;
 - g. Documentation of client participation in the treatment planning process;
 - h. Standardized diagnostic formulation(s), (e.g., DSM-III, ICD-9); and
 - i. Planned frequency of contacts.

INDIVIDUAL PROGRAM PLAN REVIEW IN OUTPATIENT FACILITIES. The facility must review and, if indicated, revise the IPP every six (6) months.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client

reassessment.

6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff or medical case manager.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
 - f. Abuse of services, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

INDIVIDUAL CLIENT RECORD REQUIREMENTS FOR ALL FACILITIES.

The governing body must ensure that an individual client record is maintained for each client being served which minimally include the following information:

- a. The name of the client;
- b. The address of the client;
- c. The telephone number of the client;
- d. The sex of the client;

- e. The date of the client's birth;
- f. The date of the client's admission to the facility;
- g. The source of the client's referral to the facility;
- h. The name, address, and telephone number of an emergency contact person;
- i. If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement must include at least the following information;
 - 1. The fee or fees to be paid by the client;
 - 2. The services covered by such fees, and
 - 3. Any additional charges for services not covered by the basic service fee;
- j. Appropriate informed, signed, and dated consent and authorization forms for the release or obtainment of information about the client; and
- k. Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting client.

AND

CLIENT RECORD REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) An individual client record must be maintained which includes the following:
 - a. Progress notes which must include written documentation of progress or changes which have occurred within the IPP and which must be developed after each service contact;
 - b. Documentation of all drugs prescribed or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason;
 - c. Narrative summary review of all medications prescribed at least every six (6) months which includes specific reasons for continuation of each medication; and
 - d. A discharge summary which states, if appropriate, the client's condition at the time of discharge and signature of person preparing the summary.

K. STAFF REQUIREMENTS

PERSONNEL REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) Provide direct-treatment and/or rehabilitation services by mental health professionals or by mental health personnel who are under the direct clinical supervision of a mental health professional.
- (2) Maintain a written agreement with or employ a physician to serve as medical consultant to the facility.
- (3) If the physician is not a psychiatrist, the facility must also arrange for the regular, consultative and emergency services of a psychiatrist.
- (4) In case of a medical or other type of emergency, the facility staff must have immediate access to relevant information in the client's record.

AND ADDITIONALLY

Direct service providers must be Master's degree prepared, licensed or license eligible mental health providers including but not limited to Medical Doctor (M.D.), Psychiatric Nurse practitioner (PNP), Licensed Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Masters Level Social Worker (L.M.S.W.) seeking L.C.S.W., or Licensed Professional Counselor (L.P.C.).

▶ SUPERVISION:

▶ TRAINING:

PERSONNEL REQUIREMENTS FOR ALL FACILITIES.

- (1) Advanced Practice Nurse (APN) - means a Tennessee licensed registered nurse who has a master's degree or higher in a nursing specialty and has national specialty certification as a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist. The four (4) recognized categories for advanced practice nurses are Clinical Nurse Specialist, Nurse Anesthetist, Nurse Midwife, and Nurse Practitioner.
- (17) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served must be provided for each staff member. The provision of such activities must be evidenced by documentation in the facility records.
- (30) Training and development activities which are appropriate in assisting volunteers (if used by the facility) in implementing their assigned duties must be provided for each volunteer. The provision of such activities must be evidenced by documentation in the facility's records.
- (27) Physician - A graduate of an accredited medical school authorized to confer upon graduates the degree of Doctor of Medicine (M.D.) who is duly licensed in Tennessee or an osteopathic physician who is a graduate of a recognized osteopathic college authorized to confer the degree of Doctor of Osteopathy (D.O.) and who is licensed to practice osteopathic medicine in Tennessee.
- (25) Licensed Professional Counselor - Any person who has met the qualifications for professional counselor and holds a current, unsuspended, or unrevoked license which has been lawfully issued by the board.

AND

Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications, including cognitive impairment and generally accepted treatment modalities and practices.

L. MISC. REQUIREMENTS:

APPLICATION OF RULES FOR MENTAL HEALTH OUTPATIENT FACILITIES.

- (1) The governing body of a mental health outpatient facility must provide services and facilities which comply with the following rules:
 - a. Rule 0940-5-4-.04(2) Life Safety Business Occupancies rule;
 - b. Chapter 0940-5-5 Adequacy of Facility Environment and Ancillary Services;
 - c. Chapter 0940-5-6 Minimum Program Requirements for All Facilities; and
 - d. Chapter 0940-5-14 Minimum Program Requirements for Mental Health Outpatient Facilities; and
 - e. If services are to be provided to one (1) or more mobile non-ambulatory person, rule 0940-5-4-.09(2) Mobile Non-Ambulatory rule.

DEFINITION OF GENERAL TERMS USED IN ALL RULES.

(17) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(30) Psychiatrist - A physician who specializes in the assessment and treatment of individuals having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training and/or experience; and who is fully licensed to practice medicine in the State of Tennessee.

DEFINITION OF TERMS USED IN MENTAL HEALTH RULES.

(2) Individualized Program Plan - A document developed by the treatment staff/team, which identifies the service recipient's problems and specifies goals to be addressed in treatment and the interventions used to accomplish these goals.

(3) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(4) Mental Health Personnel - A staff member who operates under the direct supervision of a mental health professional.

(5) Mental Health Professional - A board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy.

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual or group contacts. A unit of service is defined as 15 minutes.

PSYCHOSOCIAL SUPPORT SERVICES

A. DEFINITION:

Psychosocial Support Services is the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

B. PURPOSE:

The purpose of Psychosocial Support Services is to assist PLWHA with supportive services that enhance the person's ability to maintain/improve overall health status. In the Part B Consortium area, this will be achieved through the provision of support activities, HIV support groups, pastoral care, and bereavement counseling.

C. ELIGIBILITY:

Service providers/agencies must have written eligibility policy/standards consistent with HRSA, state, local, and/or federal standards that define who is eligible for the service and must follow those policies/standards.

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. This process includes but is not limited to:
 - a. Date of intake
 - b. Ryan White Face Sheets demographic and statistical information
 - c. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - d. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility. This is minimally: HIV status, income, residency and clinical issue that support the need for psychosocial support services.

7. Reason for ineligibility for program must be indicated (if applicable).
8. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
9. A record of the intake process must be kept and if determined eligible, a client file is created.

Note: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes intake and screening with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, specific client needs for psychosocial support services must be assessed prior to the initiation of that service. The assessment should include gathering information specific to psychosocial support services including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) should gather information the client's psychosocial support need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. Results of the assessment(s) are maintained in the client's file.

Note: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Reassessment is an on-going process that may occur throughout the process of receiving psychosocial support services. At least once annually the client should complete a reassessment including enrollment and eligibility, formal assessment of the client's psychosocial support needs and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include

confidential releases, eligibility requirements and contractual agreements per stated standards

2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

Note: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE:

A Written Plan of Care must be developed **within 30 calendar days** from assessment date and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. The plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of psychosocial support services.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care should evidence on-going involvement and review as well as update/revision as indicated by designated psychosocial support service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

Note: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process and must be completed by staff responsible for Plan of Care. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated psychosocial support services staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, progress and/ or barriers **must** be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revision and/ or modification of the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the client's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or program staff.

I. ELEMENTS

- a. Conditions which may result in a client's termination from services include:
 - i. Attainment of goals

- ii. Non-compliance with stipulations of written plan
- iii. Change in status which results in program ineligibility
- iv. Client desire to terminate services
- v. Death
- vi. Abuse of service, other participants, staff or agency
- b. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
- c. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping must allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

- a. Service providers/agencies must have written documentation standards and/or policies and procedures.
- b. Service providers/agencies standards and/or policies and procedures must be consistent with all applicable laws, standards, and/or requirements. (HRSA, local, state, and federal entities)
- c. Documentation requirements as indicated from stages C – I (as outlined in each section).

K. STAFF REQUIREMENTS

Support Activities: Must have 1) a high school diploma or GED equivalent; 2) two or more years full time relevant professional experience in health or human services field and 3) possess proficient oral and written communication, presentation, and organizational skills. It is desirable that support services staff have: 1) have volunteer or professional experience with HIV/AIDS; 2) a background and awareness of client-related issues, i.e., alcohol and drug, mental health, and related issues; and 3) an awareness of systems: healthcare, entitlement, housing, etc.

Note: Persons with these qualifications may conduct support activities and HIV support group.

Peer Counselors: Must have 1) a high school diploma or GED equivalent; 2) HIV/AIDS; and 3) professional or volunteer experience related to human services, preferably in an HIV/AIDS service organization.

Note: Persons with these qualifications may conduct support activities and HIV support group.

Pastoral Care: Must have 1) attained a bachelor's degree in religion or theology or a master's of divinity degree from an accredited institution and/or have experience as a minister, preacher, pastor, priest, rabbi or other spiritual leader and must be **ordained** or otherwise designated in conformity with the customs of a church, temple or other religious group or organization; and such customs must provide for such ordination or designation by a considered, deliberate, and responsible act.

Note: Persons with these qualifications may conduct support activities, HIV support group, pastoral care, and bereavement counseling.

Bereavement Counselor: Must have 1) attained a bachelor's degree in social work, counseling, psychology, pastoral care, or specialized training or experience in bereavement theory or counseling.

Note: Persons with these qualifications may conduct support activities and HIV support group.

Note 1: *Educational and experience requirements for psychosocial support may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Lead Agency who will in turn seek approval of the modification/waiver from the Tennessee Department of Health/STD/HIV Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to be hired as psychosocial support staff has sufficient education, certification, licensure and/or experience to merit the modification/waiver. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the psychosocial support staff receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*

Note 2: *In such cases where a psychosocial support was employed prior to the implementation of the Standard and does not meet the given qualifications, there is need to use the aforementioned /modification/waiver provision. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the Specialist receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.*

➤ **SUPERVISION:**

Agencies are required to have implemented a supervisory process that addresses the relevant skill level and/or needs of the staff providing services.

➤ **TRAINING:**

Agencies providing psychosocial support services must document efforts to assist staff in securing on-going education and training to better perform their respective job duties.

1. Individuals who hold certification and/or licensure as a part of their job duties must maintain that in good standing with the respective governance bodies.
2. Psychosocial support services staff must have opportunities to participate in annual training for **at least five (5) hours per year**. Training topics may include but not be limited to the following:
 - a. HIV 101 Updating
 - b. Treatment Adherence
 - c. Cultural Issues/Competency
 - d. Community Resources/Services (health, housing, income, etc.)
 - e. Particular Client Issues/Needs (MH, A&D, poverty, etc.)

L. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual or group contacts. A unit of service is defined as 15 minutes.

SUBSTANCE ABUSE SERVICES-OUTPATIENT

A. DEFINITION:

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. This includes but is not limited to psychiatrists, psychologists, licensed clinical social workers and licensed alcohol and drug abuse counselors.

This service provides clients with HIV/AIDS regular, ongoing alcohol and drug/substance abuse monitoring and counseling on an individual and group basis in a state licensed outpatient setting or by a licensed practitioner. This does not include case management services or time spent in therapy discussing case management issues such as TennCare/disability eligibility, housing, resource identification and/or referral, financial concerns, transportation, and other community level service needs. (*Tennessee Department of Health, Ryan White Support Services, Fee Schedule*).

Services may be delivered to non-HIV family members (as defined by the client and/or Tennessee Department of Health, AIDS Support Services guidelines).

B. PURPOSE:

The purpose of substance abuse outpatient services is to address and stabilize substance abuse issues so that a person is able to engage in and maintain participation in HIV medical care.

C. ELIGIBILITY:

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

POLICIES AND PROCEDURES

The facility must maintain a written policy and procedure manual which includes the following:

- a. A description of the intake.....process;

AND

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. The intake process includes but is not limited to:
 - a. Date of intake

- b. Ryan White Face Sheets demographic and statistical information
 - c. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - d. Client or guardian signature of authorization
- 4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
- 5. Intake process is authorized by the client.
- 6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility as described in universal standards of care and as described in each service area.
- 7. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
- 8. A record of the intake process must be kept and if determined eligible, a client file is created.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

POLICIES AND PROCEDURES.

- (1) The facility must maintain a written policy and procedure manual which includes the following:
 - b. A description of the assessment.....process;

SERVICE RECIPIENT ASSESSMENT REQUIREMENTS.

- (1) The facility must document that the following assessments are completed prior to development of the Individual Program Plan (IPP); re-admission assessments must document the following information from the date of last service:
 - a. Assessment of current functioning according to presenting problem, including history of the presenting problem;
 - b. Basic medical history, including drug usage, a determination of the necessity of a medical evaluation, and a copy, where applicable, of the results of the medical evaluation;

- c. Screening to identify service recipients who are at high risk for infection with TB according to TB Guidelines, including documentation of the service recipient's risk level, and, if applicable, a tuberculin skin test or equivalent, the results of the tuberculin skin test, the date and result of a chest x-ray, and any drug treatment for TB;
- d. Assessment information, including employment and educational skills; financial status; emotional and psychological health; social, family, and peer interaction; physical health; legal issues; community living skills and housing needs; and the impact of alcohol and/or drug abuse or dependency in each area of the service recipient's life functioning; and
- e. A six (6) month history of prescribed medications, over-the-counter medications used frequently, and alcohol or other drugs, including patterns of specific usage for the past thirty (30) days.

F. REASSESSMENT:

Reassessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

Reassessment must occur at the time the IPP monitoring.

I. ELEMENTS

- 1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
- 2. Updating assessment per stated standards.
- 3. Updating/revising written plan of care per stated standards.
- 4. Communication with client regarding services
- 5. Entries in the written plan of care
- 6. Client acknowledgement of changes resulting from the reassessment

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

INDIVIDUAL PROGRAM PLAN REQUIREMENTS:

- (1) An Individual Program Plan (IPP) must be developed and documented for each service recipient within thirty (30) days of admission or by the

end of the third face-to-face treatment contact with qualified alcohol and drug abuse personnel, whichever occurs first, and must include:

- a. The service recipient's name;
- b. The date of the IPP's development;
- c. Standardized diagnostic formulation(s) including, but not limited to, the current Diagnostic and Statistical Manual (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD), and ASAM PPC;
- d. Specified service recipient problems which are to be addressed within the particular service/program component;
- e. Service recipient goals which are related to specified problems and which are to be addressed within the particular service/program component;
- f. Interventions addressing goals;
- g. Planned frequency of contact;
- h. Signatures of appropriate staff; and
- i. Documentation of the service recipient's participation in the treatment planning process.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

INDIVIDUAL PROGRAM PLAN MONITORING.

- (1) Progress notes which include written documentation of progress or changes occurring within the IPP must be made in the individual service recipient record for each treatment contact.
- (2) The facility must review and, if indicated, revise the IPP at least every ninety (90) days. The revision shall document any of the following which apply:
 - a. Change in goals and objectives based upon service recipient's documented progress or identification of any new problems;
 - b. Change in primary counselor assignment;
 - c. Change in frequency and types of services provided; and
 - d. A statement documenting review and explanation if no changes are made in the IPP.

I. TERMINATION

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
 - f. Abuse of services, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

SERVICE RECIPIENT RECORD REQUIREMENTS.

- (4) The individual service recipient record must include the following:
 - a. Documentation of all drugs prescribed or administered to the service recipient as part of the plan of care indicating the date prescribed, type, dosage, frequency, amount, and reason;
 - b. Narrative summary review at least every ninety (90) days of all medications prescribed which includes specific reasons for prescribing and continuation of each medication;
 - c. A discharge summary which states the date of discharge, reasons for discharge, and referral for other services, if appropriate;
 - d. An aftercare plan which specifies the type of contact, planned frequency of contact, and responsible staff; or documentation that the service recipient was offered aftercare but decided not to participate; or documentation that the service recipient dropped out of treatment and is therefore not available for aftercare planning; or verification that the service recipient is admitted for further alcohol and drug treatment services; and
 - e. Documentation of any instance of restraint or restriction with documented justification and authorization.

AND

INDIVIDUAL CLIENT RECORD REQUIREMENTS FOR ALL FACILITIES.

The governing body must ensure that an individual client record is maintained for each client being served which minimally include the following information:

1. The name of the client;

- m. The address of the client;
- n. The telephone number of the client;
- o. The sex of the client;
- p. The date of the client's birth;
- q. The date of the client's admission to the facility;
- r. The source of the client's referral to the facility;
- s. The name, address, and telephone number of an emergency contact person;
- t. If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement must include at least the following information;
 - 1. The fee or fees to be paid by the client;
 - 2. The services covered by such fees, and
 - 3. Any additional charges for services not covered by the basic service fee;
- u. Appropriate informed, signed, and dated consent and authorization forms for the release or obtainment of information about the client; and
- v. Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting client.

AND

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).

K. STAFF REQUIREMENTS:

PERSONNEL AND STAFFING REQUIREMENTS.

- (1) Direct treatment and/or rehabilitation services must be provided by qualified alcohol and drug abuse personnel.
- (2) A physician must be employed or retained by written agreement to serve as medical consultant to the program.

▶ SUPERVISION:

▶ TRAINING:

PERSONNEL AND STAFFING REQUIREMENTS.

(4) The facility must provide STD/HIV education to all direct care staff.

AND

PERSONNEL REQUIREMENTS FOR ALL FACILITIES.

(3) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served must be provided for each staff member. The provision of such activities must be evidenced by documentation in the facility records.

AND

Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices

L. MISC. REQUIREMENTS:

APPLICATION OF RULES.

- (1) The governing body of alcohol and drug non-residential rehabilitation treatment facilities must provide services and facilities which comply with the following rules:
- a. Chapter 0940-5-4-.04(2) Life Safety Business Occupancies rule;
 - b. Chapter 0940-5-5 Adequacy of Facility Environment and Ancillary Services;
 - c. Chapter 0940-5-6 Minimum Program Requirements for All Facilities;
 - d. Chapter 0940-5-43 Minimum Program Requirements for Alcohol and Drug Non-Residential Treatment Facilities; and
 - e. If services are to be provided to one (1) or more mobile non-ambulatory service recipient, Chapter 0940-5-4-.09 Mobile Non-Ambulatory Rule.

AND

Must maintain linkages with one or more residential facilities and appropriate community based programs, and be able to refer or place clients in a residential program, in collaboration with the patient, his/her case manager and primary care physician when that is found to be appropriate.

DEFINITION OF GENERAL TERMS USED IN ALL RULES. As used in Chapters 0940-5-1 through 0940-5-28 of these rules, unless the context indicates otherwise, terms have the following meaning:

(17) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(30) Psychiatrist - A physician who specializes in the assessment and treatment of individuals having psychiatric disorders; is certified by the American Board of Psychiatry

and Neurology or has the documented equivalent in education, training and/or experience; and who is fully licensed to practice medicine in the State of Tennessee.

DEFINITIONS

Qualified Alcohol and Other Drug Abuse Personnel - Persons who meet the criteria described in items (a), (b) and (c) as follows:

- a. Currently meet one (1) of the following conditions:
 1. Licensed or certified by the State of Tennessee as a physician, registered nurse, practical nurse, clinical or counseling psychologist, psychological examiner, social worker, alcohol and other drugs of abuse counselor, teacher, professional counselor, or marital and family therapist, or if there is no applicable licensure or certification by the state has a bachelor's degree or above in a behavioral science or human development related area; or
 2. Actively engaged in a recognized course of study or other formal process for meeting criteria of part (1) of item (a) above, and directly supervised by a staff person who meets criteria in part (1) of item (a) above, who is trained and qualified as described in items (b) and (c) below, and who has a minimum of two (2) years experience in his/her area of practice; and
- b. Are qualified by education and/or experience for the specific duties of their position; and
- c. Are trained in alcohol or other drug specific information or skills. (Examples of types of training include, but are not limited to, alcohol or other drug specific in-services, workshops, substance abuse schools, academic coursework and internships, field placement, or residencies).

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual or group contacts. A unit of service is defined as 15 minutes.

EMERGENCY FINANCIAL ASSISTANCE

A. DEFINITION:

This service includes the provision of short-term emergency financial assistance to clients with HIV/AIDS for utilities (gas, electricity, water and sewer). Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefits programs, and is paid directly to vendors based on need and actual bill. The client's name must be on the bill and/or account. Under no circumstances shall payment be made directly to recipients of this service.

B. PURPOSE:

The provision of short-term emergency financial assistance is defined as necessary for the client to: a) gain or maintain access to medical care, adherence to medical care/treatments and/or health and wellness and B) Address financial need that arises from high and/or unexpected medical costs.

C. ELIGIBILITY:

1. Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs and is limited to 21 weeks of support per year, or a dollar amount cap set by the agency/program.

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation

- should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
- a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Reassessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.

3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes reassessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of this service.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
2. Communication with client
3. Direct observation of the client
4. Contact with service provider
5. The types of information to be gathered include:
6. Present status of client
7. Client satisfaction
8. Quality and appropriateness of services provided
9. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
10. Non-scheduled care plan meetings may occur as the need arises.
11. Monitored information must be recorded in order to aid in the client reassessment.
12. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
13. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
 - f. Abuse of service, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

K. STAFF REQUIREMENTS

Are soundly coordinated and administered by qualified persons with designated specific administrative and program responsibilities.

L. MISC. REQUIREMENTS:

Demonstrate coordination with other Tennessee emergency financial assistance to avoid duplication of services.

M. UNITS OF SERVICE FOR:

- **REPORTING:**

Units of service need to be reported by the dollars per client. Programs must report the number of unduplicated clients served each month, and the dollars spent per client on detailed utility payments.

- **REIMBURSEMENT**

Units of service for reimbursement need to be reported by the dollars per client. Providers will be reimbursed based on this unit of service plus administrative costs to cover any additional service delivery costs, including salaries for staff who distribute vouchers, payments, etc. after proper eligibility screening by a medical case manager or case manager.

CASE MANAGEMENT –NON MEDICAL

The Tennessee Department of Health, Ryan White Support Services and AIDS Centers of Excellence, established minimum standards for case management. Each Consortium operating with the Ryan White Part B funded Consortia regions were expected to develop specific regional standards according to the standards listed within the state's guiding document.

HRSA's definition of case management for the Ryan White is:

“A range of client centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include: initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.”

The Tennessee Department of Health, Ryan White Services defines case management as a process whereby a client receives a coordinated and systematic set of services. This set of standards divides this process into seven phases.

SEVEN PHASES OF CASE MANAGEMENT

- I. Intake and Screening** – Each client must participate in an initial intake and screening procedure.
- II. Assessment of Patient Needs** – After each client is determined eligible for the program, needs must be assessed in a systematic manner in order to provide for the written plan of care.
- III. Development and Implementation of the Written Plan of Care** – A written plan of care must be developed with the participation and agreement of the client or guardian.
- IV. Monitoring** – The needs and status of client receiving case management services will be monitored on a regular basis.
- V. Reassessment** – Each client must be reassessed periodically or as the need arises.
- VI. Termination** – Each client may be terminated from services as a result of monitoring, reassessment, or any other form of client ineligibility including client's failure to follow the written plan of care.
- VII. Documentation** – Clients records must be maintained in an orderly manner.

INTAKE AND SCREENING

I. STANDARD

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening portions of the case management process is for client identification, eligibility determination, and screening. This stage will assist in obtaining client baseline data to be used in determining potential needs. This component is crucial in setting the foundation for providing a coordinated set of services.

II. ELEMENT

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. Process includes, but is not limited to:
 - a. Date of intake
 - b. Ryan White Face Sheets demographic and statistical information
 - c. HIV /AIDS diagnosis and if appropriate other medical diagnosis
 - d. Appropriate financial information
 - e. Health status
 - f. Insurance information
 - g. If appropriate, method of payment for services
4. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility. This is minimally: HIV status, income and residency.
5. Reason for ineligibility for program must be indicated (if applicable).
6. Intake instruments must comply with necessary laws and statues regarding the privacy and confidentiality and must comply with Tennessee Department of Health HIV Confidentiality Policy.
7. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
8. A record of the intake process should be kept and if determined eligible, a client file is created.

ASSESSMENT OF PATIENT NEEDS

I. STANDARD

After each client is determined eligible for the program, needs must be assessed in a systematic manner in order to provide appropriate information for the written plan of care. The purpose of this stage is to develop an understanding of what services the client may

need. This stage builds on the information gathered in the initial intake; however, more detailed information is sought.

II. ELEMENT

1. While the assessment of each client may require the selection from a variety of assessment tools, the assessment(s) should gather information from the many areas in which the client functions. These areas include are not limited to:
 - Medical history/physical health (i.e., HIV/AIDS, Opportunistic Infections, other medical conditions, medication(s) and adherence, medical providers / settings, hospitalizations, etc.)
 - Health Resources (i.e., Insurance, Ryan White, TennCare, Medicare)
 - Safer Sex Practices (i.e., awareness and/or practice of, resources to maintain)
 - Psychosocial (i.e., emotional functioning, alcohol and/or drug use, mental health diagnosis/history/treatment, substance abuse diagnosis/history/treatment, etc.)
 - Housing (i.e., housing resources, utilities, special needs)
 - Financial resources (i.e., income, entitlements, public assistance, budget)
 - Social functioning (i.e., family, peers, social activities)
 - Practical resources (i.e., transportation, food, clothing)
 - Functional capabilities (i.e., Activities of daily living)
 - Educational / Employment
 - Religious / Spirituality / Cultural Resources and functioning (i.e., particular affiliations, memberships, rituals, and/or role in personal well-being)
 - Service needs (Client list of personal/family resource(s) and service(s) need(s))
2. Previous assessments (i.e., medical and nursing) may be used in the determination of client needs.
3. Results of the assessments are maintained in the client's file.

DEVELOPMENT AND IMPLEMENTATION OF A WRITTEN PLAN OF CARE

I. STANDARD

A written plan of care must be developed with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

II. ELEMENT

1. The written plan must be free of ambiguity with clearly defined priority areas and time frames.
2. Information included in the plan of care may include:
 - List of client service needs
 - Establishment of short- and long-term goals
 - Objectives and action steps to meet short-term goals

- Formal and informal resources to accomplish goals
 - Gaps in services
 - Alternatives to meet client goals
 - Resources to be used to meet client goals
 - Criteria for determination of completion of goals
3. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian.
 - a. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
 4. Services must not be routinely rendered without a written plan of care.
 5. The plan must be implemented, monitored and facilitated by a case manager. This should be documented in accordance with the stated Monitoring Standard-#5.
 6. The Written Plan of Care should evidence on-going involvement and review by the case manager with the client. Minimally this should be bi-annually with contact and review within 6 months of intake and/or reassessment.
 7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

MONITORING

I. STANDARD

The needs and status of each client receiving case management services will be monitored on a regular basis. The purpose of this stage is to allow the client and case manager to observe the progress of the plan of care in order to make revisions. The intervals between monitoring may vary among clients but must reflect necessity and consistency with the written plan. However, monitoring is an ongoing process.

II. ELEMENT

1. Methods used to obtain information may include:
 - Communication with client
 - Direct observation of the client
 - Contact with service provider
2. The types of information to be gathered may include:
 - Present status of client
 - Quality and appropriateness of services provided
3. The client must be instructed to notify case manager of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures should be documented in the client chart (written plan and/or progress notes).

6. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

REASSESSMENT

I. STANDARD

Each client must be reassessed annually or as the need arises. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment will include but is not limited to the original assessment areas. The client and case manager work together to reevaluate the course of the plan of care. Reassessment also allows for client readmission to programs, assignment to another level of service, and the termination of services.

II. ELEMENT

1. Should include updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards.
2. Should include updating assessment per stated standards.
3. Should include updating/revising written plan of care per stated standards.
4. Should occur annually, on or before 1 year since initial intake and/or last completed reassessment.
5. Ryan White face sheets needs to be updated
6. Communication with client regarding services.
7. Topics to be addressed in the reassessment may include:
 - Appointment, status and referrals
 - Special intervention activities
 - Special needs
8. Entries in the written plan of care.
9. Client acknowledgment of changes resulting from the reassessment.

TERMINATION

I. Standard

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or medical case manager.

II. Elements

1. Conditions which result in a client's termination from services may include:
 - Attainment of goals
 - Non-compliance with stipulations of written plan
 - Change in status which results in program ineligibility (Determined by TDOH Medical Case Management)

- Client desire to terminate services
 - Death
 - Abuse of services, other participants, staff or agency
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the Grievance Policy in the Medical Case Management Manual.
 3. Client must be afforded information regarding transfer to an outside agency.

DOCUMENTATION

I. Standard

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

II. Elements

1. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements as indicated from stages I-VII (as outlined in each section.)

EDUCATION/EXPERIENCE REQUIREMENTS

The Tennessee Department of Health and the AIDS Centers of Excellence have adopted the education and experience guidelines set forth for Social Work classifications by the Tennessee Civil Service System.

Requirements:

All case managers hired by subcontractor/provider agencies that are funded in whole or in part to provide case management services through AIDS Support Services, Ryan White Part B funds, must possess one of the following:

- Bachelor level degree in a health or human services related discipline with equivalent to two year of full time professional case management in a public service agency

Or

- Bachelor level degree in Social Work with equivalent to two years of full time professional case management in a public service agency (an appropriately supervised BSW internship may count for one year's experience)

Or

- Master level degree in a health or human services related discipline with equivalent to one year of full time professional case management in a public service agency.

Note:

Educational and experience requirements for case may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Lead Agency who will in turn seek approval of the modification/waiver from the State. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to be hired as case manager supervision has sufficient education, certification, licensure and/or experience to merit the modification/waiver.

Supervision:

All Ryan White Services, Ryan White Part B case managers must have the supervision and guidance of a Master Level Social Worker. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g. record keeping). Clinical supervision addresses anything directly related to client care (e.g., supervision in order to address specific client issues), and issues related to job related stress. Administrative supervision addresses issues relating to staffing, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and the overall running of the program and/or agency.

Note: MSW requirements for clinical supervision may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Lead Agency who will in turn seek approval of the modification/waiver from the State. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to provide clinical supervision has sufficient education (Masters Degree in a Health or Human Services field), certification, licensure and clinical experience to merit the modification/waiver.

Training:

At this time there are no minimum standards for the amount and/or type of annual training a case manager and or clinical supervisor must receive to continue in their roles.

Agencies providing case management services should be able to document efforts to assist case management and clinical supervisory staff in securing on-going education and training to better perform their respective job duties.

1. Individuals who hold certification and/or licensure as a part of their job duties should maintain that in good standing with the respective governance bodies.
2. Case Managers and clinical supervisors should have opportunities to participate in annual training on one or more of the following topics:
 - a. HIV 101 Updating
 - b. HIV/AIDS Medical Management Updating
 - c. Treatment Adherence
 - d. Cultural Issues / Competency
 - e. Community Resources / Services (health, housing, income....)
 - f. CM Skills Building (documentation, interviewing)
 - g. Particular Client Issues/Needs (MH, A&D, poverty....)

General

Program Operation Requirements: Providers must demonstrate strong linkages with HIV/AIDS medical providers.

Service Delivery Standards: Providers will adhere to the Ryan White Part B Universal Standards Care.

Units of Service for Reporting: Units of service need to be reported by the number of individual contacts. A unit of service is defined as 15 minutes of face-to-face or phone contact or communication on behalf of client's medical care.

Eligibility Criteria: Providers must document that those clients receiving services must: 1) have HIV/AIDS; 2) have a household income, which does not exceed 300% of the Federal Poverty Level and 3) Tennessee residency.

**EXAMPLES
STANDARDS OF CARE**

Client Oriented Services.

Goal: Services are provided that are sensitive, professional, and assure client rights.

INDICATORS	STANDARDS	METHODS
1. Informed consent to participate. Includes grievance procedure and role of Consortium.	100% of clients sign consent	Chart Review
2. Release of information.	100% of clients receive appropriate information regarding release of information.	Contract process. Chart review.
3. Client grievance procedure.	Provider has written grievance procedure.	Contract process. Chart review.
4. Disenrollment procedure.	Provider has written procedure for disenrollment and client is informed.	Chart review
5. Staff are sensitive to cultural issues.	Training documented	Site review
6. Service delivery maximizes client individual and family assets and fosters their empowerment.	Client records indicate asset/resource inventory and family/community involvement.	Chart review
7. Providers protect client's confidentiality.	Provider has written procedure for protecting client and client's documents. All staff sign confidentiality form annually.	Contract process Site review Employee files

STANDARDS OF CARE.

Comprehensive Service System.

Goal: Providers will encourage community support for Ryan White Programs and participate in developing essential services.

INDICATORS	STANDARDS	METHODS
1. Community Advocacy.	Providers will be involved in community HIV/AIDS task forces, advisory boards Consortium, and/or education efforts.	Meeting minutes Community activities.
2. Identification of all community resources.	All providers will have available to clients a comprehensive HIV/AIDS resource directory.	Site visit. Contract process.
3. Identification of service gaps.	Inadequate or unavailable services are identified and reported to the Consortium.	Site visits. Annual reports.

STANDARDS OF CARE.

Administration and Data Collection.

Goal: Providers have adequate administrative skill to assure quality service delivery.

INDICATORS	STANDARDS	METHODS
1 Staff qualifications.	Project staff meets minimum qualifications specified in job descriptions.	Review job descriptions and personnel files.
2. Staff/client ratio	Not to exceed community standard for service provided.	Contract process.
3. Provider submits quarterly progress reports.	Reports submitted in required time frames.	Review reports.
4. Client records.	Stored in locked file cabinets and are unavailable to unauthorized personnel.	Site visit.
5. Provider project is fiscally accountable.	Records maintained according to generally accepted Accounting Principles. Revenuesl expenses can be tracked.	Contract process Site visit.
6. Staff orientation	Provider has internal procedure for staff orientation which includes Consortium / provider awareness.	Contract process.

STANDARDS OF CARE.

Planned Services.

Goal: Client services will be coordinated, cost effective, and of high quality.

INDICATOR	STANDARDS	METHODS
1. Client services will be cost effective and paid by payer of last resort.	95% of records document search for other funding sources.	Records review.
2. Food subsidy.	2. Provider Will have written policy for eligibility including financial standards, maximum assistance and time limit.	Contract process Records review.
3. Emergency Financial Assistance. .	Provider will have written policy for eligibility including financial standards, maximum assistance, and time limit.	Contract process Records review.
4. Medical Transportation Services.	Provider will have written policy for eligibility including financial standards, maximum assistance, and time limit.	Contract process Records review.

STANDARDS OF CARE.

Monitoring of Client Services.

Coal: All providers will monitor and evaluate services to assure quality

INDICATORS	STANDARDS	METHODS
1. Observation of services provision.	Providers will have written protocols for random service monitoring.	Contract process / Quarterly reports.
2. Documentation of cost.	Services provided are verified by time sheets, notes, and other documentation.	Records review / Site visit.
3. Prior authorization of services.	Billed services have prior authorization.	Contract process.
4. Annual client satisfaction survey.	100% returned client dissatisfactions will be investigated.	Annual report / Site visit.
5. All providers have written QA Protocol.	Protocol will include: what will be monitored who will monitor, how often monitored, and expected standards of performance and corrective response.	Contract process / Quarterly reports.

Additional Standards for Case-Management Services

STANDARDS OF CARE

Comprehensive Client Assessment.

Goal: All case-managed clients will receive an initial comprehensive assessment as the basis for a service plan and reassessments as indicated.

INDICATORS	STANDARDS	METHODS
1. Assessment contains available medical history, physical, psychosocial and financial evaluations.	95% of records contain all components detailed as part of provider contract.	Contract process / Chart review.
2. Face to face client contact at least every 60 days for reassessment.	95% of records document compliance.	Chart review.
3. Physician eligibility certification.	95% of records have signed certification.	Chart review.
4. Service plan derived from assessment.	90% of records have comprehensive individualized care plan for assessed client needs.	Chart review.
5. Client services will be cost effective and paid by payer of last resort.	95% of records document search for other funding sources.	Chart review.
6. Food subsidy programs.	Case management provider will have a written policy for eligibility including. financial standards, maximum allowance, and time limits.	Contract process / Chart review.

SECTION - XII

GRIEVANCE AND APPEALS PROCESS AND PROCEDURES

Grievance / Appeals Processes

There are three types of grievance or appeals which may occur relative to the Consortium and its decisions:

- (1) Consortium member grievance,
- (2) Client complaint / grievance and
- (3) Agency appeal after the funding process.

1. What is a “Consortium Member Grievance”?

Consortium members may have a grievance / problem / concern relative to the activities of the Consortium which they feel is not being addressed during the regular meeting or committee process of the Consortium. Consortium member grievances are confined to responsibilities of the Consortium. This process should not be used to address concerns or problems with a specific service provider’s performance, a client problem, problems with the local health jurisdictions, concern regarding activities of the state program office, etc. There are seven areas of activity which represent the “outcome” of the entire Consortium process. The general meeting and committee processes support these outcomes. The specific activities of the Consortium are:

- a. Needs Assessment
- b. Prioritization of needs dollars to service priorities
- c. Plan for Coordinated Services
- d. Implementation Plan
- e. Funding Mechanism
- f. Oversight & Monitoring of
 - Service Providers funded by Consortium
 - Lead Agency
- g. Evaluation of:
 - Consortium process
 - Quality of services funded

A Consortium member grievance may be relative to any of these activities and the operational processes developed to produce these activities the meeting process, the membership process, the leadership development & selection, committee development and responsibilities, policies & procedure development, etc.

What does a “Consortium Member Grievance” process look like? A typical grievance or complaint process includes the following steps:

- Written grievance or complaint is mailed to the Consortium’s principal leader such as the chairperson, president or selected committee chairperson.

- The person in receipt of the written grievance should acknowledge receipt of the complaint in writing within a specified number of days.
- The principal leader or his / her designee meets with the complainant with the goal of alleviating concerns and rectifying the situation for mutual satisfaction.
- If a resolution of the grievance cannot be obtained by the principal leader, a membership grievance committee can be convened to conduct an investigation of the issues, hold a hearing and develop a solution. The membership grievance committee is sometimes composed of community leaders not formally attached to the Consortium or Consortium-funded services. Potential non-members include attorneys, judges, and professional mediators.
- The decision of the membership grievance committee can be final, or a recommendation can be given to the membership of the Consortium for a vote.

2. What is a ‘Client Complaint Grievance’?

The Consortium should avoid getting involved between a service provider and its clients in any disputes or grievances. How a service provider handles client complaints and how frequently clients complain about a service provider should be included in the evaluation of a service provider’s performance and will be reflected in the Consortium’s decisions about which service providers to fund each year.

The Ryan White Part B Consortium is responsible for prioritizing the client service needs in a community, developing a coordinated implementation plan to meet those needs and directing Ryan White Part B funds to service providers who will provide the services necessary to meet the needs in the community’. The Consortium is not a direct service provider. The Consortium funds service providers. As such, the Consortium should require that, at a minimum, its funded service providers meet these criteria: (a) incorporation as a legal, business entity, (b) adequate liability insurance, (c) written personnel policies and (d) a written client grievance complaint process within the service provider structure. As a funder, the Consortium should not be tempted to “micro-manage its service providers. The Consortium is responsible for developing a community-wide response to HIV/AIDS and needs to maintain an objective unbiased perspective about the full continuum of services provided locally. The Consortium can, and should, expect their funded service providers to meet certain standards of care. The Consortium monitors and provides oversight of the services provided by its funded service providers. Further, the Consortium is responsible for evaluating the quality of services it funds. The standards of quality care expected (and the indicators of how to measure those standards) should be included in the contract between the Lead Agency and the service provider. One standard of care should be “Client Satisfaction”. Indicators of this standard could be “number of client complaints” or quality rating of specific services by clients. Therefore, it is important to get input and feedback from clients about the quality of services they are receiving. This is an appropriate function of the Consortium. Resolving the actual complaints / grievances is the responsibility of the agency providing the services.

3. What is an “Agency appeal” after the funding process?

Any agency/organization, which meets the criteria for funding, may appeal funding and / or reallocation decisions of Consortium. The appeal must be based on one of the following:

- a. Agency did not receive information made available to other agencies;
- b. Agency has additional information that might make for a more informed decision;
- c. Allegation of bias, fraud, or misuse of federal funds on the part of the Consortium;
- d. Violation of federal or state guidelines;
- e. Violation of the Consortium By-Laws.

NOTE: Dissatisfaction with level of funding is not a basis for appeal.

Potential providers / non-funded providers may have a grievance / problem / concern relative to the funding decisions procedures of the Consortium.

What does an “Agency Appeal / Grievance” process look like? A typical grievance or complaint process includes the following steps:

- Written grievance or complaint is mailed to the Consortium’s principal leader such as the chairperson, president or selected committee chairperson.
- The person in receipt of the written grievance should acknowledge receipt of the complaint in writing within a specified number of days.
- The principal leader or his / her designee meets with the complainant with the goal of alleviating concerns and rectifying the situation for mutual satisfaction.
- If a resolution of the grievance cannot be obtained by the principal leader, a special appeals / grievance committee can be appointed and convened to conduct an investigation of the issues, hold a hearing and develop a solution. The appeals / grievance committee is sometimes composed of community leaders not formally attached to the Consortium or Consortium-funded services. Potential non-members include attorneys, judges, and professional mediators.
- The finding and recommendations of the grievance committee may be presented to:
 - a. The Executive Committee for final decision or
 - b. Consortium Chair for final decision or
 - c. The Consortium Membership for final decision or
 - d. All or any combination of the above.

GRIEVANCES

FOREWORD

The following report was assembled / developed at the request of the Division of HIV Services, Bureau of Health Resources Development, Health Resources and Services Administration, U.S. Department of Health and Human Services, several years ago.

The Ryan White CARE ACT has been reauthorized more than once since this report was completed, however, this report is being included (verbatim) in this Training Manual because the principles, procedures, policies, issues and problems are as relevant today (if not more) than when this report was finalized.

**GRIEVANCE PROCEDURES
WITHIN RYAN WHITE CARE ACT PROGRAMS**

Prepared for:

Division of HIV Services
Bureau of Health Resources Development
Health Resources and Services Administration
U.S. Department of Health and Human Services

Prepared by:

Emily Gantz McKay
and
Vicky J. Borrego, Ph.D.

MOSAICA:

The Center for Nonprofit Development and Pluralism
Washington, DC
Consultant to John Snow, Incorporated
Ryan White Technical Assistance Contract

Revised June 1995

GRIEVANCE PROCEDURES FOR RYAN WHITE CARE ACT PROGRAMS

EXECUTIVE SUMMARY

This report is designed as a resource to help programs funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act develop practical and appropriate grievance policies and procedures. The report describes the experiences and issues of selected grantees, planning councils, and consortia regarding grievances, identifies approaches or models that may be useful to others, and makes suggestions which may help CARE Act grantees, planning councils, consortia, and providers to prevent and/or resolve grievances. It is based on the assumption that complaints and grievances must be expected, and having grievance policies is "good business." It is also anticipated that the reauthorized CARE Act will include a requirement that all grantees establish grievance procedures.

A framework or schema categorizing grievances, developed for the report, demonstrates the wide range of possible sources, targets, and types of grievances which might be encountered. Grievances may come from sources such as individual CARE Act clients, other community residents, community organizations, funded or unfunded service providers, and Title I- and Title II-related entities. For purposes of the CARE Act, a *grievance* might be described as a formal or informal expression of dissatisfaction about some aspect of a Ryan White CARE Act program as implemented, which is brought to the attention of an entity with responsibility for some aspect of its implementation. A *grievance procedure* is a mechanism that enables an entity to express dissatisfaction to a responsible entity and obtain an assessment and decision regarding the complaint.

The experience of CARE Act grantees indicates a need for both formal and informal grievance procedures which can address two very different categories of grievances, which appear to be of particular concern to grantees -- complaints from clients about access to or quality of services, and individual or organizational grievances or appeals about grantee, planning council or consortium processes or decisions.

The development of formal and informal grievance procedures is an evolving process, and grantees are at different stages in that evolution. Their emphasis has often been on opening up access to the planning body and developing effective lines of communication between the planning body and the community. There is a recognition that CARE Act clients may be extremely hesitant to file formal complaints, because they are dependent upon the services available through the program, but that they may be more willing to use informal avenues. Dealing with complaints at an early stage is viewed as very important, but also time-consuming. Moreover, the appropriate relationship between formal procedures and informal complaint resolution procedures is not entirely clear. Many planning councils and grantees have limited experience with formal grievance procedures and

would welcome guidance in developing and implementing grievance procedures. There is concern that funding limitations are likely to generate increased consumer complaints in the future.

CARE Act grantees, planning councils, consortia, and providers are using a wide range of internal and external approaches to grievances. Among those specifically designed for use with CARE Act programs are open forums, early intervention procedures, hotlines, patient rights statements, patient advocates, case management and quality assurance reviews and client satisfaction surveys, and formal grievance procedures at the provider and at the planning council or consortium levels. Systems external to CARE Act programs can also be used; they include governmental grievance and appeals procedures, human rights offices, mediation centers, and ombudsperson offices, as well as mechanisms developed to meet the licensing and certification requirements of other health and human services programs.

An underlying value seems to be the importance of providing several avenues through which consumers can express concerns and problems so that they can be understood and addressed individually or structurally in a non-adversarial manner -- and avoid the need for resolution through the courts. Once a complaint becomes a formal grievance, the process is necessarily formal, hierarchical, and potentially adversarial. Formal grievance procedures are often viewed as the last resort -- they must be available, but will not often need to be used, if the less "official" avenues are well understood and reasonably easy to use.

CARE Act experience demonstrates that in dealing with complaints, public information and access are critical concerns. The HIV/AIDS community should have a clear understanding of the processes available to them and the access points to those processes. One of the greatest practical challenges is how to assure that consumers become aware that informal and formal grievance procedures exist and have access to information about how to lodge an informal complaint or file a grievance. Systematic and carefully planned public education and outreach are required to make these procedures known.

Cumulative experience with the CARE Act and other health and human services systems indicates that grantees, planning councils, and consortia concerned about addressing grievances fairly and systematically might benefit from considering the following principles and considerations:

1. Establish methods for early, informal intervention and resolution of problems which may become grievances.
2. Include in planning council and/or consortium bylaws specific *policies* regarding handling of grievances, and include both individual and organizational grievances.

3. Develop detailed *procedures* to implement formal policies, with levels, steps, and timeframes.
4. Carry out systematic and carefully planned public education and outreach to make these procedures known.
5. Include in provider subcontracts a requirement for establishing client-focused grievance procedures.
6. Use existing municipal, county, or state systems to handle grievances where appropriate.
7. Remember that good documentation is critical in responding to grievances.
8. In setting up formal and informal systems, don't underestimate the time required for effective implementation and timely follow-through.
9. Establish case management review and other quality assurance procedures to help identify and resolve problems related to systems, personnel, or client assignments.
10. Be sure that those involved in handling grievances at the provider, planning council, consortium, or grantee level receive adequate information and training -- and have appropriate interpersonal skills.
11. Help prevent grievances through broad community participation, open communication, and demonstrated willingness to listen to and resolve individual, organizational, and community concerns.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
I. INTRODUCTION	1
A. PURPOSES OF THE REPORT	1
B. BACKGROUND	2
C. APPROACH	3
II. GRIEVANCES: A DEFINITION AND FRAMEWORK	6
III. GRIEVANCES WITHIN THE RYAN WHITE CARE ACT: ISSUES AND EXPERIENCES	9
A. POLICIES AND PROCEDURES USED BY GRANTEES	9
B. EXPERIENCES WITH GRIEVANCES	11
C. ISSUES AND CONCERNS	13
IV. APPROACHES FOR HANDLING GRIEVANCES	15
A. OVERVIEW: RANGE OF APPROACHES	15
B. APPROACHES WITHIN RYAN WHITE CARE ACT PROGRAMS	15
C. EXTERNAL APPROACHES	20
V. CONCLUSIONS AND RECOMMENDATIONS	23
A. CONCLUSIONS	23
B. RECOMMENDED PRINCIPLES AND CONSIDERATIONS FOR ADDRESSING GRIEVANCES	25
APPENDICES	28
A. INDIVIDUALS AND ORGANIZATIONS CONTACTED	29
B. QUESTIONS ASKED OF RYAN WHITE CARE ACT CONTACTS	32
C. SAMPLE GRIEVANCE PROCEDURES	34

I. INTRODUCTION

A. PURPOSES OF THE REPORT

This report is designed as a resource to help programs funded through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act develop practical and appropriate grievance policies and procedures. Prepared at the request of the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA), the report has the following purposes:

- To provide a framework for defining and understanding the range and types of grievances which may arise in relation to Ryan White CARE Act programs;
- To report the experiences and concerns of selected grantees, planning councils, and consortia regarding grievances, with emphasis on issues and experiences common to several grantees and locations;
- To identify approaches or models used in states or eligible metropolitan areas (EMAs) -- or in other health and human services programs -- which may be useful to others; and
- To suggest approaches and considerations which may help Ryan White grantees, planning councils, consortia, and providers to prevent and/or resolve grievances.

The report attempts to provide practical information and informal guidelines and suggestions which can be used by CARE Act grantees, planning councils, consortia, and providers in developing or strengthening their grievance procedures, formal and informal. It includes a discussion of issues and experiences from the perspective of CARE Act grantees and DHS personnel, a listing and description of approaches and mechanisms used to prevent and resolve grievances -- including some innovative methods -- and some recommendations or guidelines for establishing appropriate and useful grievance procedures.

These recommendations are intended as useful input to local decisions, not as requirements for grantees. Every grantee, planning council, and consortium operates in a unique environment, and must develop grievance procedures which are appropriate to that setting, are complementary to existing local or state grievance mechanisms, and are substantively and procedurally sound.

B. BACKGROUND

This report represents a continuation of discussions about grievance procedures in several earlier forums. A series of summer 1993 meetings of persons living with AIDS (PLWAs), Title I and II grantees, and national organizations included discussion about the lack of clear avenues for grievances at the local level. Questions were also raised about HRSA's role in grievance procedures.

To further address these questions and concerns, a meeting of Ryan White CARE Act Title I and Title II grantees and planning council members, held November 16, 1993, included an afternoon workshop on Program Grievance Procedures. Including presentations by representatives of DHS and of three local health departments which serve as CARE Act Title I lead agencies, the workshop addressed questions related to grievance procedures in the context of patient satisfaction, standards of care, quality of care, and roles and activities for handling grievances.

Workshop participants identified a number of issues and concerns related to grievances. For example:

- **Two major categories of grievances were identified:**
 - ◆ **Client or potential client grievances against the provider;** such grievances often involve accessibility of services or language- and culturally-appropriate services, and/or quality of care;
 - ◆ **Organizational or individual grievances or appeals about grantee, planning council, or consortium processes or decisions.** These include provider grievances against the grantee, planning council, or consortium, often around funding procedures or outcomes, as well as planning council or consortium grievances against the grantee.
- **In addition to individual grievances, there have been a few highly publicized situations where grantees have had to take action concerning alleged misuse of funds.** Appropriate action is facilitated if there are clear procedures for assuring an impartial investigation. While negative publicity is not useful to the program, it can help assure that grievances are addressed.
- **Many Title I and Title II grantees have no formal grievance procedures or have incomplete policies and procedures.** This is partly because of a lack of experience, partly because grantees have many other priorities that seem more critical unless or until a serious problem arises, and partly because there are no current legislative requirements for grievance procedures and no guidelines

for establishing them. Sometimes grantees do have procedures, but they lack clear stages and/or timelines.

- **The appropriate level of HRSA involvement in grievances was a matter of debate.** Many Title I and II grantees believe that grievances should be handled at the local or state level as much as possible. However, if there are possible violations of legislative requirements, then HRSA may need to be involved. Planning councils and national advocacy groups appear more eager to have HRSA become involved. One suggestion was that HRSA provide guidelines and technical assistance to help ensure appropriate procedures by local and state grantees, and perhaps review procedures to ensure that they are fair and impartial.

HRSA has given a great deal of thought to dealing appropriately with various types of grievances, and recognizes the need for procedures which provide an avenue of appeal for the major kinds of grievances – grievances from individual clients of CARE Act-sponsored agencies or from organizations, as well as disputes between planning councils or consortia and grantees. HRSA has focused its attention on assuring that enforcement mechanisms are put in place at the local and state levels. While no decisions have been made about possible federal involvement in grievance procedures, HRSA has indicated that it would take action only after consultation with state- and local-level grantees, planning council and consortium members, relevant national associations, and experts in dispute resolution. If a level of appeal were to be established at the federal level, it would be limited to inter-organizational disputes. It would be intended to be exercised in only the most extreme circumstances, to be used only if one party remained dissatisfied with the results after all local and state remedies short of legal action had been exhausted; and only if evidence existed that failure to resolve the grievance would seriously impede implementation of the Act at the state or local level.

In order to address issues raised in previous forums and provide additional guidance to grantees, HRSA arranged for additional review of grievance procedures and for the preparation of this report. The work was done by MOSAICA: The Center for Nonprofit Development and Pluralism, as a part of the CARE Act Technical Assistance Contract with John Snow, Incorporated.

C. APPROACH

This report summarizes information gained through the following major tasks:

- **A meeting with DHS personnel, to identify issues and contacts for exploring the issue of grievances in relation to CARE Act grantees, providers, clients, and affected communities;**

- **Development of a grievance framework or schema** of individuals and entities who might file a grievance related to the CARE Act, points of contact for grievances, and typical types of grievances;
- **Review of notes from the November 1993 workshop** on grievance procedures;
- **Efforts to identify grievance procedures and approaches used by other programs and entities** which may be relevant to the Ryan White Care Act situation;
- **Telephone consultation with selected Title I and Title II grantee representatives** to obtain their experiences with grievances, issues of particular concern to them, and any sample grievance procedures or approaches;
- **Review of the bylaws of several additional planning councils** which were not included in the informal survey; and
- **Synthesis of the above information in a form appropriate for field distribution**, along with sample copies of grievance procedures which may be useful to CARE Act grantees, lead agencies, planning councils, consortia, providers, and other involved individuals and entities.

The report does not attempt to present a comprehensive or quantitative analysis of the aggregate experience of Ryan White CARE Act programs with grievance procedures. A limited sample of five Title I grantees and one Title II grantee were successfully contacted for information and experiences as input to the report. In addition, contact was made with provider representatives and officials of both federal agencies and national nonprofit organizations expected to be knowledgeable about various aspects of grievance procedures. Informal telephone discussions were held with representatives of the following grantees; all are Title I except as indicated:

- Atlanta
- New Orleans
- New York City
- Mississippi (Title II)
- San Francisco
- Seattle

The report also reflects the issues, concerns, and experiences identified by Title I and Title II grantees at the 1993 meetings and reported by HRSA program officers, and attempts to address these needs. However, formal survey of grantees was undertaken, and the report

does not necessarily fully represent the experiences or concerns of all Title I and Title II programs.

The names of individuals and organizations contacted are listed in Appendix A; the questions used in informal interviews with Title I and Title II grantee representatives are provided in Appendix B. The completed document was reviewed both internally by DHS and externally by Mitchell Netburn of the New York City Department of Health.

In addition to the personal contacts, the authors reviewed several Title I and Title II funding applications for information about grievance procedures, searched through reports summarizing Title II consortium activities and Title I planning council and grantee activities to locate aggregate information, and did a search of the literature on grievance procedures.

II. GRIEVANCES: A DEFINITION AND FRAMEWORK

While it is most common to view grievances as involving disputes between labor and management, grievances and grievance procedures under the CARE Act need to be viewed much more broadly. In the context of Ryan White CARE Act programs, a *grievance* might be broadly described as:

a formal or informal expression of dissatisfaction about some aspect of a Ryan White CARE Act program as implemented, which is brought to the attention of an entity which has some responsibility for that aspect of program implementation.

A *grievance procedure* might be described as:

a structured mechanism, formal or informal, which enables an individual or entity to express dissatisfaction about some aspect of a Ryan White Care Act program, as implemented, to a responsible entity, and to obtain a fair and impartial assessment and decision regarding the complaint.

Many types of grievances may occur in relation to Ryan White, and they may originate with and be directed at a number of different entities. The following framework or schema summarizes many of the causes or kinds of grievances which might be encountered, along with their source and possible targets. As the chart indicates, grievances may come from users of the CARE Act services or groups which support or represent them -- clients or potential clients of CARE Act services, or their family members, other community members, or community organizations -- as well as from funded or unfunded service providers, and from Title I- and Title II-related entities -- planning councils, consortia, lead agencies, and grantees. They may be directed at any of the service providers or grantee-associated entities, or at HRSA.

The schema does not attempt to include every possible type of grievance, but attempts to include the most common or likely complaints. While most of the grievances from persons with HIV/AIDS or their family members are likely to be addressed initially to local or state entities, as shown in the chart, almost any grievance might ultimately be directed to HRSA if not resolved at a lower level.

The chart was designed to suggest the very broad scope of possible sources, causes, and targets of grievances related to CARE Act implementation. To be effective, grievance procedures should be capable of dealing with this broad spectrum of situations.

**A MODEL OF SOURCES, CAUSES AND TARGETS OF GRIEVANCES,
Ryan White CARE Act**

SOURCE	CAUSE OF GRIEVANCE	TARGET
Client or Potential Client -- Person Living with AIDS (PLWA) or HIV or Family Member of PLWA or Community Organization Representing Clients or Potential Clients	Lack of access to services: • not in neighborhood • no bilingual/bicultural personnel	Grantee, Lead Agency, Planning Council or Consortium
	Poor quality of services: • services not culturally relevant • services not appropriate • quality of services below minimum standards • needed services not offered • needed referrals not made	Provider, Grantee, Lead Agency, Planning Council or Consortium
	Problems in obtaining services from multiple agencies	Provider, Grantee, Lead Agency, Planning Council or Consortium
	Discrimination against a client or group in obtaining services	Provider, Grantee, Lead Agency, Planning Council or Consortium
	Lack of confidentiality, anonymity for clients	Provider, Grantee
	No mechanism in place for problem resolution	Grantee, Planning Council, Consortium, or HRSA
	Disagreements with allocation and funding	Grantee, Planning Council, Consortium, or HRSA
Community Member or Organization	Lack of inclusiveness on planning council or consortium	Planning Council, Consortium or Grantee
	Disagreement with planning council or consortium on priorities	Planning Council, Consortium or Grantee
Unfunded or Defunded Service Provider	Lack of access to planning process	Planning Council, Consortium, or Grantee
	Protest funding decision	Grantee, Planning Council or Consortium
	Improper process used to award funds	Grantee, Planning Council, or Consortium

SOURCE	CAUSE OF GRIEVANCE	TARGET
Funded Service Provider	Lack of access to planning process	Planning Council, Consortium or Grantee
	Unreasonable grant process or grant management requirements	Grantee, Lead Agency, Planning Council or Consortium
	Funding level too low or funded only for certain services	Grantee or Lead Agency
	Inequitable treatment of providers	Grantee or Lead Agency
	Unfair cash flow/reimbursement procedures	Grantee or Lead Agency
	Disagreement with planning council or consortium on priorities or funds allocation	Grantee, Planning Council, Consortium, or HRSA
Employees of Providers or Grantees	Employment practices or individual treatment	Provider, Planning Council, Consortium, or Grantee (Initial target is usually the employer, with appeal to a higher level)
Title I Grantee or Lead Agency	Underfunding	HRSA
Title I Planning Council or Title II Consortium	Unfair allocation, underfunding	Grantee or HRSA
Title II Grantee	Underfunding	HRSA
Clients, Community Members, Service Providers, Agencies	Act's legislative mandates not being followed	Grantee or HRSA
	Unclear at what level to grieve	Grantee, Lead Agency, Planning Council, Consortium or HRSA

III. GRIEVANCES WITHIN THE RYAN WHITE CARE ACT: ISSUES AND EXPERIENCES

The following section provides a composite summary of CARE Act Title I and Title II experiences with grievance procedures and some of the issues and concerns surrounding them.

A. POLICIES AND PROCEDURES USED BY GRANTEEES

While many, perhaps most, CARE Act grantees have some process -- formal or informal -- for dealing with complaints and grievances, many do not have specific, written grievance policies and procedures. A review of Fiscal Year 1994 Title II applications, for example, found that 50% of non-statewide consortia and 42% of statewide consortia had bylaws or operating procedures addressing grievance processes.* According to the grantees contacted, the emphasis has often been on *opening up access to the planning body and developing effective lines of communication between the planning body and the community* -- using a variety of approaches -- rather than on formal grievance procedures. This is being accomplished by such methods as making the planning council accessible, holding open meetings and setting aside time specifically for public input including presentation of complaints, publishing a staff contact name and telephone number for receiving problems or complaints, and identifying a planning council or consortium subcommittee responsible for assessing client satisfaction or obtaining community input.

Although many Title I planning councils and Title II consortia do not have grievance procedures as a part of their bylaws, a number are in the process of adding them. Of the six CARE Act grantee representatives consulted by telephone, only one reported a section on grievance procedures in its bylaws. A section on Grievances and Appeals was also identified within the bylaws of the Title I planning council in the Riverside/San Bernardino EMA in California, although no one from this planning council was interviewed. (A copy of these grievance procedures from the planning council bylaws is provided in Appendix C.)

The grievance procedures included in planning council bylaws vary considerably.

- Sometimes bylaws address two kinds of "Grievances and Complaints":
 - ◆ By individuals against funded providers -- with the provider responsible for responding, based on written policies and procedures,

* See Richard Conviser, Ph.D., *Activities of Ryan White CARE Act Title II HIV Care Consortia, FY 1993*, prepared for the Division of HIV Services. West Linn, Oregon: Health Policy Research and Analysis, October 1994.

and a right of appeal to the planning council through a specific committee, and/or to the grantee;

- ◆ **By agencies regarding planning council actions** -- with the Executive Committee responsible for handling the complaint, and a right of appeal to the full planning council.

Grievance procedures are likely to indicate that both kinds of complaints may ultimately be appealed to the chief elected official of the grantee jurisdiction, usually the Mayor.

- Some bylaws -- including the Riverside/San Bernardino EMA Planning Council bylaws -- address "Grievances and Appeals" through a detailed, step-by-step process with timeframes, but cover only decisions by the planning council, not client or other individual complaints against a provider.

One Title I planning council Chair had a subcommittee which is in the process of reassessing its grievance procedures, especially in relation to specifying who receives the appeal for an individual complaint against a provider -- the planning council or the grantee. Two other planning councils indicated that they are currently in the process of designing grievance procedures; they indicated that they would welcome information and models to assist them in developing appropriate procedures. Another EMA reports having a process to deal with "appeals" rather than grievance procedures.

Grantees may rely on grievance procedures designed specifically to apply to CARE Act Programs, or procedures already in use for other programs. These procedures may cover provider, client, and/or employee-related grievances. Providers licensed or certified for providing health, mental health, substance abuse, or other human services may be required to have *client* grievance procedures. In addition, many state and municipal agencies have grievance and appeals procedures focused specifically on procurement. These procedures may be used to address grievances from *providers* which applied for but did not receive CARE Act funding, or are dissatisfied with the funding process. When grievance procedures have been in place for some time, they were often designed for use with some other program with a licensing requirement, such as Medicaid. Presumably, most grantees and many providers have personnel policies which cover grievances from their own *employees*; however, small providers may have no personnel policies and no written grievance procedures for employees.

Some grantees have formal city-wide procedures involving mediation and arbitration; the grievance procedure is sometimes handled partially or entirely by an outside agency. For example, some cities now have mediation centers to which a wide range of grievances involving municipal departments or city-funded agencies can be referred.

San Diego contracts with a local Mediation Center to handle grievances related to HIV/AIDS services.

While some providers have grievance procedures to address client complaints, these are not usually required by Title I or Title II grantees as a contract requirement. One Title I grantee, San Francisco, reported putting into each provider contract the requirement that it have client grievance procedures.

Grantees often have procedures designed to handle patient complaints or to address problems before they become formal grievances. For example, New York City has a client-focused 24-hour hotline which anyone in the community can call. Mississippi's Department of Health has an Early Intervention and Care Subcommittee, which meets on a quarterly basis in order to identify problems or dissatisfaction at an early stage.

It appears that grantees, planning councils, and consortia are likely to develop formal grievance procedures after they have had to handle a grievance or appeal without a formal process. One grantee reported being unable to allocate any funds to providers until a funding appeal was resolved, and decided based on that experience to develop grievance procedures which would avoid such a situation in the future.

B. EXPERIENCES WITH GRIEVANCES

Most grantees have had to deal with some form of grievance or appeal, and most have been settled before reaching the stage of binding arbitration or legal action. A number of grantees report grievances that were found to be valid. One Title I grantee initially denied funding to a particular provider, but upon appeal did award funding. Several planning councils, in conjunction with grantees, have changed some of their procedures in response to complaints or appeals. Client complaints, formal and informal, have led to proactive methods of obtaining client feedback, such as client satisfaction surveys and quality of care assessments.

While grantees report many types of grievances, appeals of specific decisions by a planning council, consortium, or grantee are among the most frequently reported. Service providers may appeal funding decisions, including non-funding or underfunding; they may also appeal the procedures used in reaching funding decisions. There has been considerable discussion about service priorities, but none of the grantees contacted reported actual grievances related to the setting of priorities.

Client complaints are also received, although they may not come in the form of formal grievances. A very common client complaint is that there is too long a wait for services; many providers have long waiting lists, especially for certain kinds of services. However, several grantees noted that many of the people receiving services under CARE Act have minimal financial resources and therefore have no alternative means of obtaining needed

services. Therefore, they may be unlikely to file a formal grievance. Hotlines associated with the planning council, community advisory groups for individual providers, and other informal alternatives may enable them to express concerns about service accessibility or quality. In the absence of such informal methods, clients receiving services are unlikely to file a formal complaint unless the problem is extremely severe, or they have been denied services. Community organizations representing such clients, such as support groups for PLWAs or PLWA caucuses or advisory groups, are more likely to complain on behalf of groups of clients or potential clients.

Grantees often use informal procedures for finding out about and addressing client and community concerns. For example, informal sessions, using an early intervention process based on face-to-face resolution of problems and complaints, are currently being emphasized in several locations. In Mississippi, a subcommittee meets on a quarterly basis, right before regularly scheduled planning meetings, to hear and respond to problems and complaints. The subcommittee is composed of people living with AIDS, nurses, social workers, physicians, and members of the planning council.

CARE Act program staff report using existing systems external to the CARE Act to handle grievances. For example:

- A state or city human rights office may handle discrimination cases. Such cases may also be handled directly by large providers, such as hospitals.
- New York offers two kinds of hotline assistance, providing aggressive proactive models for resolving potential grievances and addressing quality of care issues:
 - ◆ The New York State Department of Health Services has a 24-hour hotline that is backed by a State law requiring that every complaint be addressed.
 - ◆ The New York City Department of Health also provides a hotline supported in part through Title I funds. The New York City hotline is especially concerned with cases of individuals being unable to obtain services.

Sometimes providers who are unhappy with funding decisions attempt to follow a political rather than an administrative process. They may go straight to the City Council, Mayor, Health Commissioner, or Governor instead of following a formal grievance procedure. Grantees with formal grievance procedures have some leverage in preventing use of the political process as the first -- rather than last -- point of appeal, while those without formal procedures are unlikely to be able to prevent such action.

C. ISSUES AND CONCERNS

Many issues and concerns have been raised by grantees, with regard to grievance processes, types of complaints, and future challenges. Following are some significant issues identified by Title I and Title II grantees:

- **Most grantees, planning councils, and consortia have limited experience with formal grievance procedures, and would welcome guidance in developing and implementing grievance procedures.** Some would like to see formal requirements or criteria for such procedures from HRSA, while others would prefer information and advice without formal requirements. HRSA has indicated that formal requirements would not be established without legislative language.
- **The appropriate relationship between informal and formal complaint resolution procedures is not entirely clear.** Many CARE Act programs have developed informal approaches for identifying and addressing problems that might become complaints if not addressed, and want to emphasize these approaches as a means of preventing formal complaints. While they recognize the need for formal procedures as well, they do not want to encourage the use of formal grievances as the primary means of resolving problems.
- **Formal and informal grievance procedures must be available to address the different kinds of complaints:** consumer complaints about access to or quality of services; individual or organizational grievances or appeals related to planning council, consortium, or grantee processes or decisions; and disputes between planning councils or consortia and grantees. The procedures needed for addressing each may be quite different.
- **In dealing with complaints, public information and access are critical concerns.** The HIV/AIDS community should have a clear understanding of the processes available to them and the access points to those processes. One of the greatest practical challenges is how to assure that consumers become aware that informal and formal grievance procedures exist and have access to information about how to lodge an informal complaint or file a grievance. Systematic and carefully planned public education and outreach are required to make these procedures known.
- **Dealing with complaints at an early stage is important, but time-consuming;** grantees are concerned about the amount of time required to receive and respond to informal complaints or problems, while recognizing the critical importance of timely response and follow-through.

- **Documentation is reportedly a critical factor in investigating and resolving complaints.** It is extremely important that grievances be formally logged in by any entity responsible for receiving them, and that appropriate documentation be available as a basis for factfinding around complaints. Yet grantees typically have limited experience with this aspect of the process.
- **Funding limitations are likely to generate consumer complaints.** There is a concern that the focus on new populations, combined with a shortage of funds, will create "chaos and hostility," resulting in more grievances filed by clients and advocacy groups.

IV. APPROACHES FOR HANDLING GRIEVANCES

A. OVERVIEW: RANGE OF APPROACHES

A wide range of approaches and procedures have been used to deal with grievances, formal or informal, related to the CARE Act. In addition, some other health and human services programs have developed procedures to address grievances within their systems. Approaches applicable to preventing or addressing grievances related to the CARE Act are described below. These approaches are divided into two categories: those which are a part of CARE Act programs and those which exist separately but can be used to address grievances arising from the CARE Act.

B. APPROACHES WITHIN RYAN WHITE CARE ACT PROGRAMS

1. Open Forums and Early Intervention Procedures

One way to deal with client or community concerns before they reach the formal grievance stage is to provide what a Chicago EMA representative has referred to as an "open door and open floor." Several grantees report that allowing people to raise concerns publicly and informally can be extremely valuable in dealing with potential problems at an early stage and thereby preventing formal grievances. A variety of approaches have been used, some offering broad opportunities for public input and others more specifically focused on enabling people to raise concerns and complaints. For example:

- A planning council or consortium can set aside a specific timeframe at each meeting to hear from anyone in the community with issues or concerns about the CARE Act. Ideally, public input should be scheduled at the same time each meeting (usually at the beginning or the end), publicized in the AIDS and general community, and handled so that individuals or organizational representatives may come and speak without prior clearances or arrangements.
- A planning council or consortium can assign a particular committee or task force to seek public input, both by holding open meetings and by going into various parts of the community and seeking public input on a regular basis. It might request input from specific segments of the community or particular types of clients, such as mental health or substance abuse clients, language and cultural minorities, etc.
- An "early intervention committee" can seek out and address consumer concerns. In Mississippi, the state task force has an Early Intervention and

Care Subcommittee, a very proactive committee which provides a forum to air grievances and addresses quality of care. Committees responsible for evaluation and/or quality of care assurances can also take on this role.

A proactive committee of the planning council or consortium can both help to prevent formal grievances by identifying and resolving problems at an early stage, and provide an informal and supportive atmosphere in which consumers feel comfortable in presenting concerns. Because many clients may still hesitate to express their dissatisfaction publicly, the full planning council or consortium, or its subcommittee or task force, may also encourage support groups and community organizations to appear before it to present concerns identified by the people they serve or represent.

2. Client Surveys

Client satisfaction surveys are another means of identifying problems or concerns, overall or for particular types of services, providers, or communities. While there are difficulties in obtaining acceptable response rates with written surveys, interviews can be used periodically to increase response rates. Even a relatively small number of responses can be valuable in identifying client concerns about services. Providers may be asked to make forms available to all clients at all times or the planning council or consortium may conduct periodic well-publicized assessments at certain times of the year. If the survey is designed for mailing to the grantee or a specific committee, confidentiality can be assured.

3. Hotlines

Another variation on the "open forum" approach is a hotline for consumers to call and express concerns about any aspect of CARE Act services. Typically, the grantee designates and publicizes a contact and telephone number. A hotline is particularly appropriate for individuals who may be reluctant to complain directly to an agency they depend on for services, are uncomfortable with a more public approach, and/or have limited literacy. Some grantees have 24-hour hotlines which use recordings when staff are not available, and some have bilingual personnel. Hotlines are a valuable way to monitor quality of care and identify problems, provide an important link to the community, and demonstrate that the grantee takes consumer concerns very seriously. However, a hotline service works well only if it demonstrates a high degree of follow-through, demonstrating that it places high priority on responding to and resolving complaints and problems. Grantees that have used hotlines caution that maintaining a hotline and providing timely responses can be very personnel-intensive.

4. Grievance Procedures in Planning Council or Consortium Bylaws

An increasing number of grantees are developing formal grievance procedures as part of their planning council or consortium bylaws or operating

procedures. While there is no single model for a grievance procedure, they often do many or all of the following:

- Establish the right of individuals or organizations to make formal complaints, submit appeals, or file other types of grievances with the planning council or consortium;
- Define and in some cases attempt to limit the types of grievances which are covered;
- Indicate whether the first step for clients is to be the provider rather than the consortium or grantee;
- Specify "an address" within the planning council or consortium for filing a grievance -- often a committee or task force;
- Describe a process by which grievances will be handled, with timeframes which specify deadlines for both parties in the grievance;
- Indicate who or what constitutes the highest or final level of appeal -- such as the full planning council or consortium, the senior elected official within that jurisdiction, or a mediation or arbitration entity.

Sometimes, the bylaws may specify the *policy* regarding grievances, while more detailed *procedures* are developed separately. This approach may be practical if there is an expectation that the procedures may require fairly frequent modification, and it is less cumbersome to revise procedures than bylaws.

Several Title I representatives have noted that the best grievance procedure is the one that is used -- and used properly. Appropriate use requires that the individual or committee responsible for receiving and responding to grievances fully understand both policy and procedures. Formal training in how to handle grievances may be extremely useful. Successful use of grievance procedures also requires that they be publicized within the HIV/AIDS community, so that people know how to file a grievance.

One example of grievance procedures is included which addresses the major points listed above. Appendix C provides the grievance procedures specified in the bylaws of the Riverside/San Bernardino, California EMA's Inland Empire HIV Planning Council.

5. Grantee Grievance Procedures

A grantee may develop its own grievance procedures specifically for CARE Act programs. They may be developed independently or in coordination with a planning

council or consortium. Sometimes, a grantee depends upon existing policies and procedures which cover the entire department or governmental unit.

Grantee grievance policies and procedures are likely to consider many of the same factors as those identified above for planning councils and consortia, and often operate in coordination with theirs. However, grantees also need to be prepared to deal with the following kinds of grievances:

- **Provider grievances related to the contracting process:** Since the grantee allocates funds and contracts with providers, the grantee needs to have grievance procedures which deal specifically with provider grievances related to the contracting process, funding decisions, or the contract relationship. Grievances may be filed by funded, unfunded, or defunded providers.
- **Client and other provider-level appeals:** The grantee will receive appeals of complaints from clients or community residents which were initially filed with a provider but not satisfactorily resolved at that level. They may go through the planning council as an intermediate step, but the grantee will typically represent the next level of appeal.
- **Planning council or consortium grievances:** The planning council or consortium may file a grievance with the grantee over funds allocations or other decisions.

It is quite common for grantee jurisdictions to have existing grievance procedures which cover contracting and client complaints, up to the level of binding arbitration or the courts. Jurisdictions sometimes have procedures to address problems at an earlier level. Wherever such procedures exist, it is important that the various HIV/AIDS communities are aware of them and how they work. (See the next section on "external" approaches.) The grantee is most likely to need special CARE Act-focused procedures to address grievances from the planning council or from consortia, entities established specifically for CARE Act implementation.

6. Requirements for Provider Grievance Procedures

Several grantees indicated the value in requiring providers to have their own grievance procedures. Having grantee staff deal directly with all client and employee complaints about providers and services takes a great deal of time. Where they exist, provider-level procedures should be the first stage for a client to use in bringing forth a grievance related to CARE Act services. The consumer is expected to file a grievance with the provider, and may appeal to the planning body or grantee if there is no satisfactory resolution at the provider level.

Some grantees now require that every provider receiving CARE Act funds have in place grievance procedures which cover employees and clients. The grantee generally does not require a particular set of procedures, leaving this to the individual provider agency, although model procedures may be provided to assist the provider. Some providers, particularly those which are licensed or certified by an independent agency to provide health or mental health services, already have client grievance procedures. Large provider agencies often have employee grievance procedures written into their personnel policies. However, many providers -- even large ones -- reportedly have no formal policies or procedures for dealing with consumer grievances.

In addition to formal grievance procedures, the provider may have other, less formal methods of quality assurance and complaint handling. Among the more proactive approaches reported are community advisory committees or Board committees that oversee or review services, hear client concerns, and in some cases do program evaluation. Some Title I and Title II grantees either require or strongly encourage providers to establish such a group, or to use other approaches which can help identify and resolve problems before they become formal grievances.

7. Patient Rights Statement

A patient or client rights statement informs the consumer about what s/he can expect from the provider of CARE Act services and clearly specifies avenues available for expressing concern or displeasure about the services provided. The statement is positive and proactive, designed to demonstrate a high level of commitment to providing high quality and responsive care to each individual patient, and to specify procedures the patient can use if these standards are not met. The planning council or consortium can both adopt such a statement itself and also require funded providers to adopt and publicize it. The San Francisco EMA has a patient rights statement in addition to requiring that every provider have written grievance procedures; Appendix C provides a sample client rights statement from the Asian and Pacific Islander HIV Case Manager Program, one of the EMA's providers.

8. Patient Advocates

A few large providers have on-site patient advocates, sometimes bilingual, from whom clients who encounter problems can request immediate assistance. Several grantees noted that consumers often need help in how to present grievances against providers; the patient advocate fulfills this role, as well as helping to resolve problems before they become formal grievances. Patient advocates may be particularly important for clients who are unlikely to raise concerns directly, such as those with mental health conditions and/or language and cultural minorities. It is theoretically possible to have a patient advocate who is responsible for multiple providers and divides his/her time among several sites. A

patient advocate is not likely to be funded through CARE Act monies, but may assist both CARE Act and other clients served by a provider.

9. Case Management and Quality Assurance Reviews

Some providers -- and some planning councils and consortia -- attempt to address potential client grievances through case reviews and other quality assurance procedures. In many health care systems, periodic case reviews may be used to identify three different kinds of problems which may be contributing to grievances:

- Problems which are a part of the *service system*, such as "missing" or inappropriate services, lack of available referrals, etc.;
- *Personnel* problems, related to inadequate skills or inappropriate attitudes, which may need to be addressed by staff development or by staff changes; and
- *Client* factors, such as a poor "match" between client and case manager, client characteristics such as language or cultural factors which keep the provider from being able to provide appropriate services, unwillingness to accept services, etc.

Some CARE Act providers view regular, random case reviews as a major tool in identifying potential problems and thereby preventing grievances. Similarly, reviews of particular types of cases may be carried out after a grievance or an informal complaint is received, in order to understand whether the reported problem is isolated or more widespread. Many planning councils and consortia are addressing the issues of case management and quality assurance, although these efforts are not necessarily directly linked to a grievance process. As part of such efforts, some planning councils and consortia have instituted client satisfaction surveys in cooperation with providers. Sometimes, a standardized survey form is developed and made available to clients at all funded provider facilities; one approach is to ask clients to complete the form and mail it directly to the planning council, consortium, or grantee.

C. EXTERNAL APPROACHES

1. Governmental Grievance Procedures

Often, state or municipal agencies have their own grievance procedures, which may be handled by staff or by an external body on contract. Many states and municipalities have elaborate grievance systems; some, like Maine, have a fair hearings process for people to use as a last resort. Collective bargaining agreements typically include detailed procedures for handling employee grievances. Often, a public agency involved in contracting for services has a specific appeals process which applies to CARE Act provider

subcontracts. Agencies which provide human services may have grievance procedures for clients as well.

It is not always clear whether and under what circumstances existing grievance procedures apply to CARE Act programs. For example, planning councils are defined entities, yet are also associated with municipal government. It may not be well understood by consumers whether grievances directed at the planning council are or are not covered by the procedures that are already in place for the city.

2. Human Rights Entity

Many cities and states have human rights commissions or offices of civil rights which already have legal responsibility for handling cases of alleged discrimination against protected classes of people. Several grantees reported that grievances related to alleged discrimination are automatically referred to the human rights agency for investigation and resolution.

3. Mediation and Arbitration Services

A growing number of municipalities have mediation centers which provide dispute resolution services. Most are incorporated as independent nonprofit organizations. They may have contracts which give them responsibility and authority to handle certain kinds of complaints, sometimes on a voluntary basis. For example, courts may refer disputes for voluntary arbitration as an alternative to formal litigation; landlord-tenant and small-claims cases are often referred to mediation services. Mediation centers may also be willing to handle individual disputes on a per-case basis. Many public, private, and nonprofit employers include in their personnel policies procedures for the use of arbitration as the final step in resolving employee grievances.

The San Diego Mediation Center provides mediation for HIV/AIDS clients and service providers. A description of the Center and the services it provides is included in Appendix C of this report.

4. Ombudsperson

Some public agencies have established an ombudsperson function, which serves as an independent investigative agency for individual problems. The ombudsperson advertises available services, receives complaints from individuals and organizations, and works with all appropriate public bodies to resolve problems. Where a state or city has an ombudsperson office, it can be used to handle CARE Act-related complaints and grievances. Where the function does not formally exist, a similar role may be fulfilled by someone within the CARE Act structure. One Office of AIDS reportedly

serves as an unofficial ombudsperson, and reports being able to resolve nine out of ten complaint calls.

In a sense, the ombudsperson fulfills the same role as a local elected official who attempts to resolve the problems of constituents. However, the ombudsperson function is professional, independent, and nonpolitical. Moreover, the ombudsperson is trained to be familiar with the complexities of the governmental system, from the structure of service delivery to the judicial system. An ombudsperson does not replace existing functions, but provides an ongoing evaluative process of how responsive government is to the public. An ombudsperson function reportedly can reduce the number of lawsuits filed against the jurisdiction.

One of the greatest benefits of an ombudsperson function is its ability to bridge communication gaps and misunderstandings. One study found that in nearly half the cases handled by an ombudsperson office over a ten-year period, complaints were due to communication problems. The ombudsperson typically has strong communication skills, and is able to resolve these problems.

5. Licensing Entities

Some providers, particularly those receiving third-party reimbursements for health, mental health, and/or human services, already meet extensive licensing or certification requirements. Such organizations may be required to have in place grievance procedures covering employees and/or clients. However, contacts with a number of licensing and certification entities suggest that specific requirements for grievance procedures are far less common than various types of quality assurance reviews.

A CARE Act grantee may consider requiring that providers adopt a particular type of grievance policy or procedure. However, this would mean that providers which receive funding from other public sources -- especially those which are licensed or certified -- could face conflicting funder requirements. One solution is to require that providers have in place specific client grievance procedures. A provider without procedures might be given model procedures or asked to assure that its procedures include certain minimum components. A provider with existing procedures might be asked to submit a copy of those procedures for review, so the grantee could assure that they provide adequate client protections.

V. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

The experiences of CARE Act grantees, planning councils, consortia, and providers suggest that:

- **There is considerable interest and involvement in proactive, early intervention methods which can address complaints and problems before they become formal grievances -- particularly those coming from clients.** Many different approaches are being used. An underlying value seems to be the importance of providing multiple avenues through which consumers may express concerns and problems so that they can be understood and addressed individually or structurally in a non-adversarial manner. Once a complaint becomes a formal grievance, the process is necessarily formal, hierarchical, and potentially adversarial. Formal grievance procedures are often viewed as the last resort -- they must be available, but should not often need to be used.
- **Grievance procedures have received relatively low priority from many providers and grantees because they must address so many other needs;** grantees, planning councils, and consortia realize their importance, but often do not have time to focus on them during the first year or two of operations.
- **Most Title I grantees have had to deal with formal grievances or appeals, most often organizational complaints around funding decisions.** Often, grantees, planning councils, and consortia develop grievance policies and procedures *after* they have had to deal with a complicated grievance which delays funding or otherwise complicates operations.
- **The development of formal and informal grievance procedures is an evolving process, and grantees are at different stages in that evolution.** A number of planning councils are reportedly working on grievance procedures, and those with grievance procedures in their bylaws may be reviewing and revising them. Few grantees currently require providers to have their own formal grievance procedures for dealing with client complaints, and the responsibilities of providers versus the planning council or consortium in handling client grievances is not fully defined in most locations.
- **While many other health and human service programs have had to address grievances, there is relatively little written documentation of formal procedures.** Investigation into other federal programs turned up few guidelines or models for formal grievance procedures, although case management and quality assurance review procedures have been established for identifying and resolving problems related to systems, personnel, and the client-provider "match."

The experience of CARE Act grantees and other health and human services programs suggests that an effective grievance procedure should have certain critical characteristics, which are described in the box below.

CHARACTERISTICS OF AN EFFECTIVE GRIEVANCE PROCEDURE

1. People know it exists and how to access it.
2. It is applied consistently and impartially.
3. People feel encouraged to use it -- it is viewed as fair, impartial, and responsive.
4. The same people that are involved in the problem are also involved in the solution -- the grievance procedure is a part of or is linked to the program.
5. It attempts to ensure that each grievance is described sufficiently clearly and specifically that it can be resolved through the grievance process -- unlike vague concerns which offer no basis for action.
6. It is decision- or solution-oriented -- it is unlikely to leave a grievance unresolved.
7. It includes clear timeframes for each step in the process.
8. It focuses on determining *what* is right, not *who* is right; the procedure does not personalize the conflict.
9. It is accompanied by appropriate orientation and training, so that those responsible implementing it have the necessary knowledge and skills.
10. Prompt follow-through is a high priority in its implementation.
11. It is reviewed periodically by program administrators and by "consumers" of the process and revised if it is not working.

Many different approaches can be used to address a grievance, but a complete grievance process for the CARE Act use seems to need certain steps. They are listed in the box below.

STEPS IN THE GRIEVANCE PROCESS

1. A grievance prevention process designed to prevent or address problems or dissatisfaction which might become grievances.
2. An attempt to resolve the grievance informally.
3. A procedure for filing a formal grievance.
4. A clear procedure with timeframe for fact-finding and responding to the grievance at an initial level.
5. A procedure through which a grievance can be elevated or appealed to the next higher level in the hierarchy for further consideration [Sometimes there are several levels or stages involving different entities, such as a service provider, a planning council committee, and the grantee].
6. A final level of consideration and resolution, usually involving a system such as arbitration.

B. RECOMMENDED PRINCIPLES AND CONSIDERATIONS FOR ADDRESSING GRIEVANCES

Grantees, planning councils, and consortia concerned about addressing grievances fairly and systematically might benefit from considering the following principles and considerations:

1. **Establish methods for early, informal intervention and resolution of problems which may become grievances, through a planning council or consortium committee, hotline, ombudsperson, or other readily accessible avenue for raising concerns and settling grievances informally. Most CARE Act programs agree that the best grievance system is one which resolves most**

problems before they reach the formal grievance stage. This requires public education and outreach, clearly defined ways for consumers or organizations to raise concerns, and establishment of community confidence that their concerns will be listened to and considered seriously.

2. **Include in planning council and/or consortium bylaws specific policies regarding handling of grievances**, and include both individual and organizational grievances. The bylaws themselves need not necessarily specify the detailed procedures to be used, but should provide the foundation for detailed procedures. Grantees should also consider whether they need CARE Act-specific grievance procedures, especially to deal with grievances from a planning council or consortium.
3. **Develop detailed procedures to implement formal policies**, and be sure that they include levels and steps in the grievance process as well as timeframes which must be met by both parties. There should be a clear line of appeals -- ending with binding arbitration, the chief elected official, or some other individual or entity.
4. **Carry out systematic and carefully planned public education and outreach to make these procedures known**. Make sure that the HIV/AIDS community understands the grievance processes available to them -- formal and informal -- and how and where to access them. Complaints and grievance procedures are useful only when the widest possible range of consumers are aware that they exist and know how to use them.
5. **Include in provider subcontracts a requirement for establishing client-focused grievance procedures**; make available a model set of procedures for provider consideration, but allow providers to develop procedures appropriate for their organizations. A patient rights statement might also be adopted by the planning council or consortium, with funded providers expected to adopt it.
6. **Use existing municipal, county, or state systems to handle grievances where appropriate**. This might mean referring grievances related to discrimination immediately to the human rights commission, or having a local mediation center handle some or all grievances which go beyond the informal stage.
7. **Remember that good documentation is critical in responding to grievances**. Careful and complete records at the provider, planning council, or grantee level help determine what happened and why, and contribute to prompt resolution of grievances.

8. **In setting up formal and informal systems, don't underestimate the time required for effective implementation and timely follow-through.** The best designed hotline is useful unless callers receive quick and appropriate follow-up.
9. **Establish case management review and other quality assurance procedures** to help identify and resolve problems related to systems, personnel, or client assignments; client satisfaction surveys can be a useful tool in this effort.
10. **Be sure that those involved in handling grievances at the provider, planning council, consortium, or grantee level receive adequate information and training -- and have appropriate interpersonal skills.** As the experience of ombudsperson offices has shown, a "professional" approach is extremely important in resolving complaints and grievances.
11. **Help prevent grievances through broad community participation, open communication and demonstrated willingness to listen to and resolve individual, organizational, and community concerns,** through outreach, community education, and open forums providing access to grantee officials and planning councils or consortia. This process begins with establishment of participatory community needs assessment, planning, program priority-setting, and program evaluation processes which assure adequate representation of affected communities, people living with HIV/AIDS, and community-based service providers.

APPENDICES

**APPENDIX A
INDIVIDUALS AND ORGANIZATIONS CONTACTED**

INDIVIDUALS INTERVIEWED BY TELEPHONE

ATLANTA

Kathy Bush, Director
Ryan White Projects
Division of Communicable Disease
2 Peachtree Street, N.E.
6th Floor Tower
Atlanta, GA 30303
Telephone 404-657-3129
Fax 404-657-3119

MISSISSIPPI

Bob Lowery, Director
Ryan White Programs
Mississippi State Department of Health
2423 N. State Street
Annex Building, Room 316
P.O. Box 1700
Jackson, MS 39215-1700
Telephone 601-960-7723
Fax 601-960-7909

NEW ORLEANS

Beth Scalco, Chair
New Orleans Planning Council
City of New Orleans
Mayor's Office of Health Policy & AIDS Funding
New Orleans, LA 70130
Telephone 504-524-4611
Fax 504-523-2084

NEW YORK

Mitchell Netburn and Joanne Hilger
New York City Department of Health
125 Worth Street, Room 326 Box 22
New York, NY 10013
Telephone 212-788-4719
Fax 212-788-4734

SEATTLE

Michael Curnes
Director, Regional Division
Seattle King County
Department of Public Health
400 Yesler, 3rd Floor
Seattle, WA 98101
Telephone 206-296-4568
Fax 206-296-4803

SAN FRANCISCO

Valerie Dorr
Chief, Health Services Branch
AIDS Office
San Francisco Department of Public Health
25 Van Ness, Suite 500
San Francisco, CA 94102
Telephone 415-554-9060
Fax 415-431-7547

ADDITIONAL CONTACTS

American Management Association
Washington, DC

Mary Medued
Association of State and Territorial Health Officials
Washington, DC

James D. Belt
Denver Indian Health and Family Services
Denver, CO

David Cavanaugh
National Association of Community Health Centers, Inc.
Washington, DC

Roger Dahl
U.S. Conference of Mayors
Washington, DC

Richard Bohrer, Director
Primary Health Care
Health Resources, DHHS
Rockville, MD

Alaska Office of the Ombudsman
Juneau, AK

APPENDIX B
QUESTIONS ASKED OF RYAN WHITE CARE ACT CONTACTS

Contact: Name and Title _____
Agency _____
Phone Number _____ Fax _____

Are you responsible for:

- Title II (states)?
- Title I (EMAs)?
- Both (regional consortium and EMA)?

1. What kind of grievance procedures does your agency have in place that applies to Ryan White CARE Act programs? (Request copies.)
2. Does your Planning Council or consortium have grievance procedures as part of its bylaws or charter? What do they say? (Request copies.)
3. If you have grievance procedures in place, were they developed specifically as part of management planning to implement CARE Act programs, or for more general purposes (e.g., used for all human services contracts)?
4. Are your grievance procedures part of your city or state regulations and incorporated within your procurement procedures?
5. Do you require providers to have grievance procedures, as part of their contract with you?
6. What has been your experience with grievances: causes, who grieves, to whom, specific grievances, what happened? Has each one been resolved, and if so, how? Did any go to court?

7. Please look at the "Typical Sources, Causes and Targets of Grievances" schema we sent you. Are there sources, causes, or targets you feel should be added or changed so this will provide a representative if not complete picture of potential and actual grievances under Ryan White?
8. What do you see as the most critical areas of priority for grievance procedures related for CARE Act programs? Consider the following four purposes for grievance procedures:
 - a. Fair and consistent process for handling individual grievances
 - b. Preventing more serious problems in the future
 - c. Source of information indicating the need for changes in procedures or regulations
 - d. A way of opening up communication between sources and targets of grievances
 - e. Other?
9. What do you see as the major issues related to grievance procedures for the CARE Act overall, nationally?
10. What else do we need to know?
11. Who else should we be talking to that may be helpful, knowledgeable?

**APPENDIX C
SAMPLE GRIEVANCE PROCEDURES**

**SECTION ON GRIEVANCES
FROM THE BYLAWS OF
THE RIVERSIDE/SAN BERNARDINO
INLAND EMPIRE HIV PLANNING COUNCIL**

Article IX

Grievances and Appeals

- Section 1 It is the intent of the Inland Empire HIV Planning Council to provide an appropriate administrative channel by which individuals and/or agencies may set forth grievances and appeal decisions of the Council. The procedures adopted by the Council are intended to enhance timely factfinding, hearing and decision making in the event of a grievance or appeal. These three procedures constitute the process of appeal.
- Section 2 Persons or agencies must submit an appeal request in writing to the Executive Committee, Inland Empire HIV Planning Council. This appeal request must meet the following criteria:
- A. The appeal request must be received by the Planning Council within ten (10) days of a Planning Council decision.
 - B. The appeal request must specify the reasons for an appeal. Available supporting documentation regarding an alleged violation or act of neglect or omission in the Council's process must be included.
 - C. At least one of the following criteria must form the basis of an appeal:
 - 1. Irregularity in the process,
 - 2. Inconsistency with findings of fact.
- Section 3 Requests for appeals shall be subject to factfinding conducted by the Executive Committee Chair. The Committee shall review the request and determine within fifteen (15) working days if a basis for appeal exists. If a basis for appeal is found, the Executive Committee shall notify the appeal applicant in writing of the planned schedule for factfinding, hearing, and decision making.

- Section 4 The Chair of the Executive Committee will appoint a Review Committee, to include a Review Committee Chair, to conduct a review of the pertinent facts of the appeal. Representatives of the appealing agency will be consulted, in addition to other persons as deemed appropriate by the Review Committee. The appealing agency shall be provided the opportunity to meet with the Committee during the factfinding process. The Review Committee will make a recommendation regarding the appeal in ten (10) working days.
- Section 5 The appeal and facts from review will be heard by the Executive Committee. The Chair of the Review Committee will present the findings and recommendation of the Review Committee.
- Section 6 Determinations of appeals will be made by the Executive Committee. Appeal determinations will be forwarded to the Planning Council membership for approval. The decision of the Planning Council will be final.
- Section 7 The Chair of the Executive Committee shall notify the agency in writing of the decision within five (5) working days of the Planning Council decision.

**STATEMENT OF CLIENT RIGHTS
ASIAN AND PACIFIC ISLANDER
HIV CASE MANAGEMENT PROGRAM
GAPA COMMUNITY HIV PROJECT
SAN FRANCISCO**

Asian and Pacific Islander HIV Case Management Program
GAPA Community HIV Project

STATEMENT OF CLIENT RIGHTS

Any person presenting him/herself for services at the GAPA Community HIV project is considered and entitled to the following rights:

- a. The right to treatment with dignity and respect in a non-judgmental manner, regardless of his/her personal identification. The GAPA Community HIV Project does not discriminate on the basis of race, ethnicity, religion, age, country of origin, sexual orientation, or sexual identification.
- b. The right to complete confidentiality. Information will be withheld from all inquirers, including family members, friends, spouse/lover and medical or law enforcement personnel--except in cases of life-threatening situations, child abuse or with the written request/permission of the client.
- c. The right to be seen privately. This includes the following services, if applicable: intake, assessment of needs, case management and individual counseling. Exceptions to this right include enrollment in a group session provided in association with the program.
- d. The right to refuse or discontinue services at any time for any reason. This includes the right to request services from another provider.
- e. The right to full information about the services offered in association with the project.
- f. The right to inspect all client-specific documents. This includes all intake forms and notes, assessment forms and notes, case notes and any other documents pertaining to the client only.
- g. The right to information pertaining to the appeals process in the event s/he has a grievance with the project or a project staff person.
- h. The right to know what rules and regulations the project has established in regard to inappropriate client conduct and what penalties an/or consequences may result.
- i. In the event of problems with (an)other client(s), the client has the right to present the problem to the Provider staff. The client can expect to be heard, be provided with a response and be notified of final determination/resolution.

Client will not be:

- Sexually or physically harassed,
- Solicited for favors, labor or money by a staff member
- Discharged without due cause and notice.

**DESCRIPTION OF THE SAN DIEGO
MEDIATION CENTER**

WHAT IS THE SAN DIEGO MEDIATION CENTER?

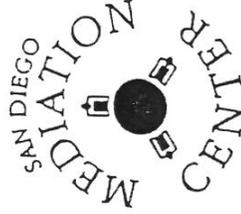
San Diego Mediation Center (SDMC) was founded in 1983 by the Law Center, a project of the University of San Diego and the San Diego County Bar Association. In 1990 it was incorporated as an independent non-profit agency. It is sponsored by the San Diego County Bar Association.

SDMC provides dispute resolution services to businesses, corporations, organizations, government institutions, neighbors, landlords, tenants and families.

WHO ARE THE MEDIATORS?

The mediators are individuals from the San Diego community who have been screened, selected and trained by San Diego Mediation Center. They have received more than 50 hours of training and have been mediating for a minimum of one year. Mediators participating in this project have had additional relevant training.

MEDIATION FOR HIV/AIDS CLIENTS & SERVICE PROVIDERS



San Diego Mediation Center
2150 W. Washington Street
Suite #112
San Diego, CA 92110

(619) 295-0203
Fax (619) 295-0384



Sponsored by:
San Diego County Bar Association
Funded in part by:
County of San Diego
City of San Diego
Private donations

Brochure funded by:
Title I, Ryan White Act Funds
April 1993

WHAT IS MEDIATION?

Mediation is a method of handling conflict in which two or more disputing parties meet with trained, impartial mediators to resolve their issues.

The mediators do not offer legal advice, counseling or impose solutions to the dispute. The role of the mediators is to assist the parties to identify the issues and explore possible solutions. An agreement is reached when all parties are satisfied with all of its terms.

The process is non-adversarial and informal, but structured.

WHAT HAPPENS DURING A MEDIATION SESSION?

Mediation sessions are informal, structured discussions. Both parties are given the opportunity to speak without interruption. The mediators facilitate an exchange in which the parties clarify the issues, hear each other's perspectives, and move toward an agreement. The agreement is written down and signed by each party and the mediators.

A mediation session takes two or three hours. Sometimes more than one session is needed.

WHAT ARE THE ADVANTAGES OF MEDIATION?

EFFICIENT: A mediation can be scheduled within two weeks. Most issues are resolved in a single, two to three hour session. Occasionally more than one session is needed and it can be scheduled to take place soon after the first session.

PRIVATE & CONFIDENTIAL: The mediation sessions are not open to the public or recorded. The Mediation Center keeps confidential who participates in a mediation and what takes place during the mediation.

CONVENIENT: Mediation sessions take place during the day, in the evening or on Saturdays. Generally, sessions take place at the Mediation Center or at Western State University School of Law.

NON-ADVERSARIAL: The focus of the mediation is on the mutual best interests of the parties rather than on positions.

VOLUNTARY: Parties are not forced to come to an agreement, but are encouraged to create one that will work for them.

NON-RESTRICTIVE AS TO ISSUES:

Unlike legal or other formal processes, mediation can include discussion of emotional, personal and other issues which may need to be addressed in order for the parties to be able to resolve the conflict.

EFFECTIVE: Mediation works. Parties are more satisfied with and are more likely to follow through with agreements they create to meet their own needs.

WHAT TYPES OF CONFLICTS CAN BE MEDIATED?

- **Provider/Client:** benefits, service, personal.
- **Relationship:** family, friends, room-mates, partners.
- **Business:** partnership dissolution, contracts, subcontracts.
- **Consumer-Merchant:** repairs, service, merchandise.
- **Real Property:** sales, leases, property lines.
- **Neighborhood:** noise, harassment.
- **Landlord-Tenant:** rent, security deposits, repairs.
- **Employer-Employee:** non-union, wages termination.
- **Other**

HOW CAN I ACCESS MEDIATION SERVICES?

CALL SAN DIEGO MEDIATION CENTER,

(619) 295-0203. The staff will contact the other party to arrange a mediation. The sessions are typically scheduled within one to two weeks of the request.

Mediation sites are available throughout the county.