Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020
Tel: 954-561-9681 / Fax: 954-561-9685

MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE MEETING AGENDA

Thursday, October 4, 2012, 9:00 a.m.

Karen Creary, Chair **Tara Wilson, Vice Chair**

Reminder: Meeting Attendance Confirmation Is Required ***at least 48 Hours Prior to Meeting***

1. **CALL TO ORDER**
   a. Welcome and Introductions
   b. Review Meeting Ground Rules, Statement of Sunshine and Review Public Comment Procedure
   c. Committee Member and Guest Introductions

2. **MOMENT OF SILENCE**

3. **APPROVE TODAY'S AGENDA**

4. **APPROVE 9/6/12 MEETING MINUTES**

5. **NEW BUSINESS**
   Training Session(s) Outline
   ACTION ITEM: Develop training topics and timeline for annual training of Planning Council members to comply with HRSA mandate, in order to as Executive Committee for a training time slot during Council retreat in January.
   Time permitting: Discuss topics and details for other training sessions identified by members of Planning Council and JCCR Committee.

6. **REVIEW PLANNING COUNCIL MEMBER CHANGES** *since last meeting*

7. **PUBLIC COMMENT**

8. **REQUEST FOR INFORMATION/DIRECTIVES**

9. **AGENDA ITEMS FOR NEXT MEETING –** 11/01/12 at 9:00 a.m. **Venue:** BRHPC

10. **ADJOURNMENT**

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MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE
September 6, 2012 at 9:00 a.m.
Broward Regional Health Planning Council
200 Oakwood Lane, Hollywood, 33020
MEETING MINUTES

ATTENDANCE				
#	**Members**	**Present**	**Absent**	**Guests**
1	Katz, H.B. *Chair*	**X**		Runkle, D.
2	Wilson, T. *Vice Chair*	**X**		
3	Creary, K.		**E**	**Grantee Staff**
4	Dyer, L.		**A**	Odusanya, S.
5	Greenwood, J.	**X**		
6	Hanson-Evans, B.	**X**		**HIVPC Staff**
7	Pearl, J.	**X**		Crawford, T.
8	Roberson, C.	**X**		Hosein, F.
	Quorum = 5	**6**	**2**	LaMendola, B.
				Rosiere, M.

1. **CALL TO ORDER**
The Chair called the meeting to order at 9:14 a.m.

WELCOME AND INTRODUCTIONS
The Chair welcomed everyone and self-introductions were made. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. In addition, it was stated that the acknowledgement of HIV status is not required but is subjected to public record if it is disclosed.

2. **MOMENT OF SILENCE**
A moment of silence was observed.

3. **APPROVAL OF THE 9/6/12 MEETING AGENDA**

Motion # 1	To approve the 9/6/12 meeting agenda
Proposed by:	Jodi Pearl
Seconded by:	Tara Wilson
Action:	Passed Unanimously

4. **APPROVAL OF THE 7/5/12 MEETING MINUTES**

Motion # 2	To approve the7/5/12 meeting minutes
Proposed by:	Barbara Hanson Evans
Seconded by:	Tara Wilson
Action:	Passed Unanimously

5. **PUBLIC COMMENT**
A guest described his health situation and urgent need for housing assistance. A long-standing member of the Council offered to 'walk' the gentleman through the process of seeking assistance after the meeting.

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6. REVIEW PLANNING COUNCIL DEMOGRAPHICS

The Committee reviewed the HIV Planning Council (HIVPC) Demographics

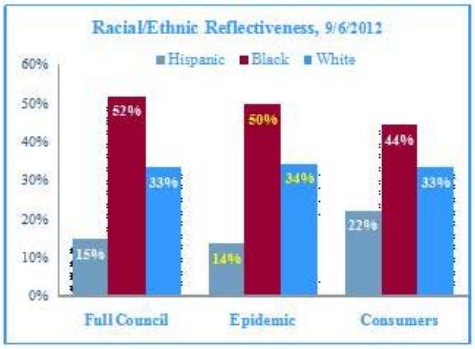
a. **Racial, Gender & Ethnic Reflectiveness** (Unaffiliated and Full Council)
The committee reviewed the Council demographics with regard to race and ethnic reflectiveness as shown in the table and graphic below:

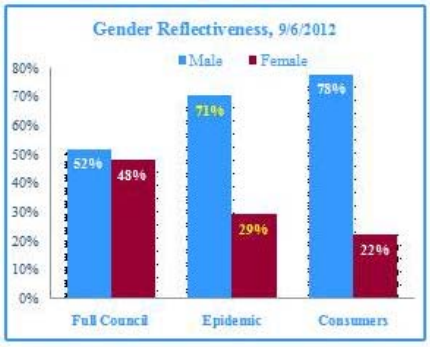
Membership Council Development Report September 6, 2012

Gender	Epidemic	Full Council	Consumers		Full Council	Epidemic	Consumers
Male	11,836	14	7	Male	52%	71%	78%
Female	4,944	13	2	Female	48%	29%	22%
	16,780	27	9		100%	100%	100%

Race	Epidemic	Full Council	Consumers		Full Council	Epidemic	Consumers
Hispanic	2,290	4	2	Hispanic	15%	14%	22%
Black	8,361	14	4	Black	52%	50%	44%
White	5,772	9	3	White	33%	34%	33%
Other	357	0	0	Other	0	2%	0
	16,780	27	9		100%	100%	100%

Percent of PC Members That Are Unaffiliated Consumers
33%





7. REVIEW OF VACANCIES

The current Council vacancies were reviewed. There are currently three vacancies present or impending: (i) State Government Administering Ryan White Part B (effective 9/13/12), (ii) Prevention and (iii) Grantees of Other Federal Programs/HOPWA. There are currently two applications from Broward County Health Department one of which can be suited to the Prevention vacancy. The Council membership is currently 27. At this point the HRSA requirement that 33 percent of Council members be Ryan White consumers has been met. Guest, HIVPC Chair, noted that the HOPWA vacancy and the State Government Administering Ryan White Part B mandated seats are out of our control, with members for those seats recommended by outside agencies. A member was concerned about the number of members having fallen to 27. Support staff noted that the HIVPC Bylaws state there can be a maximum of 35 members but sets no minimum number.

Subsequent to the meeting support staff researched and the Broward County, Florida, Administrative Code Section 12.108, Membership (a) states: *The Council shall consist of not less than twenty (20) members nor more than thirty-five (35), to be appointed by the Board of County Commissioners.*

8. CURRENT APPLICANTS AND INTERESTED PARTIES

This was reviewed. There are four consumer applicants and four non-consumers in the process of becoming qualified as shown below:

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HIV Planing Council Applicants as at September 6, 2012												
W	B	H	F	M	T	Orientation	Committee	Member	Date 1	Date 2	Date 3	Application Status
CONSUMERS												
	1			1		Yes	MCDC	Yes				
	1		1				JCCR	Yes	6/5/2012	7/10/2012	8/7/2012	**Complete**
	1		1			No	JCCR	No	6/5/2012	9/5/2012		New Applicant
1				1		No	HIVPC	No	6/21/2012			New Applicant
NON-CONSUMERS												
	1		1			No	Planning	No	Feb-12	Mar-12	Apr-12	**Complete**
1				1		No	JCCR	Yes	4/3/2012	5/1/2012	6/5/2012	**Complete**
	1			1			Priorities	Yes	3/22/2012	6/20/2012	8/15/2012	**Complete**
1				1		No	None	n/a	n/a	n/a	n/a	New Applicant

The committee recommended that inactive applicants (persons having applied but not in attendance for over 6 months) to be moved to the 'inactive applicants' list.

9. REVIEW ATTENDANCE

Attendance letters sent were reviewed.

10. OTHER BUSINESS

a. Results of Training Surveys

The results of the surveys were reviewed. 13 HIVPC members responded, with "By-Laws/Policies and Procedures" the top-ranked training topic, followed by "Roberts Rules/How to run a meeting." 7 members of JCCR responded, with "Data on the Epidemic" the top-ranked training topic. There was discussion on developing training to meet HRSA mandate of one annual training for Council members. One member noted that the HRSA training should be the first priority. It was noted that the HRSA mandate includes topics on which the HIVPC & JCCR members were polled. Division Director suggested these trainings take place at the HIVPC Annual Retreat planned for January every year. The Committee also discussed forming a subcommittee to plan training. Support Staff also recommended that as a group the 'seasoned' members can lead these trainings, which can be a participatory process by all trainees. A member noted that we have the expertise on the Committee to do the training, and several members agreed to take an active role in developing training for various topics that Council members need or want. The Committee decided to meet in October and November in order to build a training outline. When complete, the Committee will ask Part A Executive Committee to allot time for the training during the retreat. Action was taken on the following motions:

Motion #3	To form a training subcommittee with members from the full HIV Planning Council
Proposed by:	Jodi Pearl
Seconded by:	Barbara Hanson-Evans
Friendly Amendment	To form a training subcommittee
Proposed by:	Barbara Hanson-Evans
Action:	**Motion withdrawn**

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Motion # 4	To move that the HRSA mandated training(s) be conducted at the annual HIVPC retreat (January) with a draft training outline being brought to the November 2012 MCDC meeting
Proposed by:	Carl Roberson
Seconded by:	Tara Wilson
Action:	**Passed Unanimously**

Motion #5	To move that MCDC meets in October 2012 to develop the training outline
Proposed by:	Carl Roberson
Seconded by:	Tara Wilson
Action:	**Passed Unanimously**

11. NEW BUSINESS

a. Discuss Training on Sunshine Law
The committee agreed to discuss at the October meeting the suggestion of adding the Sunshine Law subject as a training topic.

b. Banner for Recruiting Events
This was discussed. The MCDC chair requests a second banner to assist with logistical issues. Support staff will meet with the MCDC chair to discuss specifications of said banner.

12. PUBLIC COMMENT

There was no public comment at this juncture.

13. WORK PLAN REVIEW

The HIVPC Vice Chair (guest) commended the MCDC on having worked updated their FY 12/13 work plan. He then noted that the FY 13/15 work plan will be developed in order to put into effect March 1, 2013.

14. REQUEST FOR INFORMATION/DIRECTIVES

Data requests from staff were finalized.

15. AGENDA ITEMS FOR NEXT MEETING

- Training Outline Development (only item on agenda)

16. NEXT MEETING DATE: October 4, 2012 at 9:00 a.m. **Venue:** BRHPC

17. ADJOURNMENT

Without objection, the meeting was adjourned at 11:16 a.m.

MCDC Attendance CY 2012							
#	**Members**	**Jan**	**Mar**	**May**	**June**	**Jul**	**Sep**
1	Katz, H.B. *Chair*	P	P	P	P	P	P
2	Wilson, T. *Vice Chair*	P	P	P	P	P	P
3	Creary, K.	P	P	**E**	P	P	**E**
4	Dyer, L.	P	P	P	P	P	**A**
5	Greenwood, J.	**E**	P	**A**	**A**	E	P
6	Hanson-Evans, B.	P	P	**A**	P	P	P
7	Pearl, J.	P	P	P	P	P	P
8	Roberson, C.	**A**	P	P	P	P	P
	Quorum = 5	**6**	**8**	**5**	**7**	**7**	**6**

Membership Council Development Report October 4, 2012

Gender		Epidemic	Full Council	Consumers		Council	Epidemic	Consumers
	Male	11,836	14	7	Male	52%	71%	78%
	Female	4,944	13	2	Female	48%	29%	22%
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Race		**Epidemic**	**Full Council**	**Consumers**		**Council**	**Epidemic**	**Consumers**
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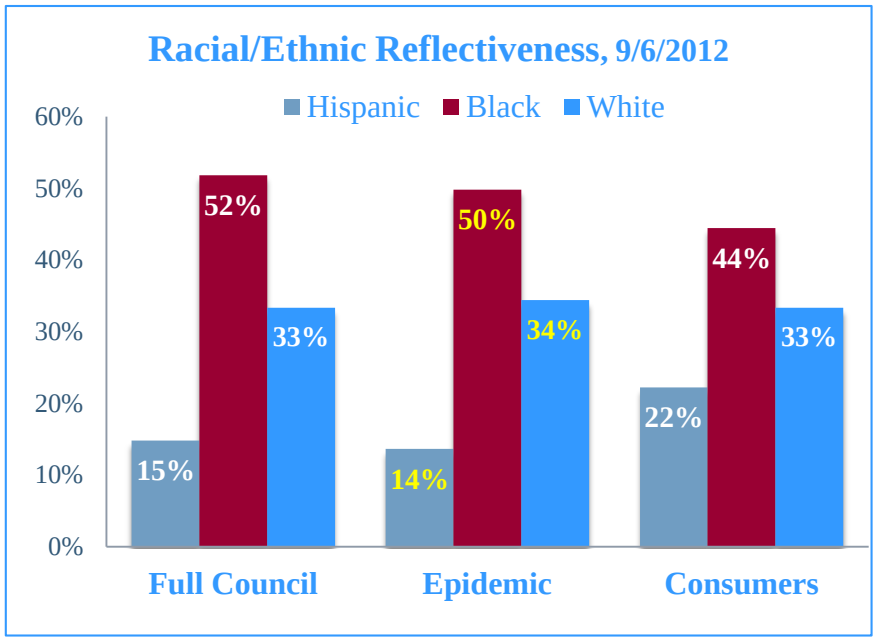
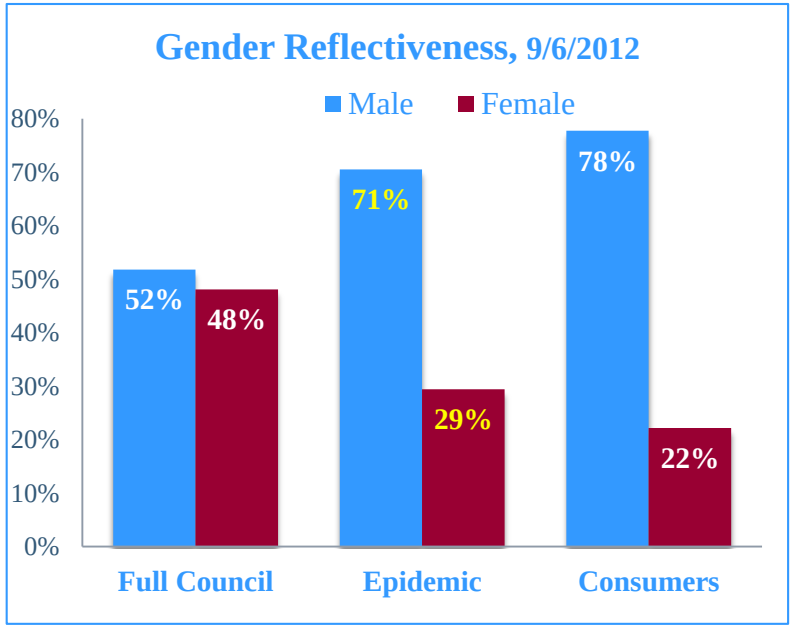
Percent of PC Members That Are Unaffiliated Consumers
33%





Increasing Consumer Involvement:

Ryan White Part A Planning Council Training

What is Part A of the CARE Act?

Part A provides grant funds to eligible metropolitan areas (EMAs) that are severely and disproportionately affected by the HIV epidemic.

Part A Grantees

- Funds are awarded to the Chief Elected Official (CEO) of the city or county that administers the health agency providing services to the greatest number of people living with HIV disease within the EMA.
- The CEO designates the grantee to select service providers and administer contracts.
- The CEO establishes the Planning Council & appoints members to it.

Part A Funds *may be used to provide a wide range of community-based services:*

- **Outpatient and ambulatory health services** *(including medical and dental care as well as substance abuse and mental health treatment)*
- **Support services** *e.g., case management, home health and hospice care, housing and transportation assistance, nutrition services, day/respite care*
- **Early Intervention Services** *that include outreach, HIV linkages with counseling and testing, referral, and the provision of outpatient medical care designed and coordinated to bring individuals into the continuum of care*

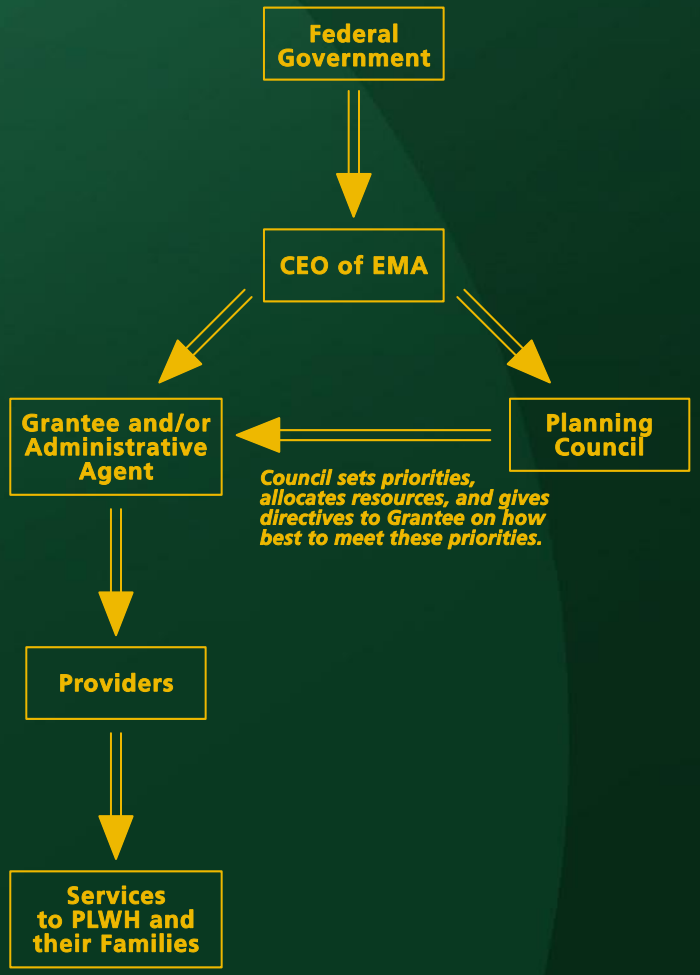
Minority AIDS Initiative (MAI) Grants:

- Used to modify or expand HIV care services for disproportionately impacted communities of color.
- Subject to the same requirements as “regular” Part A funds.

Part A Providers may include:

- **Public or nonprofit entities**
- **Private for-profit entities, IF** they are the only available provider of quality HIV care in the area

Flow of Part A Decision-Making and Funds



Structure of Part A Planning Councils

- Established by the Chief Elected Official.
- Membership must reflect local HIV/AIDS epidemic.
- Must include representatives from groups designated by the CARE Act.
- At least 33% of voting members must be PLWH not affiliated with Title I service providers and receiving Title I services.
- Must have an open nominations process and grievance procedures.

Major Requirements of Planning Councils

- Planning Council Operations
- Needs Assessment
- Comprehensive Planning
- Priority Setting
- Resource Allocation
- Service Coordination
- Assessment of Efficiency of Administrative Mechanism

Other Responsibilities of Planning Councils

- Evaluation of Effectiveness of Care Strategies (optional/best practice)
- Quality Management (shared with grantee)

Planning Council Operations

- Rules (by-laws, open nominations process, policies and procedures) to help Councils operate smoothly and fairly.
- Includes new member recruitment, orientation and training.

Needs Assessment

Find out:

- Number and characteristics of persons living with HIV/AIDS in the EMA
- Needs of people who know their HIV status but are not in care
- Differences in care for different populations
- Capacity development needs of agencies
- How CARE Act services can coordinate with other services (substance abuse, HIV prevention, etc.)

Comprehensive Planning

- Develop the roadmap or vision for HIV service delivery system in the EMA.
- Guides decisions for next several years.
- Should be in harmony with the Statewide Coordinated Statement of Need (SCSN).

Priority Setting

- Deciding which HIV/AIDS services are the most needed and important in the EMA.
- Giving directives to the Grantee about how best to meet these priorities.

Resource Allocation

- Deciding how much funding to use for each of the priority service categories.
- Is solely the responsibility of the planning council.
- May use funds to pay for special projects, studies, or capacity building.

Service Coordination

- Coordinates with other CARE Act programs and other services for PLWH.
- Avoids duplication and reduces gaps in care.
- Participates in the Statewide Coordinated Statement of Need process along with other CARE Act Titles.

Evaluate the Effectiveness
of Care Strategies

- How well are Part A funded services meeting the needs of PLWH?
- Are PLWH engaged in care and remaining in care?
- Are we reducing morbidity and mortality in the EMA?

Assess the Administrative Mechanism

- Is the grantee funding the Planning Council priorities?
- Are the Planning Council directives incorporated into the RFP and the contract language?
- How quickly are contracts for service providers signed?
- Are providers paid in a timely manner?

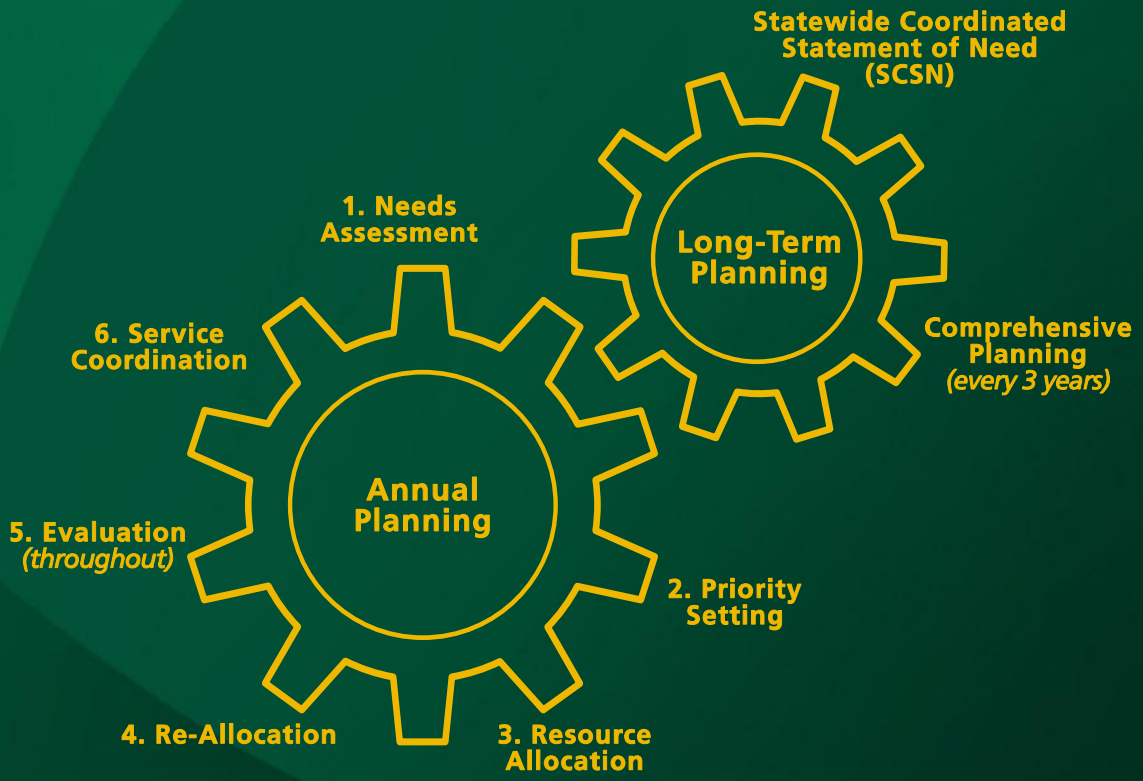
CEO & Grantee Responsibilities

- Establish the Planning Council
- Participate in needs assessment
  Provide information to accomplish tasks
- Participate in comprehensive planning
- Manage procurement
- Distribute funds according to the priorities
- Monitor contracts
- Support Planning Council operations
- Quality management

CEO/Grantee & Planning Council Roles and Responsibilities

Task	Responsibility	
	CEO/ Grantee	Planning Council
Establish the Planning Council	X	
Needs Assessment	X	X
Comprehensive Planning	X	X
Priority Setting		X
Resource Allocation		X
Manage Procurement	X	
Monitor Contracts	X	
Assess the Administrative Mechanism		X
Evaluate Effectiveness of Care Strategies (optional)		X
Quality Management	X	X

Part A Planning Cycle



Comprehensive Planning

- Developing the overall roadmap and vision for the HIV continuum of care in the EMA.
- Fully revised plan is due every three years.
- Targeted updates should occur in the interim.
- One best practice is a periodic review by the planning council on progress made toward comprehensive plan goals.

The Comprehensive Plan
should answer these questions:

1. Where are we now?
2. Where do we need to go?
3. How will we get there?
4. How will we monitor our progress?

CARE Act Requirements

The Plan must include:

- A strategy for identifying individuals who know their HIV status and are not receiving services
- Attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities
- Goals, timetable, and funding allocation
- A strategy to coordinate the provision of services with HIV prevention and substance abuse programs
- Compatibility with any State or local plans that have been developed for HIV services

Components of a Needs Assessment

- Epidemiologic Profile
- Assessment of Service Needs
- Resource Inventory
- Profile of Provider Capacity and Capability
- Estimation and Assessment of Unmet Need

Planning a Needs Assessment:
Pieces of the Puzzle

What do you need to find out?	What is this part of the needs assessment called?
Number of people in the community living with HIV/AIDS (both in and out of care) • Who they are • Where they are	**Epidemiologic Profile**
• What their service needs are • Barriers to using services	**Assessment of Service Gaps**
Number of people living with HIV or AIDS who know their status but are not in HIV primary care	**Estimation of Unmet Need**
• Who they are • Where they are • What are their primary care needs • Barriers to accessing primary care	**Assessment of Unmet Need**

Planning a Needs Assessment:
Pieces of the Puzzle *(continued)*

What do you need to find out?	What is this part of the needs assessment called?
For all of the service providers in the community, inventory of: • Who provides services • Types of services they provide, where, & to whom	**Resource Inventory**
• How easy is it for PLWH to access the services? • How much of the services can they provide? • How appropriate are services for PLWH in this EMA?	**Profile of Provider Capacity and Capability**

Interpreting the Needs Assessment:
Putting the Pieces Together

Knowing who needs services and how to reach them + Knowing who the service providers are, where they are, and what they can provide and for whom = Making good, objective decisions about which services are most needed

Unmet Need

- Refers to the unmet need for HIV-related primary health care among individuals who know their HIV status but are not in care
- Estimation of unmet need is a determination of the approximate number of individuals in your service area who are HIV-positive, know their status, and are not receiving regular primary medical care
- Assessment of service needs and gaps for this population

Priority Setting

- Process of deciding which HIV/AIDS services are the most needed and most important in the EMA.

CARE Act Requirements

Priorities should be based on:

- Size and demographics of the population of PLWH and their needs
- Cost effectiveness and outcome effectiveness of strategies
- Community priorities
- Coordination of services, including substance abuse
- Availability of other governmental and non-governmental resources
- Capacity development needs related to reaching underserved communities

Priority Setting - Directives

Directives are instructions to the grantee on how best to structure priorities to meet the needs of PLWH, particular subpopulations, and/or PLWH or providers in a specific geographic area.

Priority Setting - Directives

Example: The grantee must target Spanish language case management services in the 33311 and 33304 zip codes.

Example: Agencies with a history of service to women with children must be awarded funds under this service category.

Principles to Guide Decision Making

- Decisions must be based on documented needs.
- Services must be responsive to the HIV profile in the service area.
- Priorities should strengthen the continuum of care.
- Address overall needs, not narrow concerns.
- At this stage, do NOT consider other sources of funding.

Some factors to consider for how best to meet service priorities

- Provide for geographic parity.
- Focus on the needs of low-income, underserved, and severe needs populations.
- Facilitate culturally and linguistically appropriate services.
- Ensure equal access to services.
- Ensure primary care services should meet Public Health Service treatment guidelines.

Resource Allocation

- Process of distributing the available Part A funds across service categories in the EMA.
- Resource allocation is **not** the same as procurement. Procurement is the process of awarding funds to specific providers in accordance with the planning council's decisions regarding allocation and priorities.

Some Factors to Consider in Resource Allocation

- Same principles used for Priority Setting
- Other funding sources – since CARE Act is payer of last resort
- Size/extent of service gaps – quantitative data where possible on additional service "slots" needed
- Unit or per-client costs – for use in calculating costs of adding service slots
- Unmet need – expected number of additional people who will enter care
- Multiple scenarios – flat funding, increase, decrease
- Calculations using both percent of total allocations and dollars

What guidelines need to be in place so that planning bodies can make sound decisions?

Many Planning Councils use **Robert's Rules of Order** which are based on parliamentary procedure.

Under this system, business is conducted by acting on **motions** – ideas or actions that are suggested by committee members.

Robert's Rules of Order

- Are based on three important "rights" or principles:
  - The right of the majority to rule
  - The right of the minority to be heard, and
  - The right of the individual to have a voice in the decision-making process

Guidelines for Good Group Decisions: *Summary*

- Have good and clear policies in place, including objective criteria for decision making
  - governance
  - ground rules
- Follow the process the Council has agreed upon
- Don’t get personal – Planning Councils make decisions on behalf of their constituency. The needs of PLWH should be the major focus.

Action Plans Should:

- Describe specific activities.
- Identify responsible parties.
- Include a target date.
- Identify required resources and/or information.
- Reflect the needs of the Planning Council.
  - recruiting and maintaining consumer involvement
  - attending to required tasks of the annual planning process
  - participating in long-term planning

HIV Planning Council (HIVPC)

HIV Planning Council: Vision Statement

To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

HIV Planning Council: Mission Statement

We direct and coordinate effective response to HIV epidemic in Broward County in order to ensure quality, comprehensive care and positively impact the health of people with HIV at all stages of illness. In so doing, we:

- Foster substantive involvement of HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs and planning a responsive system of care
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations and federal, state and municipal governments.
- Monitor and report progress within continuum of care to assure fiscal responsibility and increase community support and commitment.

What does the HIVPC do?

- Conducts a Needs Assessment
- Establish Priorities for the Allocation Funds
- Develops a Comprehensive Plan
- Assess the Administrative Mechanism
- Coordinate with Other Services
- Establish Service Continuum of Care
- Establish Method to Obtain Community Input
- Determine HIV Population Demographics

How does the HIVPC achieve its goals?

Committees are formed to provide support to the HIVPC in accomplishing goals.

- Executive Committee
- Joint Priorities Committee
- Joint Planning Committee
- Quality Management Committee
- Joint Client/Community Relations Committee
- Membership/Council Development Committee

Executive Committee

- Develops Planning Council agenda
- Develops, maintains & monitors Comprehensive Plan
- Establishes and reviews committees' recommendations
- Addresses conflict of interest Issues
- Reviews Membership/Council Development Committee attendance report to identify Council members not in compliance with attendance requirements
- Develop and oversee committee work plans which address comprehensive planning goals and objectives
- Address Joint Client/Community Relations Committee unresolved grievance issues

Joint Priorities Committee

- Analyzes Needs Assessment data
- Establishes service priority categories
- Recommends annual funding levels for services
- Develops language on how to meet priorities
- Reviews service category eligibility criteria

Joint Planning Committee

- Reviews Unmet Need Research
- Identifies Gaps in Care
- Establishes Needs of Community
- Develops & Maintains Needs Assessment Studies

Membership/Council Development Committee

- Ensures Council membership reflects demographics of epidemic in the County
- Recruits new members
- Makes nominations to Planning Council
- Oversees mentoring & training of members
- Plans and conducts Council retreat

Joint Client/Community Relations Committee (JCCR)

- Bridge between Council and PLWHA community
- Encourage involvement of individuals infected with and affected by HIV/AIDS in Council decision-making
- Networking with Community Groups
- Addresses unresolved grievances relative to the Council's decisions regarding Ryan White Part A and Part B funding

Quality Management Committee

- Develop client & system outcomes & indicators
- Provide standards of care oversight
- Develop program evaluation study scopes of services
- Assess client satisfaction
- Assess quality management training needs
- Ensure standards of care facilitate outcomes achievement

Ad Hoc Committees

- **Local Pharmacy Advisory Committee (LPAC)**
  - Formulary Additions and Deletions
  - Assess Pharmacy Quality and Cost Effectiveness
- **ad Hoc By-Laws Committee**
  - Maintains and Updates HIV Planning Council By-Laws
- **ad Hoc Nominations Committee**
  - Oversees HIVPC Chair and Vice Chair Elections
  - 2 Year Terms
- **ad Hoc PCIP (Pre-Existing Condition Insurance Plan)**
  - Focuses on Identifying ideal characteristics of insurance coverage for Ryan White clients

Membership Representation

Ryan White Legislation mandates planning involve a range of representative categories to ensure broad community input.

Planning Council must include at least one member to separately represent each of the 16 membership categories.

Mandated Membership Categories

1. Health Care Providers (including Federally qualified health centers)
2. Community-based organizations
3. Social service providers (including providers of housing and homeless services)
4. Mental health Providers
5. Substance abuse providers
6. Local public health agencies
7. Hospital or health care planning agencies
8. Non-Elected community leaders
9. State government (including State Medicaid and Part B Agency)
10. Part C grantees
11. Part D grantees
12. Grantees of other Federal HIV programs (including prevention)
13. Representatives of individuals who were formerly incarcerated
14. Native American Representation
15. Individuals co-infected with hepatitis B or C
16. Affected communities (No less than 33% of members must be consumers)

Membership Reflectiveness

Extent to which demographics of Planning Council's membership mirror the HIV epidemic in Broward County

Reflectiveness applies for the **WHOLE** Planning Council membership and the **CONSUMER** membership

Since establishment of Planning Council (1992) in Broward County, the Council has consistently met demographic reflectiveness

Membership Representation Requirements

No more than 40% of Members are Ryan White Part A providers

No more than 3 members employed by one governmental agency or provider

At such time as a member's professional responsibilities changes such that he/she no longer represents the constituency for which he/she was originally appointed, that member shall immediately resign and his/her seat shall be filled in accordance with the provisions contained in the Membership policies and procedures. The member shall have the ability to reapply for membership to the Council.

What Are Member's Responsibilities?

Planning Council Member

- Must be a Committee Member
- Attendance: Monthly Planning Council Meeting
- Participation: Bring your ideas and provide input!

Committee Member

- Attendance: 1 Committee Meeting Monthly
- Participation: Bring your ideas and provide input!

Meeting Attendance Policy

The following policy applies to the Council and Committees:

A member will automatically be removed if he/she:

- Has **three (3) consecutive** unexcused absences **regardless of year,** or
- Misses **four (4) meetings in one (1) calendar year** (January-December) because of unexcused absences.

A member will automatically be removed from a committee that meets on a quarterly or less frequent basis if he/she:

- Has **two (2) consecutive** unexcused absences **regardless of year,** or
- Misses **two (2) meetings in one (1) calendar year** (January-December) because of unexcused absences.

A member shall be deemed absent from a meeting when the member is not present at the meeting at least seventy-five (75) percent of the time.

Attendance records are based on the sign-in sheet. **Members must sign in to be considered present at the meeting.**

Excused Absences

- HIVPC or Committee Chair reviews all excused absence requests.
- A Council or Committee Member must request an excused absence.
- An absence shall be deemed excused under the following circumstances:

HIV-related illness

Member is performing an authorized alternative activity relating to outside Planning Council business that directly conflicts with the meeting

Death of member's domestic partner or immediate family member

Member's hospitalization

Notification of Attendance

Members must notify Support Staff at least **two (2) business days** prior to the meeting regarding their attendance, unless the occurrence of an excused absence makes such notice impracticable.

Failure to notify Support Staff 2 business days prior to meeting shall be considered an absence.

Members who have notified Support Staff that they cannot attend will be considered absent even if the meeting is cancelled due to lack of a quorum.

Attendance Via Phone

Once a quorum has been established by members who are physically present at a meeting, members who are not physically present may attend and participate in such meeting by phone.

If quorum is not achieved by members who are physically present, members who are not physically present but participating via phone will be considered absent.

If a member would like to participate via phone, they must inform Support Staff at least **two (2) business days** prior to the meeting.

Questions?

Want to Learn More?

Refer to the HIVPC Calendar for Upcoming Training Opportunities

OR

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