

New York City Planning Council Assessment Report

Ryan White Technical Assistance Contract

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Introduction

Purpose of the TA: The New York EMA requested technical assistance through the Ryan White Technical Assistance Contract (TAC). Purposes of the TA were:

- To assist the Planning Council (PC) and Grantee to assess and address issues related to roles, responsibilities, boundaries, and the relationship between the two entities
- To help in the adoption of best practice policies and procedures related to Planning Council member orientation and training, meetings, operations and Grantee support, and decision making

Scope of the Assessment: The first step was to assess issues related to Planning Council roles, responsibilities, boundaries, and the relationship between the PC and Grantee. The focus of the assessment was on how the Planning Council is structured and how it operates, member knowledge of roles, responsibilities, and boundaries, how legislative responsibilities are carried out, and the relationship between the PC and Grantee. The TA was requested by the Grantee partly as a result of an action by the PC that appeared to indicate a lack of clarity about its roles and boundaries, so exploring that issue was a priority.

Assessment Process: The assessment process was specified in the consultant's Scope of Work. As implemented, it encompassed the following:

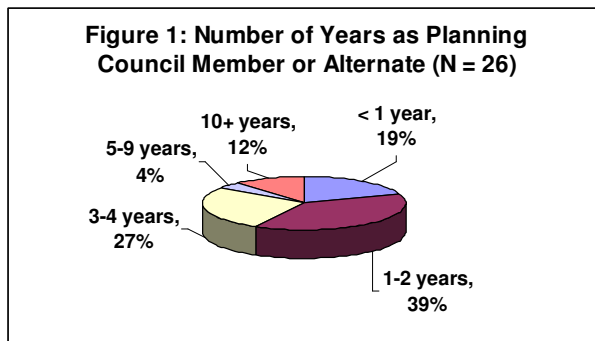
- Individual interviews with 8 key individuals, including Grantee (Department of Health and Mental Hygiene) staff, PC members, and the administrative agent by telephone, using structured interview guides
- Three small-group meetings in New York on July 1 that involved discussion based on a structured set of questions – with 9 Executive Committee members, 2 senior Grantee staff, and 4 Planning Council support staff – to obtain an in-depth understanding of their perspectives on the issues
- An online survey that was extensively reviewed and revised by Grantee staff, PC members, and PC staff, as well as the HRSA/HAB Project Officer; it was completed by 35 people: 25 PC members, including 23 who listed their primary affiliation as PC members and 2 others who are Grantee and PC staff, plus 4 alternates, 3 Grantee representatives, and 5 PC support staff; 14 respondents self-identified as PLWH
- Review of materials from the EMA, such as the PC's Bylaws, the draft Memorandum of Understanding between the Grantee and Planning Council, and summary templates being used to present refined service models, as developed by the Grantee with the Integration of Care Committee
- Aggregation and analysis of the information obtained, to prepare this summary report

Basis for Consultant Analysis and Recommendations: Consultants are, of course, hired by HRSA/HAB to help Ryan White programs run effective programs and follow legislative requirements and HRSA/HAB guidelines. The consultant assessed the identified issues based on

the legislation and its interpretation into guidance, expectations, and best practices by the HRSA/HAB Division of Service Systems (DSS). These are specified in several official HRSA/HAB documents, primarily the *Part A Manual* (particularly the chapters on Planning Council Operations) and the *Planning Council Primer*. In addition, the consultant used experience gained through serving as a HRSA/HAB consultant for over 16 years and participating in numerous TAC assignments, meetings, and conferences. The consultant asked the Project Officer for advice on several issues, and identified several issues that need to be clarified by DSS.

Online Survey Respondents

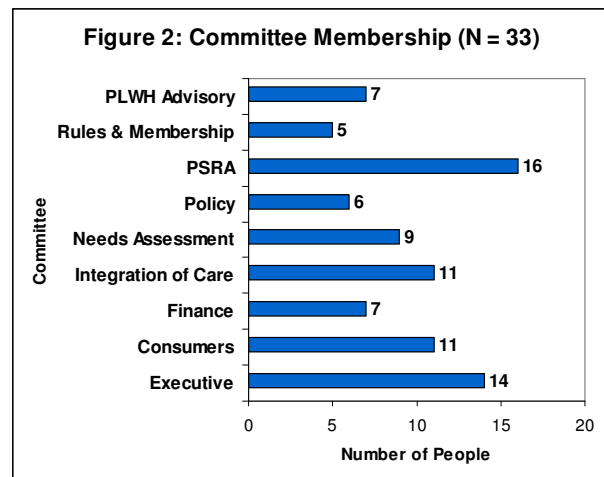
Description of Respondents: A total of 35 people responded to the online survey: 23 Planning Council members, 4 alternates, 5 PC staff, and 3 Grantee staff. A majority of members and alternates (58%) said they have been on the Planning Council for 2 years or less, as Figure 1



members and alternates said they have attended 5 or more PC meetings this calendar year (the survey was conducted in July), and 6 of the 8 Grantee and PC staff responding also reported attendance at 5 or more meetings this year.

Committee Membership: Those responding serve on a variety of committees and on the PLWH Advisory Committee. They most often reported serving on the Priority Setting and Resourced Allocation (PSRA) and Executive Committees, but most committees were well represented. Figure 2 shows reported committee membership.

shows. Grantee and PC staff all reported tenure of at least 3-4 years, and 2 have been on staff more than 10 years. Fourteen respondents self-identified as PLWH. Most of the Planning Council members indicated a high level of participation in PC meetings; 25 of 27 PC



EMA Assessment of Planning Council Status

Overview: The assessment indicates a functional Planning Council with an identified need for additional training on the PC's roles, responsibilities, and boundaries; differences of opinion about the system of care and the need and responsibilities for changing it; issues around PC staffing and budget; difficulties in the relationship between the Grantee and Planning Council; and challenges in the relationship between the Part A program and some parts of the community. The survey showed broad agreement that overall, the PC is meeting its roles and responsibilities and the planning process is being implemented. Nearly three-fourths (73%) of individuals responding to the online survey said the PC is meeting its roles and responsibilities as defined

through the legislation and guidance from HRSA/HAB. The Planning Council and Grantee agree that changes are needed, and want to see agreement on PC and Grantee roles and responsibilities, greater collaboration, increased trust, and an improved planning process.

Perceived Strengths: Asked to identify the greatest strengths of the PC as it currently operates, respondents to the online survey most often identified the following (list includes all strengths identified by more than one respondent):

- Member expertise – 6
- Member diversity – 5
- Member commitment to the cause – 4
- Consumer involvement – 3
- The priority setting and resource allocations (PSRA) process – 3
- Community involvement – 2
- Planning Council operations – 2

Interviews indicate that another strength is the Government Co-Chair. He is widely viewed as very effective in his extremely challenging role. He was described by both staff and PC members as “experienced and knowledgeable, an excellent facilitator,” and “respectful of consumers and everyone else.”

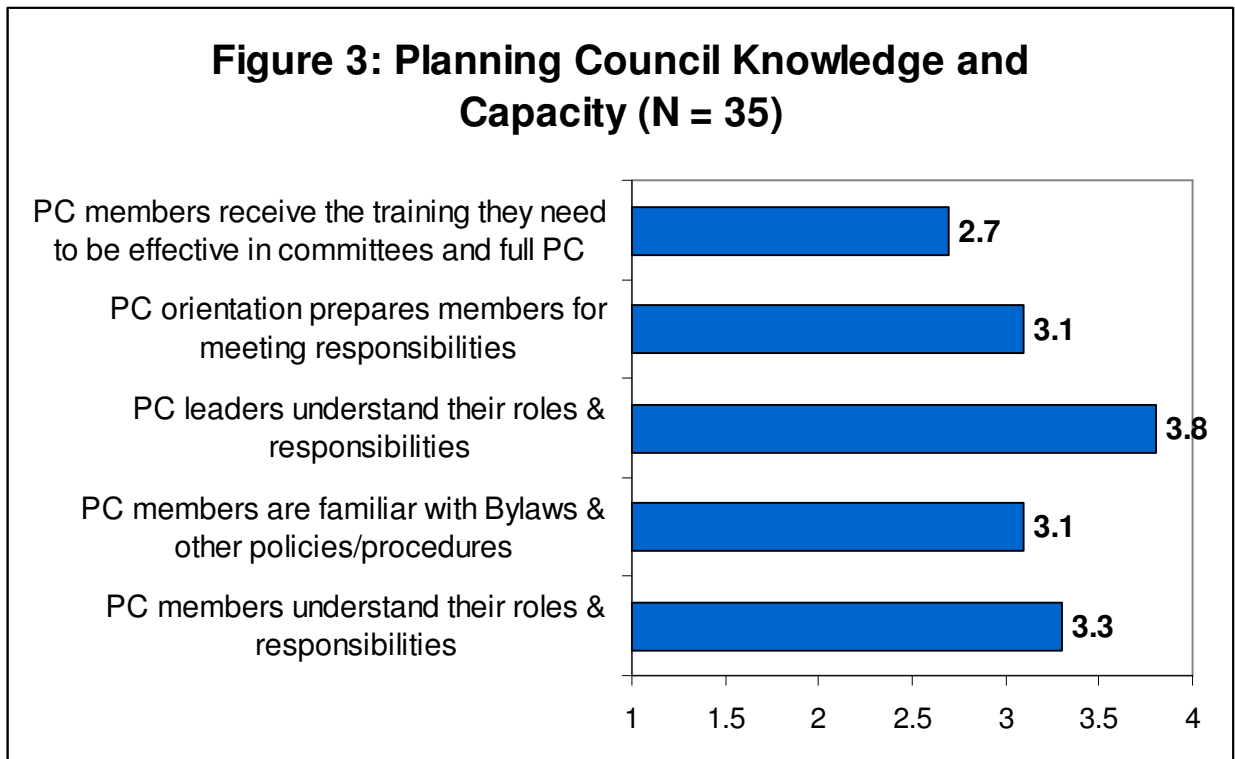
Perceived Weaknesses or Challenges: Asked about the Planning Council’s perceived weaknesses or challenges, survey respondents identified the following:

- The relationship with the Grantee – 7
- Less than full understanding of PC roles and responsibilities and their relationship to those of the Grantee – 6
- Members working together as a team – 4
- Need to adjust to a new chronic disease model of care – 3
- Need for more orientation and training – 2
- Fear on the part of some members of taking positions that are not supported by powerful interests (whether consumers or the Grantee) – 2

Both PC members and staff described negative results of the current situation. For example, one person noted that the PC only had 10 new applicants this year, when normally three times that many people apply for membership.

The online survey asked respondents to assess various aspects of Planning Council operations and support, using a 4-point scale where 1 = Not at all, 2 = A little, 3 = Moderately, and 4 = Very/Fully. Although they feel the EMA can do better, most respondents indicated that many aspects of the work are going “moderately” well. The charts that follow provide mean responses for all 35 respondents. Figure 3 assess Planning Council Knowledge and Capacity, Figure 4 focuses on Planning Council Operations, and Figure 5 on the Relationship between the Planning Council and the Grantee.

As Figure 3 indicates, most ratings of Planning Council Knowledge and Capacity were in the moderate range. Respondents gave their highest rankings to PC leaders and their understanding of their roles and responsibilities. This was the only category receiving ratings close to the 4.0 “very/fully” level. Lowest rankings went to several areas also identified in interviews as problematic: PC training, orientation, and member familiarity with Bylaws and other policies and procedures. The mean rating for *PC members receive the training they need to be effective in committees and the full Planning Council* was 2.7, between “a little” and “moderately. Four respondents, all PC members and alternates, did not provide a rating for the Orientation question; one indicated that s/he did not attend the orientation, which is not mandatory. (In some EMAs and TGAs, a new Planning Council member is not seated until after orientation.)



The ratings for PC Operations during the current calendar year are somewhat higher, as Figure 4 indicates. All overall rankings are in the “moderate” range or higher, and the overall ranking for most of these measures is 3.5 or higher, approaching the “very/fully” level. The highest overall rating (3.8) went to *PC staff provide comprehensive support to the Planning Council - including information, assistance, advice, and logistical support*. Lowest rated – but still in the high moderate range – was the coordinative role of the Executive Committee, *The Executive Committee coordinates and oversees the work of the committees* (3.3). Several people (Executive Committee members among them) indicated that that work is needed to ensure a regular flow of information from the committees through the Executive Committee to the full PC as specified in the Bylaws, with the Executive Committee providing coordination, ensuring that committees collaborate, and reviewing committee recommendations before they go to the full PC.

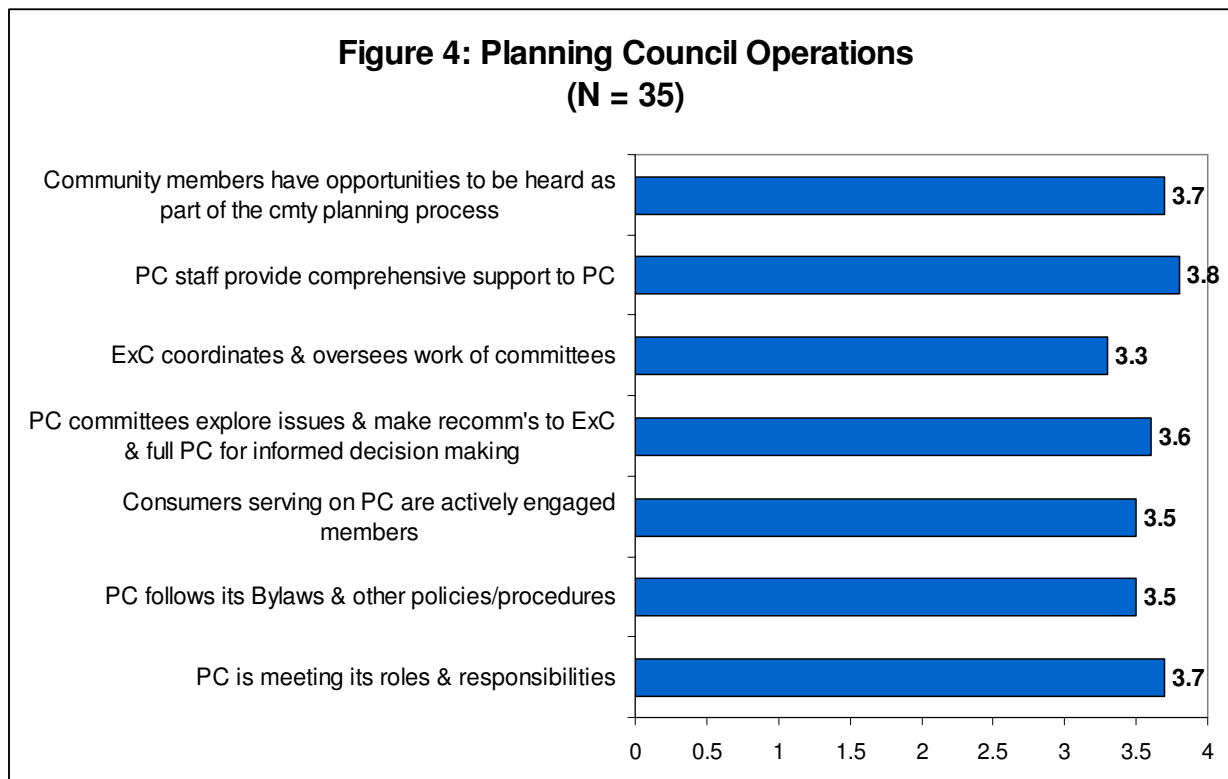


Figure 5 on the following page shows ratings on the relationship between the PC and the Grantee. Ratings in this area are generally lower than for Planning Council operations, and range from “a little” to “moderate.” The areas with the highest ratings are:

- *The PC provides the Grantee with the decisions and information the Grantee needs to meet its responsibilities (3.5)*
- *The PC and its committees receive timely, comprehensive, reports, data, and other information needed to make sound and informed decisions (3.4)*

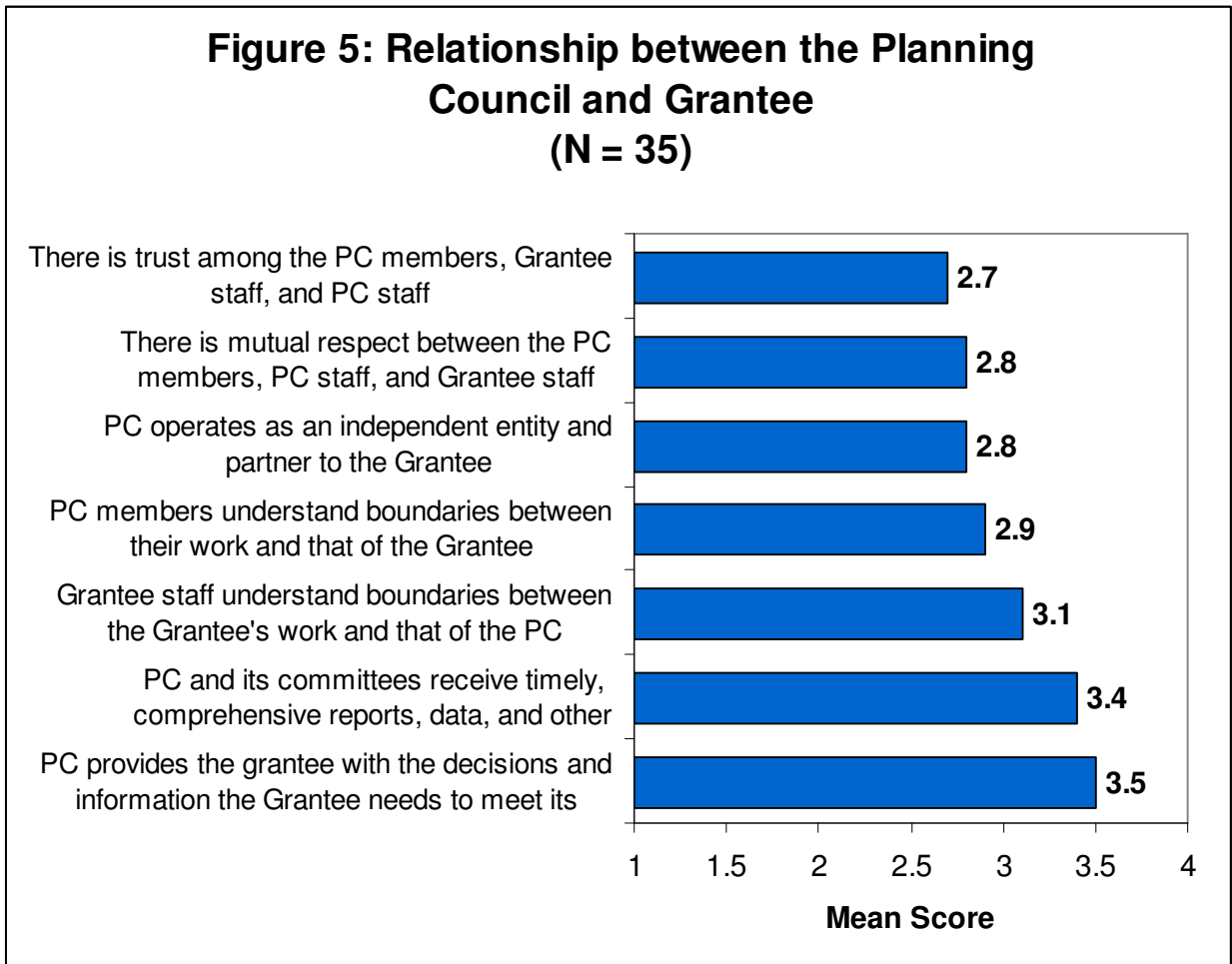
Ratings in the other relationship areas are lower. The lowest ratings are around trust, independence of the PC, and PC boundaries:

- *There is trust among the PC members, Grantee staff, and PC staff (2.7)*
- *There is mutual respect between the PC members, PC staff, and Grantee staff (2.8)*
- *The PC operates as an independent entity and partner to the Grantee (2.8)*
- *PC members understand boundaries between their work and that of the Grantee (2.9)*

The statements in Question 8 received many more negative ratings than the statements in either PC Knowledge and Capacity or PC Operations. Almost no respondents to the survey gave ratings of “not at all” in the other two categories, but 12 respondents gave “not at all” ratings related to relationship issues.

Comments indicate considerable concern among both PC members and staff. There is concern about how the two groups treat each other, and about the negative impact this can have on the planning process. As one person noted, “Much of the distrust has become personal” and is

reflected in how the Grantee and PC “approach each other. Once things are said that shouldn’t have been said, it is hard to rebuild trust.”



Interviews and group discussions identified several additional areas of concern:

- **Committee role:** Committees need to have more voice – to be given the time to address an issue in depth and then to present their findings and recommendations first to the Executive Committee and then to the full PC (as the Bylaws specify).
- **Time and information for decision making.** PC members indicated a need for more information in order to make informed decisions, and more time to review it. They would like to receive meeting packages with background information and recommendations several days ahead of the PC meeting, not at the meeting. It was noted that Public Health Solutions provides fewer reports than in the past and this leaves an information gap. Several PC members who are professionals in the health field feel they are sometimes asked to vote on important issues for which they lack sufficient background information, so they feel pressured to “rubber stamp” proposals rather than seriously considering them and making a data-based decision.

- **Managing public input:** PC members are deeply committed to hearing and understanding the concerns of the public, especially consumers, but feel the PC does not have sound procedures for managing that process – to ensure that the public is heard and the process is informative, civil, and organized. The current process of hearing from providers who advocate for funding of their service categories is also seen as problematic. There is a perceived need to clarify and specify the role of non-members during meetings, then follow the agreed-upon procedures.
- **Relationship with Consumer Advisory Committee:** The relationship between the PC and its Consumer Advisory Committee is reportedly very difficult and somewhat unclear. The Committee is described in the PC Bylaws, PLWH serving on the Planning Council are members, and the PC provides food, logistical support, and sometimes staff support at its meetings. The Committee has been very upset with a number of issues in recent months, and interactions with the PC and Grantee are often negative. Some staff are unwilling to participate in its meetings because of what they perceive as personal attacks. Some PC members reportedly feel intimidated, while others support the positions of the Committee. There is a reluctance to address the issue and try to improve the relationship because of its “political sensitivity.”
- **Managing conflict of interest:** COI policies do not allow providers on the PC to *vote* on an issue on which they have a conflict of interest, but several people noted that the controls are insufficient since they allow the person with the conflict to *advocate* on that issue.

Key Issue Areas

Following is the review and assessment of the Planning Council, which builds upon what PC members and staff said in the online survey and in group meetings and individual interviews but also includes reference to legislative requirements and HRSA/HAB expectations for Planning Councils and EMAs.

Boundary Issues: One reason for the TA request was an action taken by the Planning Council that went beyond its responsibilities and authority as defined in the legislation and specified in its Bylaws. A Task Force recommended and the PC voted to adopt a policy specifying that in order to receive Part A service funds, a provider must have a PLWH on its Board of Directors. This recommendation comes from the Denver Principles and is viewed as highly desirable in many parts of the HIV/AIDS community. However, such a requirement or directive can limit the Grantee’s procurement role. Some entities, such as non-AIDS-specific entities, would be excluded from contracting as a result of the policy, regardless of their capacity to provide services. It is within the purview of a Planning Council to require a funded provider to have some form of consumer involvement (such as a consumer advisory board); Planning Councils often include such a requirement in universal standards of care.

The process through which this situation occurred was complex, and there was considerable community pressure on the PC to adopt the policy. Its own Rules and Membership Committee, which has responsibility for managing, interpreting, and enforcing the Bylaws, later told the PC that the action was beyond its authority. However, this was not specified prior to PC action on the Task Force recommendation. Several people noted that the Bylaws are not always available

at meetings to serve as a resource. The Grantee felt that the incident indicated that some PC members are not adequately familiar with PC roles, responsibilities, and boundaries of PC action or with their own Bylaws. One survey respondent commented that the PC “sometimes oversteps its boundaries in an attempt to advocate for consumers.” This is not a frequent occurrence, but it does happen, and the situation appears to reflect both a lack of knowledge of the Bylaws and boundaries and a perceived need to respond positively to community advocacy. There also seems to be a lack of policies and procedures to structure PC responses in such situations.

Orientation and Training on Roles and Responsibilities: In discussions with the consultant as well as in the survey, PC members and staff generally agreed that PC members do not receive adequate orientation and training about their roles, responsibilities and a Planning Council’s rights and boundaries, or about their specific roles as committee members or committee or Council leaders. It seems clear that more intensive and specific training is needed to avoid boundaries problems and to enable all members of the PC to participate fully and knowledgeably in fulfilling its legislative responsibilities. The assessment indicated that:

- There is no *training plan* for the PC – no overall set of defined training requirements and periodic sessions based on an assessment of the knowledge and skills needed by all PC members and alternates or by members of specific committees.
- Orientation is insufficient. New PC members receive only a half-day orientation, and it apparently is not mandatory. Three survey respondents emphasized the need for more comprehensive orientation for new members. In interviews, several people noted that the current orientation does not adequately prepare PC members for their roles and responsibilities. There is also a perceived need for a buddy or mentoring program for new members, so each new member can consult and learn from a veteran member.
- New York’s PC still allows each member to have an alternate who can participate and vote on his/her behalf when the PC member is absent from a meeting. Alternates are apparently neither vetted by the Mayor’s Office nor required to participate in orientation or training. They vary in their level of knowledge about the Part A program and PC roles and responsibilities.
- There is no formal committee-specific training, though each committee has specific, different, and often technically demanding roles.
- There is no mandatory training for all PC members (not just new members), along with PC staff and Grantee staff, on PC roles, responsibilities, boundaries, and relationships. Ten survey respondents would like to see such training, another three would like to see broader training on the Ryan White legislation, particularly recent legislative changes, and two see a need for training on Bylaws.
- Other identified training needs include using data for decision making, working effectively in teams, understanding the disease, *Robert’s Rules of Order*, understanding fiscal reports on service expenditures, planning in a chronic care environment, and how to work better with the Grantee.
- The Executive Committee members and the broader group of committee co-chairs do not receive training in their roles as PC leaders, and many would like to receive such training.
- The Leadership Training Institute (LTI), which used to contract train PLWH both on and off the Planning Council, now trains only current PC members, committee members, and alternates; training is optional, and several people indicated that current recruitment efforts are insufficient.

Differences in Perception and Approach: The New York EMA’s Planning Council and Grantee have different views about the Planning Council and about how decisions should be made about services and programs. These appear to stem from at least four interrelated factors:

- **The Grantee (Department of Health staff) and the Planning Council have different philosophies and priorities regarding Ryan White services.** The Grantee is deeply committed to changing the Ryan White system of care to a chronic care model, with a strong focus on medical services and “interventions with proven medical outcomes.” As one person put it, “Our focus is to help PLWH become as self-sufficient as possible and not have supports that are not needed.” However, many PC members – possibly a majority – do not yet fully understand or support the Grantee’s proposed changes. This is a challenge facing many Ryan White programs across the country. HIV/AIDS treatment has entered a new phase, more and more PLWH will be entering care and fewer will be dying. In order to provide essential services to all, the system of care will need to change, to focus on teaching disease self-management to newly diagnosed PLWH so that most will need fewer supports in the long term. The Grantee wants to move quickly to a system of care that reflects these changes, but the PC has the right to determine how funds will be used. This disagreement on direction creates a serious challenge. Only the Integration of Care (IOC) Committee is significantly involved in discussions about this new direction, and there does not appear to be a significant effort under way to inform and persuade the entire Planning Council of the need for new directions. Several PC members believe that the disagreement could be reduced significantly through sharing data, educating PC members, and having serious, honest discussions with the PC as a whole about the changing environment and the need to change the system of care.
- **The experience of the Medical Case Management (Care Coordination) model and RFP has contributed to Planning Council distrust of the Grantee – and to Grantee frustration.** Everyone involved is well aware of the nature of the controversy. Grantee representatives indicated that the PC should approve the general outline for a service model, and leave it to the Grantee to develop an evidence-based program based on that outline. The PC believes the Grantee went beyond the service model it had approved when it developed the very prescriptive RFP. Some PC members are also upset that Medical Transportation was folded into Care Coordination, believing that this limits access to such services for people who are not served through Care Coordination programs. The Grantee has been working closely with the IOC Committee to establish new models. Some members of the PC feel information was withheld from them, so they are determined to require much more detailed information before approving any more new service models, such as detailed templates (similar to those used in the past). Some members are very resistant to allocating any additional funds to the Care Coordination Program (which receives at least 25% of service dollars), and distrustful of Grantee financial and service utilization reports. Some members now have an almost “automatic negative reaction” to Grantee recommendations.
- **The Grantee and Planning Council differ in their views of community planning and the roles of consumers and service providers in that process.** The Ryan White program calls for a high level of consumer involvement and assumes that consumers will receive appropriate orientation and training and become full partners in all aspects of PC planning and decision making. It requires a very specific set of categories for PC membership. The New York City Planning Council Bylaws call for active committees that report their findings and

recommendations through the Executive Committee to the full PC for decisions. The process is very inclusive, but can also be slow, and effective decision making requires a lot of education, training, and discussion. As one person put it, “It’s very frustrating to sit on \$120 million and be told you don’t have authority to set priorities – but you don’t.”

Some people believe that efforts are being made by the Department of Health to undermine the planning process and the independence of the Planning Council. They say the role of the PC has “eroded.” One person said: “Community planning can become less effective if you diminish the players and facilitators and process and choke it off. Slow the process, give them only data you have spun and crafted to best present your argument. It disables the community because they don’t have access to program and evaluation data, they don’t have resources.” Others believe that PC members, particularly consumers, “need to understand that we are the public health department; our goal is to help them.”

- **Personality and style issues further complicate the situation.** There have been clashes in style and personality between several Grantee staff and some Planning Council members. Both groups feel they are being treated with a lack of respect. Grantee representatives were described as “arrogant,” and some PC members as “irrational and immature and kneejerk.” Several indicated that the Planning Council staff are “disempowered and caught in the middle.” These views make it more difficult for the PC and Grantee to work together. As one person put it, “The relationship has become strained, seriously impacting the ability to conduct business. The often-necessary give and take by both Grantee and PC is gone, as both dig in their heels.” However, the stated hope of both Grantee and PC is to “move beyond personalities. We can’t change beliefs, but must control inappropriate behavior.” It’s not as bad as it once was, but “we feel stuck.”

Roles of the Planning Council: The Ryan White legislation defines a number of roles for the PC, some to be carried out alone, others in collaboration with the Grantee. The *Part A Manual* (Section VI. Planning Council Operations, Chapter 1. Planning Council Duties) states that

Use of Part A Ryan White funds is guided by planning, which takes place through the planning council....The planning council is not advisory. It has legislative authority to carry out its assigned tasks, along with roles recommended by HRSA's HIV/AIDS Bureau (HAB), Division of Service Systems (DSS).

The legislation gives the PC the lead role in the assessment of PLWH service needs and gaps and in comprehensive planning, requires it to conduct an assessment of the efficiency of the administrative mechanism, and gives it sole responsibility for establishing “priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Grantee should consider in allocating funds [procuring services]....” The *Planning Council Primer* describes these roles and responsibilities and related HRSA/HAB expectations.

The New York Planning Council’s level of engagement in some of the legislatively defined roles and responsibilities of a PC is unclear. For example, needs assessment is a shared responsibility but is typically led by the Planning Council since the legislation specifies it as a PC responsibility. It does not appear that the Needs Assessment Committee is playing a lead role in

establishing a multi-year plan for needs assessment and then overseeing the needs assessment process, ensuring that its efforts meet HRSA/HAB expectations as stated in the *Part A Manual* or *Needs Assessment Guide*. A HRSA sound practice calls for the entire PC to be involved in priority setting and resource allocation, rather than having this done by a committee, as appears to be the case in New York.

PC Staffing and Budget: According to the *Part A Manual* (Section VI. Planning Council Operations, Chapter 1. Planning Council Duties):

Planning Council Support

The planning council needs funding to carry out its responsibilities. HAB/DSS refers to these funds as "planning council support." Administrative funds under Part A formula and supplemental grants can be used as a source of planning council support. The planning council must negotiate the size of the planning council support budget with the Grantee and is then responsible for developing and managing that budget within the Grantee's grants management structure. Planning council support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need, identifying barriers to access and care, conducting planning activities and assuring PLWHA participation.

Procedures for Selecting Support Staff and Consultants

The procedures to be used in hiring planning council support staff or contracting with consultants need to be agreed upon ahead of time with the Grantee. Planning council staff may be employed through the Grantee's payroll system, but measures must be taken to ensure that the planning council, not the Grantee, directs the work of the planning council's staff.

New York City Planning Council staffing does not meet those expectations. For many years, the Planning Council was staffed out of the Mayor's Office. When the staff was moved to the Health Department, they initially reported to the Assistant Commissioner of Health. They currently report to Dr. Laraque, the Director of the Bureau of HIV Prevention and Control. It is not clear whether she is officially the Part A Grantee. The PC staff are viewed positively by most Planning Council members, but many PC leaders see them as working for and responsible to the Grantee. They are not seen as working for the Planning Council, responsible to the Planning Council, or able to ensure that the Planning Council functions independently. Leadership also indicated that the Planning Council does not receive a budget or have a say in how those funds will be used.

Challenges related to HRSA: The Grantee has identified situations in which the EMA feels that a lack of HRSA policy guidance and specificity has contributed to negative interactions between the Grantee and PC and negative views about the program in the local HIV/AIDS community. One specific example is Legal Services. Following the 2006 reauthorization, HRSA indicated a considerable narrowing of the services that could be provided under that service category, and the Grantee took action to meet those requirements – although this was not stated in a formal HRSA policy. There was considerable local opposition to this narrowing of allowable services on the part of legal services providers and consumers. In addition, there was a belief among some individuals that other Part A programs were continuing to provide more extensive legal services. In the spring of 2010, a new policy guidance was issued, allowing many of the previously provided services (such as permanency planning) to be provided. Several people indicated that

the lack of clear written guidance from HRSA during the interim period left the Grantee in a very difficult position.

Conclusions

1. **Some Planning Council members do not fully understand their roles, responsibilities, and boundaries.** The entire PC needs training on roles and responsibilities, orientation of new members needs to be more extensive and mandatory, and alternates should have the same orientation and training requirements as PC members. Grantee staff, including those at operational rather than management levels, need to participate in the training so there is a shared understanding of roles, responsibilities, and relationships. Bylaws need to be understood and followed by the PC, and respected by the Grantee.
2. **The Grantee and PC have some fundamentally different views about Ryan White services and about the community planning process.** The Grantee's focus on addressing HIV/AIDS as a chronic disease seems both appropriate and necessary given trends in the epidemic and in treatment. There are many ways to approach this transition, and many views about the extent to which non-medical services will continue to be necessary for some PLWH. These differences need to be resolved sufficiently that the two entities can work together collaboratively during a challenging period. This will require a greater PC appreciation of the chronic care model and its implications for the system of care, and a greater Grantee appreciation of the role of the PC and a respect for its processes, even when they do not seem to move quickly enough.
3. **There needs to be a mutual understanding of what it means to have a Planning Council that is an independent body, and a role that is well defined and not advisory.** The PC needs staff that are responsible to it and a budget negotiated with the Grantee but managed by the PC and its staff. HRSA input is needed to clarify requirements and expectations around staffing and budget. The Grantee needs to honor and follow them. PC members need to actively participate in decisions, including difficult ones, and PC leaders need the confidence and mutual support to manage the process. All PC members need to make themselves available for much more extensive orientation and training.
4. **Both entities need to commit themselves to interacting with mutual respect and civility.** This means working hard to change the rhetoric and rebuild trust. There is also a need to develop groundrules for public comment that enable opinions to be expressed while implementing guidelines for respectful interaction. As one person put it, "Personalities are unlikely to change, but inappropriate behavior can be eliminated."

Areas for HRSA/HAB Clarification

HRSA/HAB can facilitate positive change by providing clarity on several issues:

- **Written sources of information on program requirements:** There appears to be a lack of clarity as to whether the Grantee and Planning Council are expected to follow the guidance contained in the *Part A Manual* and the *Planning Council Primer*. The consultant routinely

uses them as the basis for training and advice to Part A programs, and a way of determining which actions are required and which are a matter of local choice.

- **Service models:** Clarity is needed from HRSA on the extent to which the PC is to be informed and engaged in the development and approval of new service models. Since the New York EMA reportedly follows the standards of care (SOC) established by the State, this PC does not have the opportunity to shape service models through refining a service category's SOC. The EMA has resumed the use of service category templates to guide discussion about service models, but there is a need for more guidance as to the level of involvement of the PC in designing and/or approving detailed service models: what can be included in directives and service model development, and what goes beyond PC responsibilities and falls into the category of procurement. It appears that the Health Department believes that the PC gives guidance, but the Health Department plans and implements the intervention. The PC feels it should be provided a full description of a proposed new service model and then has the right to approve, refine, or reject it.
- **Role of Government Co-Chair:** The PC support staff manager serves as the Government Co-Chair of the Planning Council – and is widely respected for the effectiveness with which he plays this extremely challenging role. The assignment reflects a practice established when the PC was managed out of the Mayor's office and the AIDS office provided policy advice to the Mayor as well as managing the PC. The situation is more complex now that the PC is supervised within the Health Department. An interesting challenge is how to maintain a separation of PC and Grantee staff roles if the PC manager is the Government Co-Chair. This is a particular concern at a time when the Community Co-Chair role is apparently vacant.

Training and Technical Assistance Needs

The following training and technical assistance is recommended:

- **Orientation:** The consultant should work with PC staff to develop a more extensive orientation package that calls for about two days of orientation done several weeks or a month apart, mandatory for new members and for alternates, then help deliver it in the fall of 2010 once new members are seated. The orientation should cover not only roles, responsibilities, boundaries, Bylaws and policies, but also the Grantee-PC relationship. This year, all members and all Grantee staff that regularly interact with the PC and its committees should attend. The PowerPoints, activities, and reference materials developed should provide the basis for future orientation.
- **Training for leadership:** The Executive Committee and other committee co-chairs should receive training to prepare them for their leadership roles. This should include the roles of committees and especially the Executive Committee, managing public input, managing conflict, and related skills. This can occur before or after the orientation. If it occurs before, the leadership will be able to play a very useful role in the orientation.
- **Training plan for the PC:** The consultant should work with staff to develop a training plan for the PC that calls for committee-specific training, training on topics like using data for decision making and *Robert's Rules of Order*, etc. PC staff should have clear responsibility for ensuring that this training occurs, with PC and Grantee staff often serving as trainers.

- **Policies and procedures:** The PC needs to adopt a set of written policies and procedures to guide committee work, the flow of reports and recommendations from working committees to the Executive Committee and then to the full Planning Council, and the role of PC staff in supporting these processes.
- **MOU:** The MOU between the Grantee and Planning Council should be finalized. The current draft includes some excellent information, but additional information is needed around some broader issues. They include: clarifying the independence but close collaboration of the two entities, describing roles that are solely a PC responsibility, those that are shared but led by the PC, those that are shared but led by the Grantee, and those that are solely the responsibility of the Grantee, the roles of PC staff and how they are responsible to the PC although hired by the City, and how the PC budget will be negotiated and then managed.
- **Committees:** Work needs to be done with committees to ensure that they are carrying out assigned roles, reporting to the Executive Committee and then the Planning Council, playing an appropriate educational role in their areas of responsibility, and receiving needed information and resources. In addition, conscious planning needs to be done to increase communication and collaboration among committees.
- **Public comment/input at meetings:** Procedures are needed for organizing and managing public input at PC meetings, including procedures that enable the PC to hear from consumers, manage advocacy by providers or their service categories, and hear from other members of the public in a way that is transparent, organized, and civil.
- **Clarification of role of the Consumer Advisory Committee:** The Consumer Advisory Committee has a Bylaws-specified but unclear relationship with the PC. It operates as an independent body, but receives meals and logistical support from the PC, and staff are supposed to attend meetings. Most members and staff feel there is a need to explore the relationship, but many are frankly afraid to do so. Leaders of the PC and Advisory Committee need to address this, with external assistance as required.