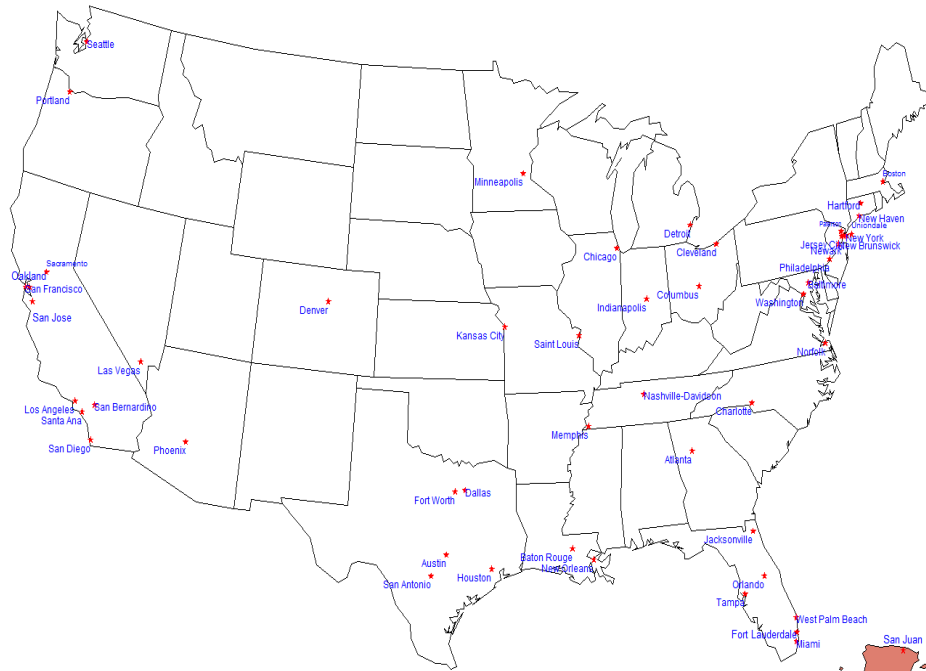


Planning Council/Planning Body Assessment Webinar

Division of Metropolitan HIV/AIDS Programs (DMHAP)

March 28, 2017



Webinar Agenda

- 1) Welcome
- 2) DMHAP Updates
- 3) Introduction of Speakers
- 4) Presentation

Planning Council/Planning Body Assessment: Key Findings and Implications

**Webinar for Part A Programs
March 28, 2017**

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Purpose of the Assessment

To assess the perceived successes, key structural issues, abilities, challenges, and technical assistance (TA) needs of the Ryan White HIV/AIDS Program's (RWHAP's) Part A Planning Councils/Bodies (PC/Bs) in assuming their legislatively required responsibilities

Disclaimer: This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services under Task Order Number TA001955. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Webinar Scope and Focus

- Quick review of assessment purpose and methods
- Presentation of assessment findings, focusing on key topics
 - Polling and discussion
- Plans for follow-up webinar in April to address questions and issues raised during discussion
 - Send topics/questions for discussion to:
PCQuestions2017@gmail.com

Download webinar materials:

- Slides
- Supplemental handout: PC Profile
- Discussion Guide

Key Webinar Topics

1. PC Membership and the Role of Consumers
2. Planning Council Structure
3. Implementing Legislatively-Required Roles & Responsibilities
4. PC as an Independent Planning Body Working in Partnership with the Recipient
5. Training & Technical Assistance Needs
6. Key PC Accomplishments and Challenges
7. Summary of Conclusions & Recommendations

Assessment Methods

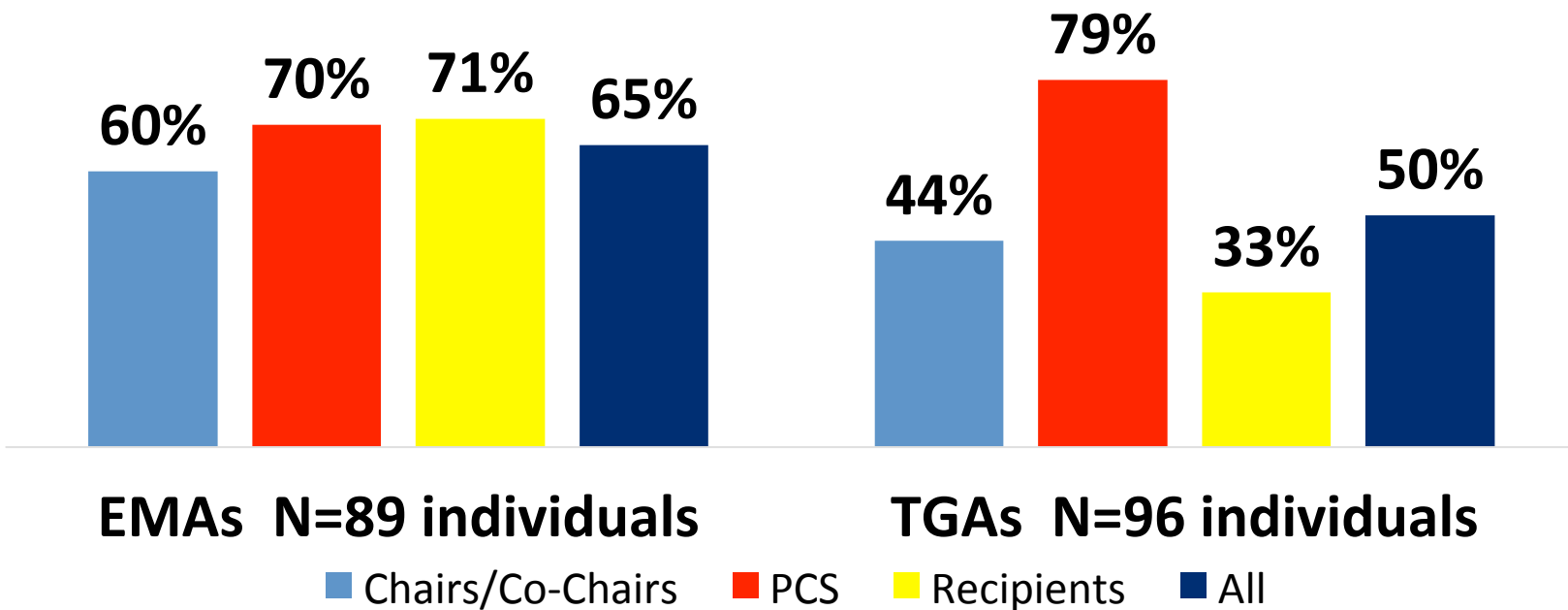
- On-line voluntary request for information (VRI) to Chairs/Vice-Chairs, recipients, and PC Support (PCS) staff of all Part A programs
- Site visits to 8 jurisdictions
- Interview & consumer telephone input sessions including another 3 jurisdictions
- Bylaws review – all Part A jurisdictions
- Collection/review of existing materials from PC/B websites, TARGET Center, other sources

Scope of Assessment/VRI

- PC within the municipal structure
- Funding/budget
- Staffing
- Roles and involvement of consumers & other PLWH
- Orientation and training
- Unmet training & technical assistance needs
- Greatest value/benefit of having a PC
- Important recent accomplishments
- Problems and challenges
- Current relationship between PC and recipient
- Desired changes in requirements and expectations

VRI Responses

Responses to Part A Voluntary Request for Information by Respondent Category (Percent of Targeted Individuals Responding)



Responses received from:

- 23 of 24 EMAs (96%)
- 23 of 28 TGAs (82%)
- 106 of 185 individuals (57%)

Response rates for Chairs and recipients much lower in TGAs than in EMAs

Poll: Top Priorities of Your Planning Council/ Body

1. PC Membership and the Role of Consumers



Membership Profile: Bylaws

- **PC size:** EMAs have larger PCs than TGAs
 - All EMAs allow more than 30 members, ¼ permit 45 or more
 - 1/3 of TGAs have maximum size of 30 or fewer members
- **Member terms:** EMAs have longer terms – usually 3 years, compared to 2 years for TGAs
- **Term limits:** Varied use/enforcement of term limits

PC Membership Issues

- **Meeting legislative requirements:**
 - ***Representation:*** members with diverse affiliations and expertise as stated in the legislation
 - ***Reflectiveness:*** Both PC & its consumer members look like/reflect the local epidemic in terms of characteristics such as race/ethnicity, gender & age
- **Addressing complex planning** in an era of change
- **Providing training and support** for people who have not previously been community planners
- **Exploring diverse views about PLWH/consumers**
 - Input vs. decision making
 - Role of race/ethnicity & class

Membership Challenges

- Overall challenges in recruiting and maintaining active membership, including PLWH and non-PLWH members
 - Temptation: abandon term limits
- “Representation” slots that often remain unfilled
 - e.g., State Medicaid agency, hospital or health planning agency
- Results of recruitment/participation challenges: over-representation of providers and potential Conflicts of Interest (COI)



Unaligned Consumer Members

- Most PCs meet or exceed the legislative requirement for 33% unaligned consumer membership:
 - 17% (7 PCs) said they don't
- About 2/3 of TGAs & EMAs have a PLWH Committee/Caucus
- About 1/3 of Bylaws require or urge PLWH on all committees – often including non-PC members
- TGAs are more likely than EMAs to require in their Bylaws that a Chair, Vice Chair, or Co-Chair be a PLWH
 - Required by 54% of TGAs and 29% of EMAs

Roles for PLWH Committees

Many PLWH committees/caucuses play roles well beyond basic functions such as:

- Providing input re consumer needs & services
- Serving as a “safe space” for consumer discussion

Other identified roles:

- Overseeing efforts to ensure “meaningful and substantial involvement” of PLWH in all PC committees and activities
- Helping design & implement needs assessments
- Doing structured community outreach
- Helping recruit & orient consumer members of the PC
- Serving as a training ground for PC membership

Best Practice Examples

Some PCs successful in maintaining consumers as fully engaged PC & committee members – “best practices” offered:

- **Houston:** LEAP training for potential PLWH members of PC and HIV Prevention Planning Group (HPG)
- **Atlanta:** Large number of non-voting “At-large” members, many of them consumers, who apply for PC membership and serve as a pool & training ground for PC voting members
- **Hudson County/Jersey City:** Strong consumer involvement is both a recipient and a PC priority; committees meet when there is work to be done and always provide useful information

Factors Supporting Consumer Engagement

- Demonstrated respect for consumers & their contributions by the PC, PCS staff, and recipient
- Inclusion as full partners in decision making, not just a source of input
- Adequate PCS staffing & support
- Clearly defined roles, responsibilities & expectations
- Orientation, training & opportunities for leadership – including pre-membership training
- Open discussion about disparities in service access, quality, appropriateness & outcomes and the implications of race/ethnicity & class

Barriers to Consumer/PLWH Engagement

- Greatly increased employment of PLWH
- Assumed limitations on consumer capacity for sound decision making in an increasingly complex HIV prevention & care environment
- Perception that other members hold most of the power & influence
- Hiring of unaligned consumers – constant need to recruit

Barriers to Consumer/PLWH Engagement, cont.

- Insufficient orientation, training, and support
- Stigma and disclosure issues
- Transportation challenges and expenses
- Health status and co-morbidities

Poll: Member Recruitment/ Retention Challenges

Questions and Discussion: Focus on Membership



2. Planning Council Structure

- Committees
- Bylaws
- Policies and Procedures
- PC Staff Support
- Resources/Budgets



PC Structure

- **Officers:** All PCs have at least 2 key officers (Chair & Vice Chair or 2 Co-Chairs) –38% of TGAs have 3
 - Over 1/3 of PCs have other officers – secretary, treasurer, parliamentarian
- **Committees:** Defined in Bylaws but sometimes need review/restructuring
- **Bylaws:** Mostly reasonably up-to-date
- **Policies and Procedures:** Generally in place, but not necessarily regularly reviewed or addressed in PC Orientation (e.g., Conflict of Interest, Grievance Procedures)
- **PCS Staff:** Expected to be “responsive & accountable to the PC”

Resources/Budgets Affect Ability to Meet Legislative Requirements

- All Part A programs and PCs have the same legislative responsibilities but widely differing resources
- Part A funding (FY 2016):
 - 17 EMAs had Part A funding of \$10 million+
 - 25 TGAs had funding of less than \$7 million
- Most EMAs reported 3 or more full-time equivalent staff
- More than half of TGAs reported 0.5-1.5 FTE staff
- Funds for tasks like Needs Assessment not necessarily included in PC budgets



HAB/DMHAP: Expectations for PCS Managers

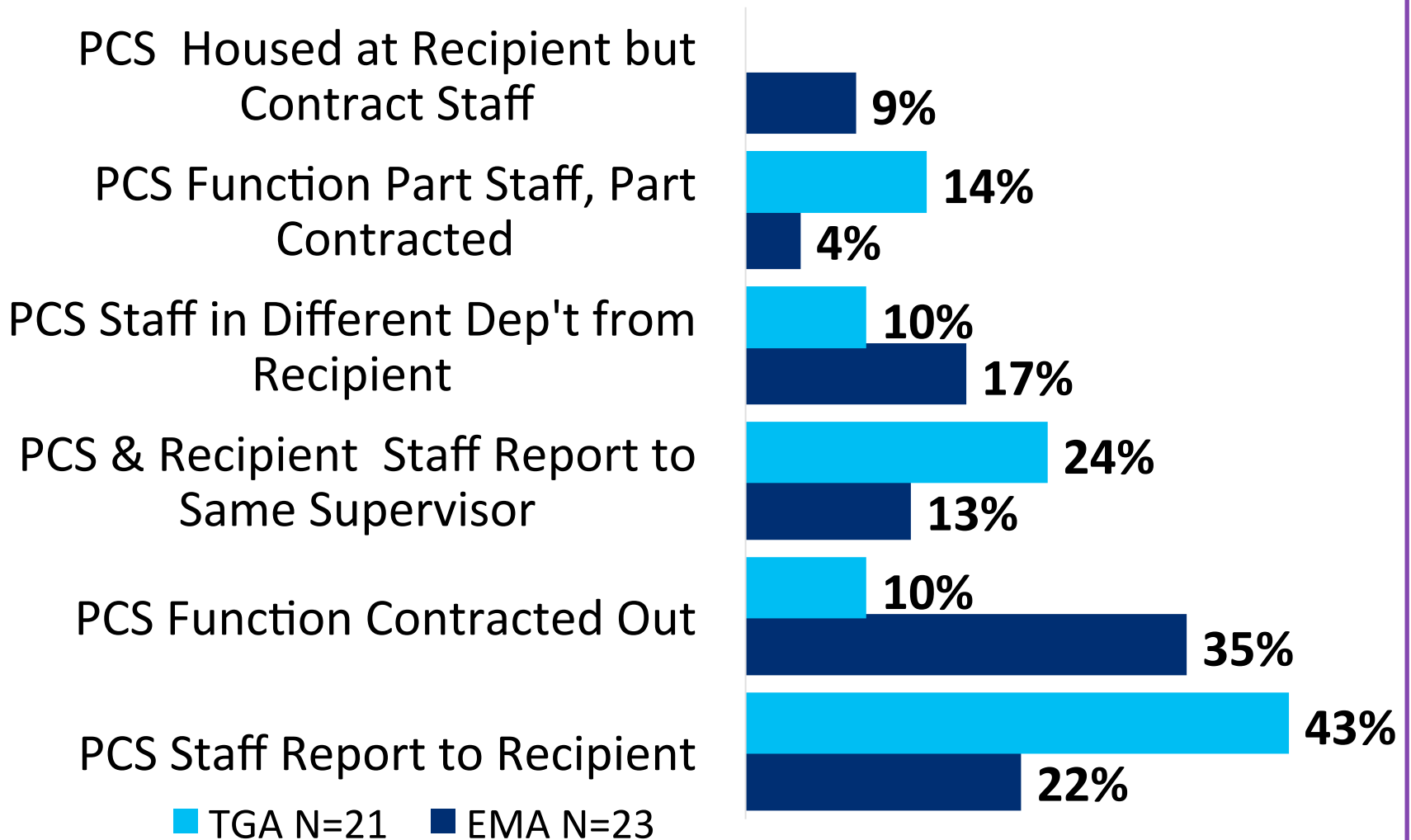
- Strong knowledge of planning and data
- Expertise in PC legislative mandates
- Understanding of HRSA expectations for planning process
- Ability & time to work with committees
- Ability to work with PLWH & diverse stakeholders
- Ability to facilitate a partnership between planning body & recipient

**...But at present, often no direct link between
PCS & HAB/DMHAP**

Models for PC Support (PCS) Staff

1. **PCS staff report to recipient** (especially common in TGAs)
2. **PCS & recipient both report to the same supervisor** – unit head or a more senior official
3. **PCS staff located in a different department or agency from the recipient** – or to office of CEO
4. **PCS function contracted out** (most common in EMAs)
5. PCS part staff, part contracted
6. PCS housed at recipient offices, but contract staff

Planning Council Support (PCS) Staff Models Used by EMAs and TGAs (Percent)



3. Implementing Legislatively Required Roles and Responsibilities

Focus on:

- Needs Assessment
- Comprehensive/Integrated Planning
- Priority Setting & Resource Allocations (PSRA): “Establish priorities for the allocation of funds... including how best to meet each such priority...”



Needs Assessment

- **Many jurisdictions not doing comprehensive needs assessment**
- **Quality issues** such as limited analysis of data and overdependence on small-sample methods
- **Issues of cost and expertise**
- **Some PCs and recipients doing innovative needs assessment** in spite of limited resources

Comprehensive/Integrated Planning

- **9 programs reported integrated prevention-care planning bodies**
- **Value of an integrated plan** widely recognized
- **Increasing focus on HIV Care Continuum as a key source of data** – but some Part A programs are not receiving complete data or needed subpopulation bars
- **Challenges for TGAs & smaller EMAs** with no regional or local prevention planning function
- **PC role often reduced** from prior years
- **Cross-Part issues/concerns**
- **More guidance & assistance needed** due to new and challenging expectations
- **New cooperative agreement on planning**

Priority Setting & Resource Allocations

- **Key issue = data:** ensuring data access, quality, needed analysis, understanding by both PC and recipient staff, availability in appropriate formats, and use in decision making
- **Need for new knowledge & adjustments in PSRA process,** due to continuing changes in HIV service structure & funding
- **Importance of full PC involvement in PSRA**
- **Ongoing challenges** re conflict of interest, “impassioned pleas”
- **Need for an appropriate rapid reallocations process**

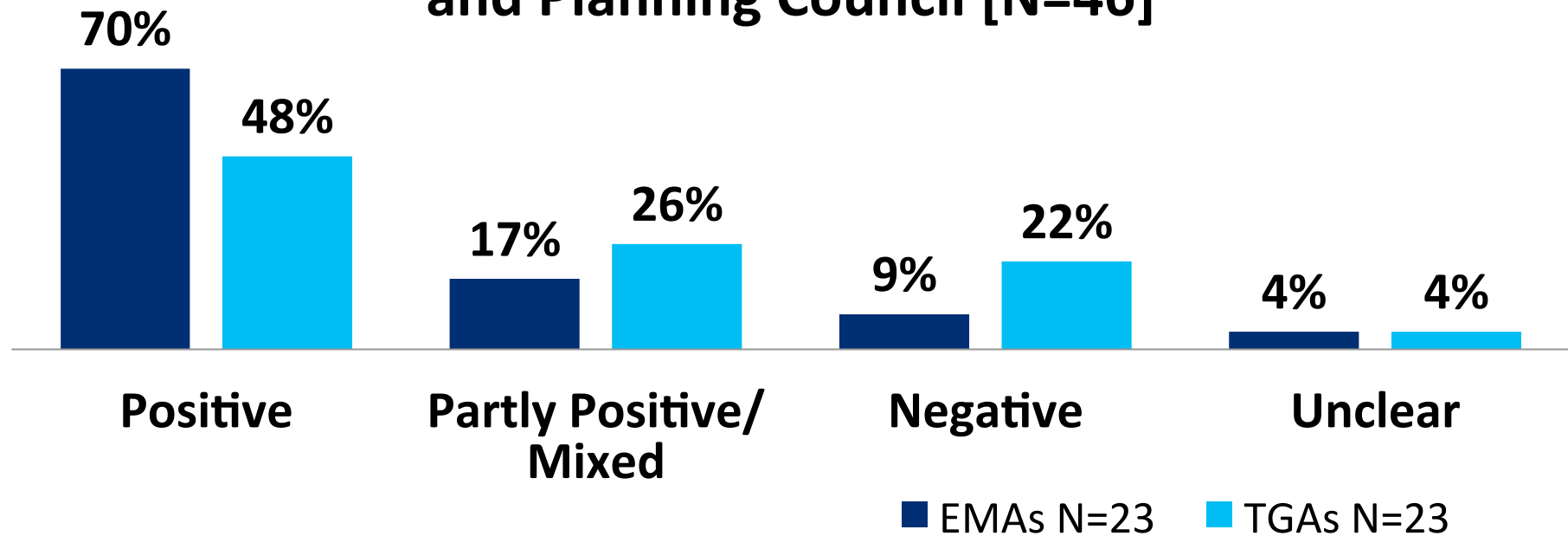
4. PC as an Independent Planning Body Working in Partnership with the Recipient



Expectations and Issues

- Expectation for the PC as a planning body with independent decision-making authority
 - *Part A Manual* says the PC “works in partnership with the grantee but not under its direction” (p 108)
- Effects of legislative changes
 - Includes making PC support funds a part of administrative funds, capped at 10%
- Many PCs now seen as largely managed by the recipient in terms of staffing and budget
- Desire for DMHAP/HAB clarity/guidance
- Relationship between PC and recipient sometimes challenging

Reported Relationship between the Recipient and Planning Council [N=46]



- Most EMAs (70%) reported a positive relationship between PC & recipient
- One EMA leader said: *“The reason we are working well together is because we listen to each other and bring issues to the recipient, who listens to us”*
- More TGAs than EMAs reported mixed or negative relationships, often reflecting differing views from different respondents
- **PC Budgets:** 59% of EMAs and 39% of TGAs indicated that the PC budget is negotiated with the recipient; in the others, the recipient sets the PC budget

Use of a Memorandum of Understanding (MOU)

- About 1/3 of EMAs and TGAs have a current MOU
- MOUs often developed to help resolve conflicts between PC and recipient
- MOUs considered very helpful when fully implemented, but are often only partially implemented
- 43% of EMAs and 30% of TGAs have no MOU



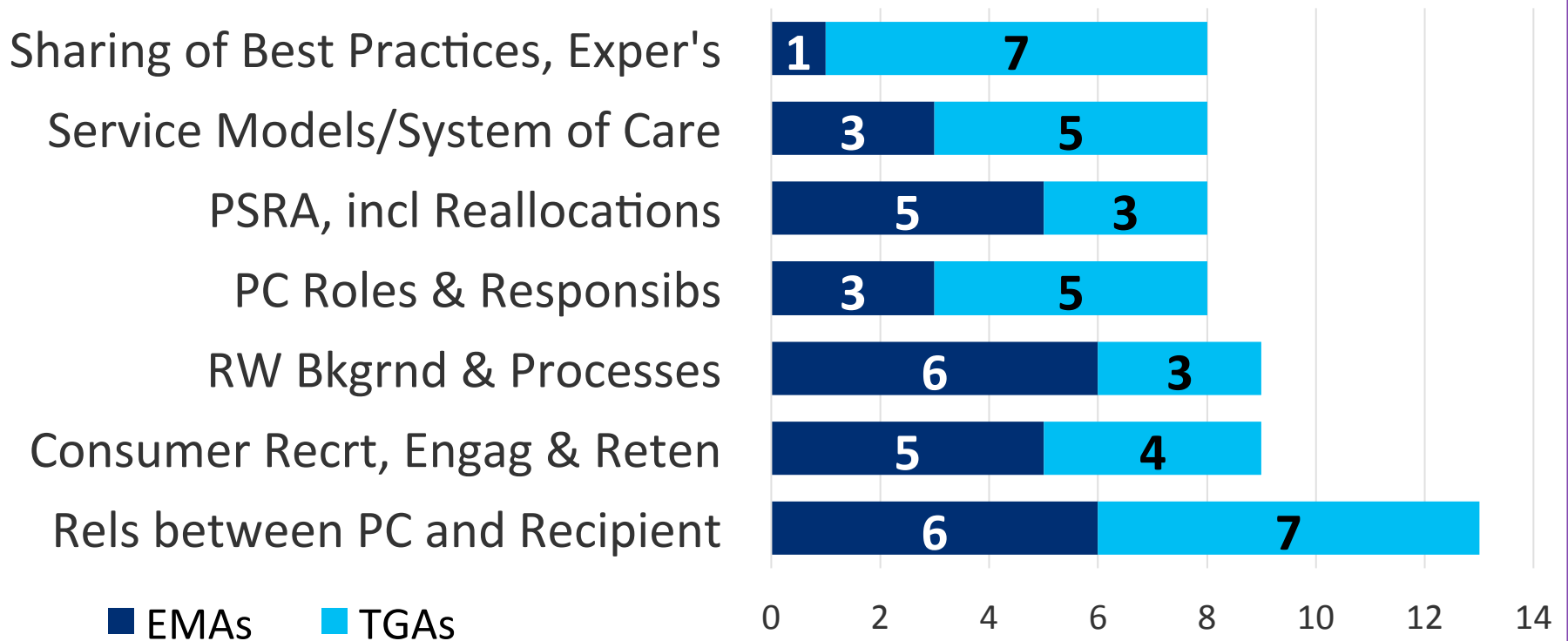
5. Training and Technical Assistance Needs



PC Orientation and Training

- **Wide recognition of the importance of orientation & training**, given complex HIV landscape
- Few PCs reported annual training plans
- **Current orientation often very brief**, especially TGAs
 - 60% of responding TGAs provide 1 to 2 hour orientation
 - 93% of EMAs provide at least half a day
 - 70% do orientation only once/year
 - 65% provide it for new members only
- **Most frequent topics:** PSRA process, PC & recipient roles & responsibilities, understanding data, and the components of RWHAP community planning
- Increased use of and interest in online modules
- **Issues:** attendance, cost, capacity, lack of national models and materials

Unmet Training and Technical Assistance Needs: Most Frequent Individual Responses [N=62]



- 23 PCs reported recent DMHAP TA, from a Project Officer or consultant; most found it helpful
- Consultant “matching” is an issue: 5 PCs indicated unsuccessful experiences with contract consultants from large EMAs and/or different regions who recommended actions that were not appropriate or feasible for their jurisdictions

Poll: T & TA Needs

Questions and Discussion: Structure, Staffing, Operations, T&TA Needs

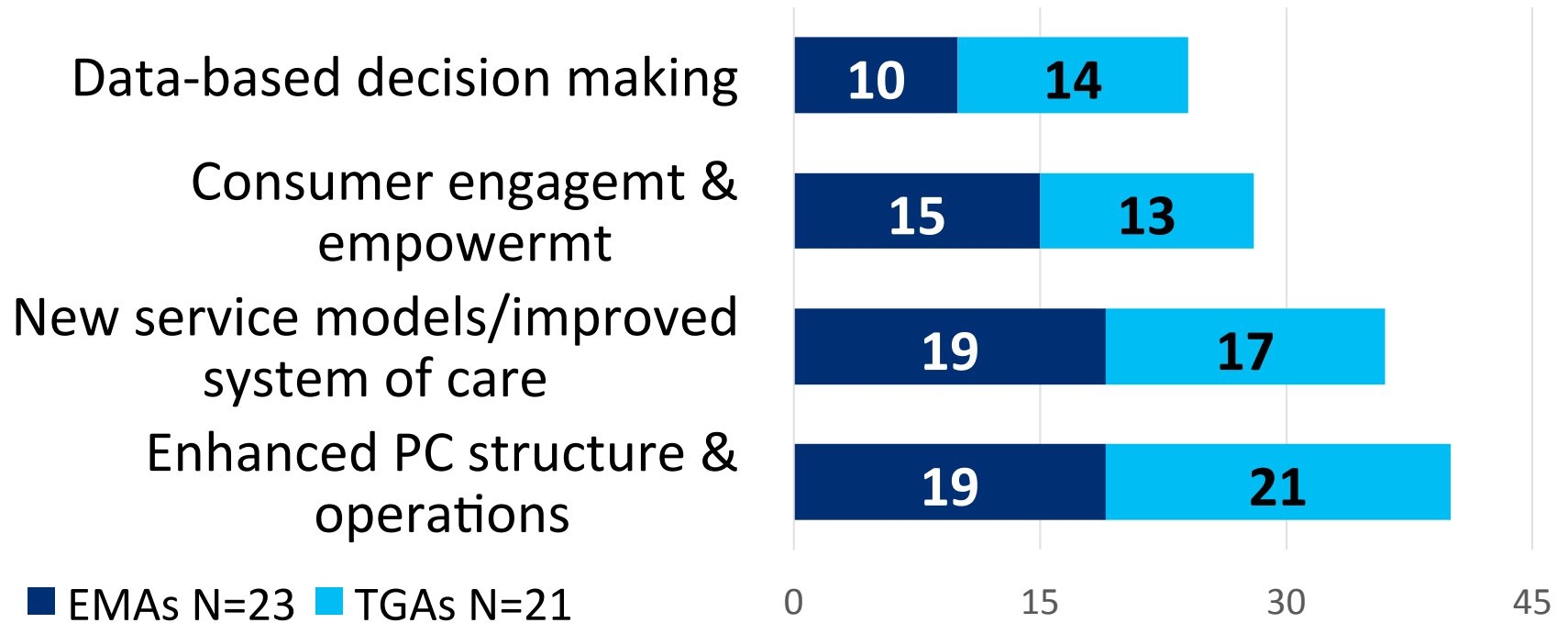


6. Key PC Accomplishments and Challenges



Most Frequently Identified Recent Planning Council Accomplishments

[Identified by 91 respondents from 23 EMAs and 21 TGAs]

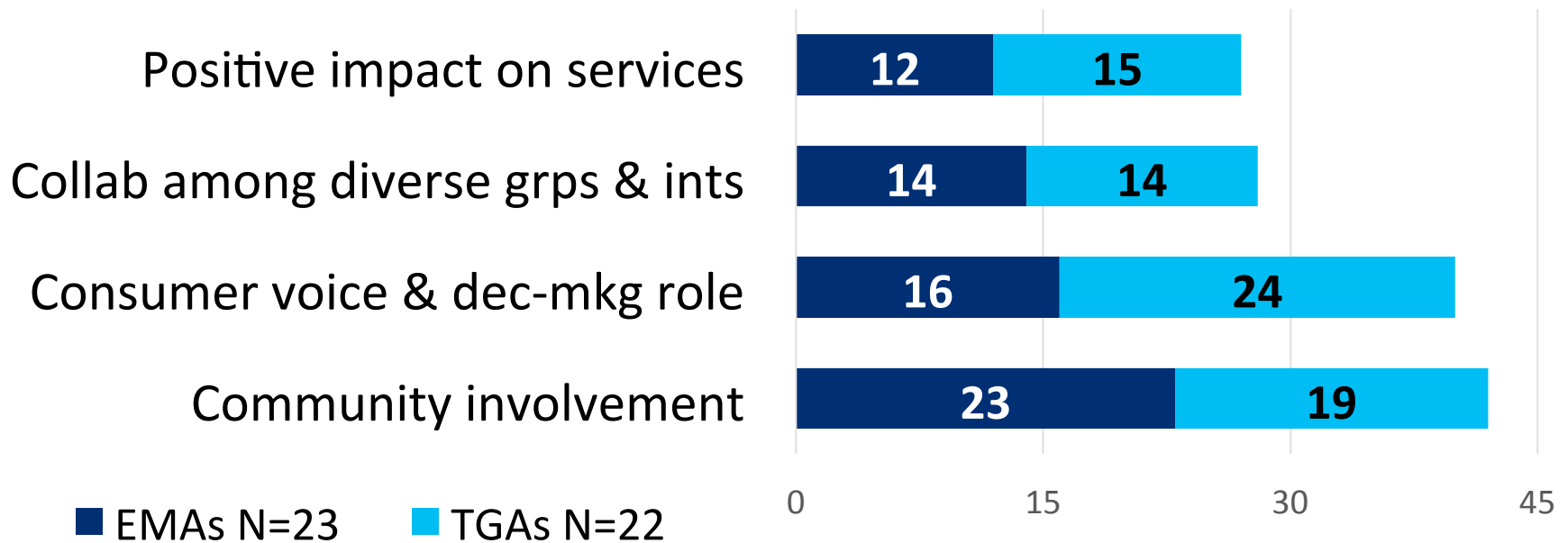


Most frequently mentioned important recent Planning Council accomplishments:

1. Improving their PC structure and operations to do better planning (40)
2. Helping to develop & allocate funds for new service models that have improved the system of care in their jurisdiction (36)

Greatest Value/Benefit of Having a Planning Council: Most Frequent Responses

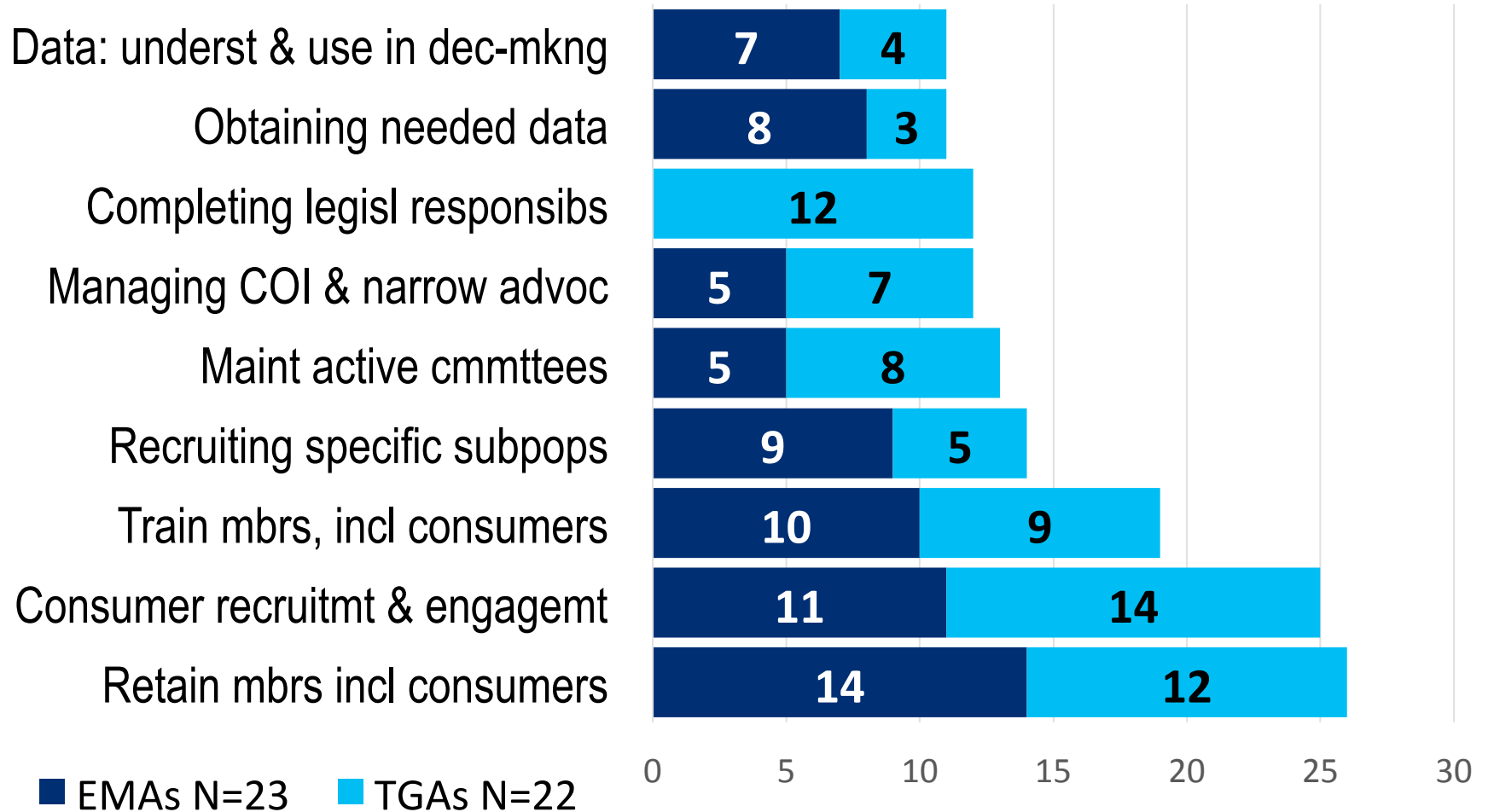
[Responses from 102 individuals in 23 EMAs and 22 TGAs]



- Most often identified value/benefit of having a PC was community involvement in HIV planning (42), followed by the consumer voice & decision-making role (40)
- Some respondents identified more than one benefit

Most Frequently Identified PC Problems and Challenges

Identified by 102 respondents from 23 EMAs and 22 TGAs]



Most Frequent Suggestions

- Respondents from 22 EMAs and 22 TGAs suggested changes in some aspect of PC/B structure, operations and/or DMHAP/HAB support & oversight, most often the following:
 - Reduce mandated member categories, eliminating or providing flexibility for those that are hardest to fill (19)
 - Maintain current PC requirements for EMAs & require TGAs to have PCs (14)
 - Provide consistent support, oversight, and guidance to maintain the independence of PCs, so they work in partnership with recipients but are not controlled by them – in terms of budget, staffing, & the PSRA process (11)
 - Revise/reduce the unaligned consumer membership requirement (10)

7. Assessment Conclusions and Consultant Recommendations to HAB/ DMHAP



Conclusions

1. **PCs bring great value** as unique community planning vehicles & a source of consumer and other PLWH input & decision-making role
2. **Representative & reflective PCs** contribute to improved care quality & positive clinical outcomes for diverse subpopulations
3. **EMAs and TGAs are most effective** when the PC/B, PCS staff, & recipient work in partnership
4. **Rapid changes** in the HIV landscape make community planning & active consumer engagement in decision making more challenging
5. **Most respondents, including recipients,** support continuation of decision-making PCs but would like fewer mandated PC slots & more flexibility

Conclusions, Cont.

6. **PCS staff** play a key role, but sometimes lack needed training & support
7. **Some Part A programs are uncertain** about the extent to which PCs are still expected to be independent bodies that work in collaboration with – but are not directed by – the recipient
8. **TGAs (and a few EMAs) with limited PCS funds & staffing** find it very difficult to meet all PC legislative requirements
9. **Advisory bodies** face considerable challenges

Consultant Recommendations to HAB/DMHAP

- *EGMC provided recommendations to HAB/DMHAP for consideration in the areas of PC/B structure, needed Guidance, and need for additional T&TA*
- *Most important recommendations are provided here*
- *Their inclusion is not to be construed as a commitment by HAB to any of the specific recommendations*

Consultant Recommendations to HAB/ DMHAP

- 1. Membership:** Maintain current requirements for consumer membership, reflectiveness, and representation, with additional guidance, flexibility, and T&TA
- 2. Budget and resource differences:** Provide guidance that ensures that all PCs meet legislative requirements, while recognizing the large differences in resources for community planning & PC support among EMAs and TGAs

Consultant Recommendations to HAB/ DMHAP, cont.

- 3. Independent planning body:** Provide guidance and support for PCs as independent planning bodies that work in partnership with recipients but not under their direction, with special attention to budget and staffing
- 4. PC support:** Strengthen PC/Bs by providing additional support to PC/Bs and PCS staff, through direct communication between the PC (including the PCS manager) and Project Officer, targeted T&TA, and the development, collection, updating, and sharing of materials and models for PC/B orientation, training, and support

Acknowledgments

Special thanks to:

- The DMHAP PC/B Work Group and our Project Officer, Helen Rovito
- DMHAP Project Officers
- PCS Staff, Recipients, and PC leadership
- Fort Lauderdale/Broward County and Indianapolis, which pretested the VRI
- The 8 Part A programs visited and the 3 involved in consumer conference calls
- The 16 programs that shared orientation & training materials

Questions and Discussion



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