Activity 2.3: PC/PB Roles, Responsibilities, and Boundaries Scenarios

TIPS FOR TRAINERS

Suggested Use

Use after your presentation and discussion on roles and responsibilities of PC/PBs and recipients.

Time

75 minutes total:

- 10 minutes to explain activity, assign groups, and for groups to organize themselves
- 15 minutes for small groups to work on their assigned scenarios and summarize their work on easel pad paper
- 45 minutes for small groups to present and the full group to discuss the scenarios
- 5 minutes for sum up by the facilitator

Materials

☐ Handout for Participants: PC/PB Roles, Responsibilities, and Boundaries Scenarios

☐ Easel pad paper, masking tape, and markers

☐ Training Aid: Scenario Notes and Key Points for the Trainer

Knowledge or Skill Development

Ability to apply information about PC/PB and recipient roles and responsibilities in the kinds of practical situations that arise during the ongoing work of a PC/PB

Activity Steps

1. Before the training, review all the scenarios and choose the ones you wish to use. They were written assuming that the group you are training will include predominantly new members, but with some veteran members and staff, so each small group would include someone with practical PC/PB experience. Revise scenarios as needed to fit your EMA/TGA, and to reflect the composition of your participant group. If it includes many "veteran" PC/PB members and/or staff, you might want to add a little complexity to some of the scenarios. If it is primarily new members, you might want to simplify a few of them.

2. Form small groups of 4-6 participants by asking the group to count off. Ideally you will have 4-5 groups. You may want to assign veteran PC/PB members to the groups so that each small group has at least one more experienced member.

3. Assign a scenario to each group and tell them they have 15 minutes to discuss how they would address it.

4. Explain to the groups that you want them to assume they are members of the planning council/planning body or a specific committee, and they need to decide how they would address their assigned scenario.

5. Ask each group to begin by choosing a **facilitator** to coordinate discussion, a **recorder** to take notes and summarize the work on easel pad paper for sharing, and a **reporter** to present a summary of the work of the small group to the full group. The same person may serve as recorder and reporter, if that is the group's preference.

6. After 10-12 minutes, ask the groups to begin wrapping up their discussion and remind the recorders to summarize their groups work on easel pad paper. Allow 5 minutes.

7. Now ask each reporter to summarize the scenario that group was assigned and present the work of the small group, focusing on what they recommend and why. Tell recorders they have 3-5 minutes to make the presentation. If 2 groups had the same scenario, ask the second group's reporter to indicate areas of agreement and disagreement or additional information. Now ask other participants to ask questions or suggest other approaches to the situation presented.

8. Summarize the main points for each scenario. If the work presented does not reflect sound practice, help the group understand a better approach and why it is preferable. Refer to the *Training Aid: Scenario Notes and Key Points for the Trainer*.

Alternative Steps

If you have a small number of participants (12 or fewer) and discussion can happen in the full group without loss of individual participant engagement, put each scenario onto a PowerPoint slide and insert it after the slide that presents the related role or responsibility, so that the scenario is discussed right after the role/responsibility information is presented. Have pairs of participants discuss the scenario for 3-5 minutes first to encourage full engagement in the discussion. This approach transforms the presentation into an active discussion and learning group.

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HANDOUT FOR PARTICIPANTS

Work in your small group, choosing a **facilitator** to coordinate the work of the small group and participate, a **recorder** to summarize the work of the small group on easel pad paper, and a **reporter** to present the small group's work to the full group. The same person may serve as recorder and reporter if this is the group's preference.

Review the ONE scenario assigned to your small group, and discuss the questions that go with it. Have your recorder list your key points on easel pad paper for sharing with the full groups

Scenario 1. Needs Assessment

A recipient staff member is participating in your Planning Committee meeting. The discussion is about adding information to your needs assessment. The committee is reviewing information on the system of care and provider capacity within the jurisdiction, and one member says she would like to know more about the individual RWHAP Part A service providers. She asks the recipient representative to provide "copies of information from subrecipient proposals so we can better understand their capabilities."

If you were chairing that committee, how would you respond to this suggestion? Why? What else might be done by the Committee to learn more about the system of care?

Scenario 2. Priority Setting

The planning council/planning body is setting priorities and will include all fundable RWHAP Part A core medical-related and support service categories. Members have agreed to make decisions based on "hard data" indicating what services are most needed by PLWH in the EMA/TGA. Two members want to add another factor: how much funding is available from other sources. They say that it doesn't make sense to give a service category high priority under Part A if it has enough funding through other sources.

Are they right or wrong? Why? What factors should be considered in setting service priorities?

Scenario 3. Resource Allocation

The planning council/planning body is doing resource allocation, reviewing last year's allocation for each prioritized service category along with available data about PLWH service needs, use, and gaps. As the allocation for Mental Health Services is being discussed, a subrecipient with funding for Mental Health Services makes a passionate plea for more funding for this service category, talking about new research on the importance of such services to retention in care and treatment adherence. Members ask him several questions. He answers them and calls on several clients who are in the room as members of the public to support his statements. But he doesn't vote on the allocation because of his conflict of interest.

Is this process appropriate? Should it be changed, and if so, how and why? What should a PC/PB do to have information for decision making but prevent actual or perceived conflict of interest?

Scenario 4. Directives

The planning council/planning body has become concerned about the lack of access to Ryan White-funded medical services in the evening and on weekends, which a recent PLWH survey identified as a problem for clients who are employed. At its last meeting before the priority setting and resource allocation (PSRA) process with the full PC/PB, the PSRA Committee develops a directive that says that all funded providers of outpatient ambulatory health services (OAHS) must be open at least six hours a month for evening or weekend care. It presents this proposed directive at the PSRA session, immediately after allocation decisions have been made.

Is this appropriate? Why or why not? What might be advisable steps and factors to consider in developing and presenting directives?

Scenario 5. Assessment of the Efficiency of the Administrative Mechanism

Note: A planning body generally does not carry out this task. Use only for planning councils, unless you have a planning body that does AAM.

Every year the planning council carries out an assessment of the efficiency of the administrative mechanism (AAM), which looks at recipient procurement, disbursement of funds, data and other support provided to the planning council for the planning process, and adherence to PC priorities and allocations. Since the PC also has the option of assessing the effectiveness of services, and this role is described in the same subsection of the legislation as the AAM, one member suggests that this year, the recipient be asked to add data on performance and outcome measures (for example, percent of clients retained in care and percent virally suppressed) by service category and for each subrecipient.

Is this a good way for the PC to address service effectiveness? If so why? If not, what other approaches might the PC consider?

Scenario 6. Clinical Quality Management (CQM)

At its most recent town hall meeting to hear about PLWH service needs, the planning council/planning body received a lot of complaints about long waiting times for HIV-related medical appointments. Two specific subrecipients were mentioned. At the next PC/PB meeting, one member asks the recipient to "check this out when you do your CQM and contract monitoring visits and tell us what you find." Another suggests that it might be time for the PC/PB to do its own evaluation of service effectiveness, since that is an optional legislative role for planning councils, and compare its findings with the CQM data.

What do you think of these two suggestions? How would you handle this situation if you were Chair? How might the PC/PB address concerns about the quality of care?

Scenario 7. Membership

The planning council/planning body has several vacant seats for unaligned consumers and for a representative of recently incarcerated PLWH, and it has not been able to fill the state Medicaid or hospital or health planning agency slots. It has "advertised" openings on its website, announced the vacancies at each meeting, and developed an online application form. Finally, after multiple outreach efforts by the recipient and Chair, a staff member from the state Medicaid office expresses interest in serving. When the Chair announces this at a PC/PB meeting, one member urges that the PC/PB vote immediately to recommend her to the CEO, without the usual review by the Membership Committee. Someone else suggests that this process be used for all applicants "until all the current vacancies have been filled."

Is this OK? Why or why not? What might the PC/PB do to assess and enhance its recruitment and nominations process?

Scenario 8. Relationship with the Recipient

The planning council/planning body and recipient have always worked well together but have no written procedures to clarify roles and boundaries. More than nine months ago, the two most senior recipient staff left to take other jobs. It took about six months to hire the new staff, and they do not seem familiar with the typical division of labor and responsibility between the recipient and PC/PB. The PC/PB was not told about the amount of the grant award until three weeks after the Notice of Award was received, even though there is a special condition of award that requires action by the PC/PB. Some data needed for priority setting and resource allocation are already two months late, and the recipient seemed surprised when reminded that this information is needed. The PC/PB manager has told the Chair privately that she has tried to get the information, but the recipient says he is dealing with other matters that have higher priority.

How should the PC/PB address this situation? What might be done to prevent such situations in the future?

Scenario 9. Roles of Planning Council Support Staff

Note: Use only for planning councils, since a planning body may be staffed by recipient personnel rather than having its own staff.

The recipient has had several staff vacancies for the past several months, and the local hiring process is slow. Planning council support (PCS) staff do not report to the recipient, but they work out of the same office and sometimes are asked to assist the recipient. At an Executive Committee meeting, one of the PC Co-Chairs expresses concern because she asked the PCS manager why materials for several recent meetings went out late and discovered that PCS staff were extremely busy because they were:

- Staffing a regular monthly meeting with Part A subrecipients, which includes helping to prepare the agenda and taking minutes
- Writing major sections of this year's annual Part A application

Are these tasks appropriate? Why or why not? How should the PC/PB and recipient address this situation?

Scenario 10. Public and Consumer Input

The planning council/planning body has been receiving complaints about services during the public comments period at recent meetings. Last month a consumer said she and several of her friends were receiving packaged foods that were well past their expiration dates and very little fresh vegetables or fruits from a RWHAP Part A-funded food bank. Another consumer said the front desk worker at a community health center violated confidentiality by announcing loudly in a crowded waiting room that "The HIV nurse will see you now" when she went for medical care. The presiding Co-Chair expressed concern, and then indicated that the information would be provided to the recipient for investigation and response and asked the recipient staff attending the meeting to follow up with the consumers. Several new members of the PC/PB reacted angrily, demanding that the PC/PB address these concerns directly.

Is this appropriate? What kind of process should be used in such situations? Who should be involved?

Activity 2.3: PC/PB Roles, Responsibilities, and Boundaries Scenarios

SCENARIO NOTES AND KEY POINTS FOR THE TRAINER

Here are some key points to touch on in summing up the discussion for each scenario.

Scenario 1. Needs Assessment

A recipient staff member is participating in your Planning Committee meeting. The discussion is about adding information to your needs assessment. The committee is reviewing information on the system of care and provider capacity within the jurisdiction, and one member says she would like to know more about the individual RWHAP Part A service providers. She asks the recipient representative to provide "copies of information from subrecipient proposals so we can better understand their capabilities."

If you were chairing that committee, how would you respond to this suggestion? Why? What else might be done by the Committee to learn more about the system of care?

Key Points for Scenario 1

The Chair should explain why this request is inappropriate. PC/PBs should not have access to applications for funding from individual subrecipients, either before or after funding decisions are made. Their focus needs to be on the system of care and the combined capacity of subrecipients. Because of concerns about conflict of interest, PC/PBs are strongly discouraged from discussing individual subrecipients at any time and from seeking information about them through external sources.

It is important for PC/PBs to understand the mix of services and service models available to consumers in their EMA or TGA, however. This information can be obtained through recipient development of service inventories and directories of both RWHAP Part A-funded and other providers, and through what is called a "profile of provider capacity and capability," which is one component of a comprehensive needs assessment. The focus should be on understanding combined capacity by service category and overall – for example, are there enough services appropriate for particular subpopulations based on race/ethnicity, language, age, gender, or sexual orientation or gender identity? How many medical providers have evening or weekend hours? Such information can be charted, reviewed, and discussed without names of individual providers attached.

Scenario 2. Priority Setting

The planning council/planning body is setting priorities and will include all fundable RWHAP Part A core medical-related and support service categories. Members have agreed to make decisions based on "hard data" indicating what services are most needed by PLWH in the EMA/TGA. Two members want to add another factor: how much funding is available from other sources. They say that it doesn't make sense to give a service category high priority under Part A if it has enough funding through other sources.

Are they right or wrong? Why? What factors should be considered in setting service priorities?

Key Points for Scenario 2

They are wrong. While other available funding is a very important consideration in resource allocations, it should not be a factor in priority setting. The intent of priority setting is to determine the relative importance of RWHAP Part A-fundable service categories for people living with HIV in the EMA/TGA who may need RWHAP services, not how the service should be paid for. The most important, most needed services should be the highest ranked. In addition, the PC/PB should never be in the situation of needing to change its service priorities in mid-year because of a change in funding from other sources. Suppose a service that is very important to PLWH was given low priority because of other funding available to meet the need, and the other funding was suddenly eliminated. It would be hard to justify to HRSA/HAB why the jurisdiction wants suddenly to move funds from a higher ranked service category to a lower-ranked one.

Among the factors that should be considered in priority setting are the number or proportion of PLWH (consumers and those not in care) who need and want each type of service—based on needs assessment data, for example. Also very important is the relative importance of that service in helping a PLWH get linked promptly to care, stay in care, receive antiretroviral therapy (ART), adhere to treatments, and achieve viral suppression. Utilization data for specific service categories during the past year help indicate the level of need and demand for a service, as do cost data indicating whether available funds were spent. If there has been a waiting list or a delay in obtaining that service, this may indicate a higher than expected level of need. The needs of specific subpopulations of PLWH should also be considered. Sometimes a particular service is a very high priority only for a particular group. For example, linguistic services may be essential to service access for some immigrant populations; only women or male caregivers with young children may need child care or transportation assistance in order to access care. Such services need to be ranked high enough to justify funding since they are so important to those populations.

Scenario 3. Resource Allocation

The planning council/planning body is doing resource allocation, reviewing last year's allocation for each prioritized service category along with available data about PLWH service needs, use, and gaps. As the allocation for Mental Health Services is being discussed, a subrecipient with funding for Mental Health Services makes a passionate plea for more funding for this service category, talking about new research on the importance of such services to retention in care and treatment adherence. Members ask him several questions. He answers them and calls on several clients who are in the room as members of the public to support his statements. But he doesn't vote on the allocation because of his conflict of interest.

Is this process appropriate? Should it be changed, and if so, how and why? What should a PC/PB do to have information for decision making but prevent actual or perceived conflict of interest?

Key Points for Scenario 3

This is not a good way to manage conflict of interest, because while it prevents the individual with the conflict from voting, it does not prevent that person from trying to convince other PC/PB members how to vote. Since the discussion occurs at the time of resource allocations, there is no opportunity to consider other data that may or may not support that individual's views.

It is appropriate for members, including subrecipients, to present data for use in decision making. To minimize conflict of interest, however, it is best to have those discussions before priority setting and resource allocation, and at a time when other data are also being presented. A sound practice

used by many PC/PBs is to encourage general public, consumer, and provider input at a town hall meeting; or to hold a service provider input session; and to allow discussion of such data at a formal data presentation. Priorities and allocations are then determined at a separate meeting, and no new data are presented at that meeting—since there is no way to assess it or compare it with other information. A member who has a conflict of interest regarding one or more service categories is not permitted to vote except on a slate of services, and is not permitted to initiate discussion about those service categories. If a question arises, it goes to staff, and the Chair may ask the recipient to respond, or allow an expert in the room to answer the question provided it does not introduce new data.

Scenario 4. Directives

The planning council/planning body has become concerned about the lack of access to RWHAP-funded medical services in the evening and on weekends, which a recent PLWH survey identified as a problem for the growing number of clients who are employed. At its last meeting before the priority setting and resource allocation (PSRA) process with the full PC/PB, the PSRA Committee develops a directive that says that all funded providers of outpatient ambulatory health services (OAHS) must be open at least six hours a month for evening or weekend care. It presents this proposed directive at the PSRA session, immediately after allocation decisions have been made.

Is this appropriate? Why or why not? What might be advisable steps and factors to consider in developing and presenting directives?

Key Points for Scenario 4

This may be an appropriate directive, but this is not an appropriate time to present it. Many important directives have financial implications. Adding evening or weekend hours requires keeping a clinic open after normal working hours, which probably means additional staff and facility costs. If the PC/PB considers such additional hours necessary, then it may need to allocate additional funds to the OAHS service category. Otherwise, the directive will lead to a reduction in the amount of care that can be provided the following program year. Directives should be drafted and discussed with the recipient prior to the allocations process so that financial and other practical considerations are identified, and can be considered when making allocations.

Many EMAs/TGAs explore the need for directives year-round, particularly in the committees responsible for needs assessment and for improving service models (often called the Care Strategy Committee). Through needs assessment and review of data from many sources, they identify ways to reduce barriers to care, such as making services more available in particular locations, for particular PLWH subpopulations, or using specific service models. They also ask consumers at town hall meetings how services might be improved. Each year a committee or a special Task Force drafts directives based on all this input, explores their practical implications and potential costs with the recipient, and then presents proposed directives, including any financial implications, to the full PC/PB prior to the allocations process.

Scenario 5. Assessment of the Efficiency of the Administrative Mechanism

Note: A planning body generally does not carry out this task. Use only for planning councils, unless you have a planning body that does AAM.

Every year the planning council carries out an assessment of the efficiency of the administrative mechanism (AAM), which looks at recipient procurement, disbursement of funds, data and other support provided to the planning council for the planning process, and adherence to PC priorities and

allocations. Since the PC also has the option of assessing the effectiveness of services, and this role is described in the same subsection of the legislation as the AAM, one member suggests that this year, the recipient be asked to add data on performance and outcome measures (for example, percent of clients retained in care and percent virally suppressed) by service category and for each subrecipient.

Is this a good way for the planning council to address service effectiveness? If so why? If not, what other approaches might the planning council consider?

Key Points for Scenario 5

Addressing service effectiveness is a legitimate PC/PB activity, but it should not become an add-on to an assessment of the efficiency of the administrative mechanism. It is not within the scope of the AAM. The AAM has a process focus--getting funds out to service providers in the areas of greatest need rapidly and efficiently, while assessing the effectiveness of services involves service outcomes.

A key question is whether there is a need for the PC/PB to provide additional attention to service effectiveness, beyond what is being learned through review of the recipient's findings on performance and outcomes measures, CQM data, and HIV care continuum data (testing, linkage to care, retention in care, use of antiretroviral therapy, and viral suppression) for RWHAP clients. If the PC feels that additional evaluation is needed, it should work with its support staff and the recipient to decide what additional assessment is needed and how best to arrange it. This might best be done as a collaborative effort with the recipient. For example, if the current HIV care continuum data provide information only about all PLWH diagnosed and living in the service area, it may be very useful to arrange for a continuum just for RWHAP clients, and special analyses might explore HIV care continuum data or other clinical outcomes for particular subpopulations. Additional performance measures might receive focus, or additional analyses might be done of CQM data.

Scenario 6. Clinical Quality Management (CQM)

At its most recent town hall meeting to hear about PLWH service needs, the planning council/planning body received a lot of complaints about long waiting times for HIV-related medical appointments. Two specific subrecipients were mentioned. At the next PC/PB meeting, one member asks the recipient to "check this out when you do your CQM and contract monitoring visits and tell us what you find." Another suggests that it might be time for the PC/PB to do its own evaluation of service effectiveness, since that is an optional legislative role for planning councils, and compare its findings with the CQM data.

What do you think of these two suggestions? How would you handle this situation if you were Chair? How might the PC/PB address concerns about the quality of care?

Key Points for Scenario 6

It is very important that systemic problems with services be investigated and resolved. It is also appropriate for the PC/PB to refer concerns about a particular provider to the recipient. However, it is not appropriate for the PC/PB to request or receive information from the recipient about the performance of specific subrecipients. The recipient should certainly indicate whether investigation indicates that long waits for medical appointments are occurring for the entire outpatient/ambulatory health services (OAHS) service category, and if so what it will do to reduce these waiting times—and whether resolving the problem requires additional allocations or other action by the PC/PB.

In general, quality of care is addressed under the recipient's leadership through CQM and subrecipient monitoring, as well as through review of data on HAB-specified performance and outcome measures. If the PC/PB is planning needs assessment activities such as a PLWH survey, focus groups, or town hall meetings, it can address quality of care issues by including appropriate questions—such as a question about waiting times for medical services. The PC/PB can also ensure that service standards address quality issues. For example, if the service standards for OAHS address the issue of waiting times, the recipient should be exploring this issue as part of its annual monitoring visits. If the data indicate that long waiting times seem to be a problem in multiple subrecipient agencies, the recipient might decide that this would be a good focus for a quality improvement (QI) project. If the PC/PB feels that the recipient's collection and analysis of CQM, HAB performance measures, and outcomes data are inadequate, it can consider some possible PC/PB-led assessment of service effectiveness and determine how to allocate needed funds to support it. Ideally, this analysis should be a collaborative effort between the PC/PB and recipient.

Scenario 7. Membership

The planning council/planning body has several vacant seats for unaligned consumers and for a representative of recently incarcerated PLWH, and it has not been able to fill the Medicaid or hospital or health planning agency slots. It has "advertised" openings on its website, announced the vacancies at each meeting, and developed an online application form. Finally, after multiple outreach efforts by the recipient and Chair, a staff member from the state Medicaid office expresses interest in serving. When the Chair announces this at a PC/PB meeting, one member urges that the PC/PB vote immediately to recommend her to the CEO, without the usual review by the Membership Committee. Someone else suggests that this process be used for all applicants "until all the current vacancies have been filled."

Is this OK? Why or why not? What might the PC/PB do to assess and enhance its recruitment and nominations process?

Key Points for Scenario 7

This is not OK. The legislation requires that all applicants for PC membership go through the open nominations process. The Part A Manual also specifies that "The CEO will approve and/or appoint as planning council members only individuals who have gone through the open nominations process" [page 118]. This process should provide for an applicant to be considered and recommended to the full PC/PB efficiently, so that a recommendation can come to the full PC/PB at its next meeting if the individual identified meets established criteria, and then go on to the CEO based on PC/PB action.

It is often difficult to arrange for someone from the state Medicaid office to serve on the PC/PB, especially if the EMA/TGA is not located in or near the state capital. However, this PC/PB seems to have a number of vacancies. This situation suggests a need not to bypass the open nominations process but to improve it. It is rarely sufficient to "advertise" on the PC/PB website. Outreach is almost certainly needed. The PC/PB should consider a careful review of the current process for recruiting new PC/PB members, to determine how it might be improved. The PC/PB will probably want to ask advice from the HRSA/HAB Project Officer and may want to contact other EMAs/TGAs to learn about their recruitment and nominations process. The Project Officer may suggest that the recipient and PC/PB request technical assistance to strengthen the open nominations process.

Scenario 8. Relationship with the Recipient

The planning council/planning body and recipient have always worked well together but have no written procedures to clarify roles and boundaries. More than nine months ago, the two most senior recipient staff left to take other jobs. It took about six months to hire the new staff, and they do not seem familiar with the typical division of labor and responsibility between the recipient and PC/PB. The PC/PB was not told about the amount of the grant award until three weeks after the Notice of Award was received, even though there is a special condition of award that requires action by the PC/PB. Some data needed for priority setting and resource allocations are already two months late, and the recipient seemed surprised when reminded that this information is needed. The PC/PB manager has told the Chair privately that she has tried to get the information, but the recipient says he is dealing with other matters that have higher priority.

How should the PC/PB address this situation? What might be done to prevent such situations in the future?

Key Points for Scenario 8

The PC/PB will need to help educate the new staff about mutual roles and responsibilities. The PC/PB leadership and support staff will probably need to take the lead, sharing information about legislative roles and responsibilities and HRSA/HAB expectations for collaboration between the recipient and PC/PB. Some useful information is provided in the Part A Manual and on the TARGET Center website. If addressing the situation proves difficult, it may be useful to ask for assistance from the HRSA/HAB Project Officer, and perhaps to request joint training or technical assistance on PC/PB and recipient roles, responsibilities, and collaboration.

The best way to prevent such situations in the future is to negotiate a Memorandum of Understanding (MOU) between the recipient and PC/PB that clearly defines individual and shared roles, responsibilities, and boundaries; specifies information that will and will not be shared; and provides a process for communications and for resolution of conflicts. An MOU provides written "institutional memory" for the EMA/TGA, laying out expectations for working together that can provide guidance to new recipient and PC/PB support staff as well as changing PC/PB leadership and membership.

Scenario 9. Roles of Planning Council Support Staff

Note: Use only for planning councils, since a planning body may be staffed by recipient personnel rather than having its own staff

The recipient has had several staff vacancies for the past several months, and the local hiring process is slow. Planning council support (PCS) staff do not report to the recipient, but they work out of the same office and sometimes are asked to assist the recipient. At an Executive Committee meeting, one of the PC Co-Chairs expresses concern because she asked the PCS manager why materials for several recent meetings went out late and discovered that PCS staff were extremely busy because they were:

- Staffing a regular monthly meeting with Part A subrecipients, which includes helping to prepare the agenda and taking minutes
- Writing major sections of this year's annual Part A application

Are these tasks appropriate? Why or why not? How should the planning council and recipient address this situation?

Key Points for Scenario 9

The planning council and recipient are considered independent entities that work together collaboratively. The primary responsibility of PCS staff is to support and assist the PC, and the PCS manager should not be getting behind on PC work because s/he is doing work for the recipient.

It is not unheard of for PCS staff to assist the recipient in a crisis, but this should not involve ongoing work, and should not interfere with the efficient operations of the PC. The recipient should hire temporary staff or consultants so the PCS manager can get back to doing the PC's work, and any work the PCS staff has done for the recipient should be billed to the recipient and not taken out of the PC budget.

It is not a good idea for the PC and recipient to share staff, partly because of the potential for conflict of interest. Staffing a monthly subrecipient meeting is a particular concern because the PC support staff generally helps to assess the efficiency of the administrative mechanism, and involvement with this meeting on a monthly basis could put PCS staff in the position of assessing their own work. It is also not appropriate for PC funds or staff time to be used to prepare the annual Part A application, other than the parts that are directly related to the work of the PC.

Scenario 10. Public and Consumer Input

The planning council/planning body has been receiving complaints about services during the public comments period at recent meetings. Last month a consumer said she and several of her friends were receiving packaged foods that were well past their expiration dates and very little fresh vegetables or fruits from a RWHAP Part A-funded food bank. Another consumer said the front desk worker at a community health center violated confidentiality by announcing loudly in a crowded waiting room that "The HIV nurse will see you now" when she went for medical care. The presiding Co-Chair expressed concern, and then indicated that the information would be provided to the recipient for investigation and response and asked the recipient staff attending the meeting to follow up with the consumers. Several new members of the PC/PB reacted angrily, demanding that the PC/PB address these concerns directly.

Is this appropriate? What kind of process should be used in such situations, and who should be involved?

Key Points for Scenario 10

The Chair acted appropriately. It is extremely important that problems such as those identified by the consumers during public comment be addressed—and the PC/PB should receive a general report back about what has been done to address the problem, without discussing individual subrecipients—but the PC/PB should not become involved in addressing individual complaints about service providers.

The PC/PB does have a role with regard to systemic issues, however, and efforts to ensure a high-quality system of care. The PC/PB should review its Service Standards for Food Banks/Home-Delivered Meals to ensure that they include appropriate clarity about expectations for fresh fruits and vegetables and specify that subrecipients must meet municipal regulations (which probably address the expiration-date issue).

Regarding the situation with the receptionist, confidentiality requirements should be included in the Universal Standards of Care covering all service categories, along with a requirement that subrecipient staff participate in training that addresses client confidentiality. Most subrecipient have policies

addressing these confidentiality issues, and clients should have a complaint process that enables them to report this kind of situation without fear of retaliation. The PC/PB might ask participants at the next PLWH or consumer committee or caucus whether they have encountered this kind of problem—without discussing individual subrecipients—and tell the recipient if this appears to be a systemic problem.

Some PC/PBs have a form they use to inform the recipient about systemic problems, issues they believe involve ongoing problems within the system of care that need to be addressed.