Memorandum of Understanding (MOU)
Between the PBC Ryan White Part A
Recipient and PBC HIV CARE Council

I. Purpose Statement

This Memorandum of Understanding (MOU) is designed to:

- Create a shared understanding of the relationship between the PBC Ryan White HIV/AIDS Program (RWHAP) Part A Recipient and the PBC HIV CARE Council
- Delineate the roles and responsibilities of each entity; and
- Encourage a mutually beneficial relationship between these important partners.

The MOU describes the legislated responsibilities and roles of each party, the locally defined roles, and expectations for how these roles and responsibilities will be carried out. The MOU will establish positive and appropriate communication, information sharing, and cooperation that will help ensure the effective and efficient delivery of medical and support services to persons affected and living with HIV in the PBC Eligible Metropolitan Area (EMA)

II. Roles and Responsibilities

A. Roles and Responsibilities of the CARE Council

The CARE Council is solely responsible for the following tasks, as specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009:

1. Priority setting and resource allocation: Set priorities among service categories, allocate funds to those service categories, and provide directives to the Recipient on how best to meet these priorities. This includes reallocation of funds as required during the program year and allocation of carryover funds.
2. Assessment of the administrative mechanism: Assess the Recipient's process for procuring services and disbursing funds to the areas of greatest need within the EMA.

B. Roles and Responsibilities of the Recipient

The Recipient is solely responsible for meeting the following legislatively mandated responsibilities:

1. Procurement: Manage the process for awarding contracts to specific service providers.

2. Contracting: Distribute funds according to the priorities, allocations, and directives of the Planning Council.
3. Contract monitoring: Monitor contracts to be sure that sub recipients are meeting their contracted responsibilities in compliance with established standards of care. Recommend re-allocations during the grant year based on service category performance.
4. Technical Assistance to Service Providers: Provide technical assistance to sub recipients on an as- needed basis to build capacity and to improve contract compliance and service delivery.

C. Shared Responsibilities

The Recipient and CARE Council share the following legislative responsibilities, with one entity having the lead role for each, as stated below:

1. Needs Assessment: Determine the size and demographics of the population of individuals with HIV in the EMA, and their service needs. The PBC HIV CARE Council Planning committee has primary responsibility for needs assessment, with the Recipient staff assisting with the process and providing the CARE Council information such as service utilization data and expenditures by service category.
2. Clinical Quality Management (CQM): Establish a clinical quality management program to assess the extent to which HIV-related primary health care services are consistent with Public Health Service guidelines and to enhance health and supportive service access and delivery and continuously improve systems of care. Includes identifying quality improvement projects. Except for service standards (see below), the Recipient has primary responsibility for other CQM activities. CARE Council members sit on the Quality Management and Evaluation Committee and People Living with HIV may be part of CQM field teams visiting Part A providers/sub recipients.
3. Service Standards: develop and maintain service standards and outcomes measures. The Quality Management & Evaluation Committee of CARE Council takes the lead in this effort, with extensive Recipient involvement.
4. Integrated Plan: The CARE Council works with the recipient to develop a written integrated plan for HIV service delivery and improving the system of care within the EMA. The CARE Council should take a lead role in plan development while coordinating closely with the Recipient. The plan should include long-term and short-term goals and should address each stage of the HIV care continuum.

D. Administrative Responsibilities

In addition to these legislative roles, the Recipient and CARE Council share the following responsibilities related to Part A CARE Council and management:

1. **Fiscal management of CARE Council support funds**: The Recipient provides fiscal management of CARE Council support funds. The annual CARE Council support

budget is funded as a part of the allocation of up to 10% of the total grant that may be used for administrative costs. The amount to be used for CARE Council support must be negotiated between the Recipient and CARE Council. The CARE Council support staff works with the P&A Committee to develop the CARE Council budget, which is reviewed by the Recipient to ensure proposed use of funds meets federal and municipal requirements. CARE Council Support staff works with the P&A Committee to monitor CARE Council expenditures, based on reports provided by the Recipient through CARE Council support staff. The Recipient is responsible for ensuring that all expenditures meet RWHAP guidelines as well as local financial management regulations.

2. **Office Space**: The Recipient and CARE Council support staff will maintain separate and distinct office space within the same building where feasible. Office space for the CARE Council must meet all Americans with Disabilities Act (ADA) requirements.

3. **Triennial application process**: The Recipient has primary responsibility for preparation and submission of the Part A grant application. CARE Council support staff provides information for the application sections related to CARE Council membership and responsibilities (such as priority setting and resource allocations), and assists with preparation and review of the application. To the maximum extent possible given time constraints, the CARE Council Chair or Vice-Chairs [and the Executive Committee] have an opportunity to review the application before submission and make suggestions for its improvement. The CARE Council Chair signs a letter of assurance accompanying the application that indicates whether the Recipient has expended funds in accordance with CARE Council priorities, allocations, and directives, and other information as specified in the annual Part A Notice of Funding Opportunity Announcement (NOFO) from HRSA/HAB.

4. **Sub recipient NOFO**: Procurement is the Recipient's responsibility. However, because contracting is required to ensure that the CARE Council's directives are being addressed, and the CARE Council develops service standards that become a part of sub recipient requirements. The Recipient therefore allows up to [two] representatives of the CARE Council who have no actual or perceived conflict of interest to review in draft the portions of the NOFO that address service standards and CARE Council directives. Any CARE Council member who reviews the NOFO sections is required to sign a statement of confidentiality and non-disclosure. No part of the NOFO is reviewed by any CARE Council member affiliated with a current or potential Part A service provider.

III. Communications

A. Principles for Effective Communications

Both the Recipient and the CARE Council recognize the importance of regular & open Communication and of sharing information on a timely basis. Information needs to be received regularly. There should be clarity regarding what will be communicated, when, and to whom. When problems or issues arise, there should be a joint commitment to resolving them through

established procedures. The parties commit themselves to the following principles:

1. All parties will take responsibility for establishing and maintaining open communications. This includes both sharing information on a timely basis and reviewing shared information once it has been received. If issues or problems arise, it means communicating with the other parties to clarify the situation and decide how best to address it.
2. CARE Council standing committees except the Membership Committee will have a Recipient staff member who is assigned to it and attends meetings regularly. That staff member will serve as liaison to the Recipient for that committee and will be responsible for responding to communications and information requests from the committee.
3. The Recipient and CARE Council will each have a designated liaison responsible for sharing and receiving information for all other communication requests, and for disseminating information within their entity. When questions or concerns arise, the designated liaison will ensure that they are addressed in a timely manner. For the CARE Council, the designated liaison will be the CARE Council coordinator. For the Recipient, it will be the Ryan White Program Manager.
4. Both entities will use designated liaisons and channels of communication. When someone needs information or materials beyond those that are regularly shared, they will request it through the designated liaison, and the request will be made in writing (via e-mail or letter). This means, for example, that a Committee Chair who needs information from the Recipient will request it either through the assigned Recipient staff member during the meetings or through CARE Council support staff. For information beyond normal reports and information, it is the responsibility of the CARE Council coordinator and Ryan White Program Manager to determine whether the Recipient is the appropriate source for this information and whether the information is available and can be provided within the Recipient's resources. Where the Recipient feels it cannot meet the request, the Ryan White Program Manager will consult with the CARE council support staff member and with the Chair or Committees chair as necessary
5. Staff of both entities and CARE Council members will avoid inappropriate communication requests or channels. This means not asking for information from individuals other than the designated individuals, using and not bypassing established communication channels, and maintaining the confidentiality of information that should not be shared outside the Part A program.
6. When policies or procedures appear problematic, the parties will work together to clarify and, if appropriate, refine them – while adhering to legislative requirements, HRSA/HAB guidance and expectations as stated in Part A-related manuals, policy statements, and guidance, and state and local statutes and policies.

7. Communications and problem solving will protect the separation of roles between the CARE Council and Recipient. For example, the CARE Council is not supposed to have access to information about the performance or expenditures of individual providers; it should receive such information only by service category. In cases where there is only one service provider for a service category, the CARE Council will have access to this information but without identifying information.
8. If either Recipient staff or CARE Council support staff or members receive complaints about the other party, they will inform the other party, with appropriate protection of confidentiality.
9. The CARE Council will not become involved in consumer complaints about services. If the CARE Council or its support staff receives consumer or provider concerns or complaints about a specific provider, it will refer the individual expressing the concern to the individual provider for resolution through its own complaints process. If the CARE Council or support staff receives broader, systemic complaints or concerns about services, it will refer them to the Part "A" Program Manager.

B. Implementing these Principles

To facilitate communications and implement these principles, all parties agree to the following actions:

1. **The signatories to this agreement will participate in a face-to-face Executive meeting including both entities and all parties following the elections of CARE Council Leadership annually.** The first meeting, held just before the Part A program begins on March 1, will be used to lay out specific mutual expectations for the year, ensure a mutual understanding of the Part A program's status and directions, clarify a calendar for the year including dates when materials and information will be shared, and address potential issues or problems. This includes identifying additional or different reports or information needed. Subsequent meetings will be used to monitor progress and refine the calendar as needed, further define information sharing needs, and address any issues that may arise in the relationship between the Recipient and CARE Council.

2. **When making special requests for information or materials, both parties will provide as much lead time as possible; when sharing information, both parties will do so as quickly as possible**. Requests for information will generally be met within five business days. If requests will take longer to meet, the party responding will contact the other party within three business days to discuss and agree on a time frame for meeting the request. Both parties commit themselves to responding rapidly to any requests that involve meeting Conditions of Award, satisfying other HRSA/HAB requirements or requests, and addressing other matters that may affect the funding or reputation of the EMA/TGA's RWHAP Part A program.

IV. Information/Document Sharing and Reports/Deliverables

A. Overview

It is the intent of this MOU to encourage regular sharing of information and materials throughout the year. This section specifies a set of materials to be provided and information to be shared through meetings. Parties to the MOU may request and receive additional materials or information, except for those that should not be shared for reasons of sensitivity or confidentiality.

B. Information to be Provided by the CARE Council to the Recipient

The CARE Council will provide the Recipient Part A Program Manager with the following information and materials:

1. A dated list of CARE Council members and their terms of office, with primary affiliations as appropriate, to be provided annually and updated as needed throughout the year, in accordance with current HRSA/HAB requirements.
2. Notification of the CARE Council's monthly meetings, retreats, orientation and training sessions, and other CARE Council events, at the same time notification goes to CARE Council members.
3. The meeting notice, agenda, and information package for each CARE Council meeting, to be provided at the same time they are provided to CARE Council members.
4. The annual list of service priorities and resource allocations, along with the process used to establish them and directives to the Recipient or edits to existing directives on how best to meet these priorities – the same information that is submitted to HRSA/HAB as part of the annual Part A application. This information will be provided within two weeks after the CARE Council has approved the priorities, allocations, and directives.
5. Copies of final planning documents prepared by the Recipient staff Health Planner, such as needs assessment reports and the integrated Plan, within ten days after their completion and approval by the CARE Council.
6. Information or documents needed by the Part A Program Manager to complete the sections of the annual application related to the CARE Council and its functions, to be provided on a mutually agreed-upon schedule.

C. Information to be Provided by the Recipient to the CARE Council

The Part A Program Manager will provide the CARE Council Support Coordinator the following reports and information. These will be the minimum requirements. Additional or different information needs will be discussed and agreed upon at the beginning of each year. Use list or chart specifying data or document to be provided, frequency, and timing for providing

the information to the CARE Council.

1. A copy of the annual Notice of Award (NOA) including Conditions of Award, a copy of any approved carryover request, and a copy of other official communications from HRSA/HAB that directly involve the CARE Council, within three business days after they are received from the funding agency and more quickly where time-sensitive responses are required.
2. A written monthly expenditures report by service category, provided in writing at least THREE business days before the meeting of the appropriate committee. The Recipient will also provide an oral presentation to the Priorities & Allocation & Executive Committee, highlighting any unexpected expense levels.
3. A report to the CARE Council regarding over- and under-expenditures and any unobligated balances, by service category and jurisdiction, and any suggested reallocations, to be provided monthly at least [THREE]business days before the meeting of the Priorities & Allocations, Executive & CARE Council Committee. This report is to be submitted monthly due to the importance of avoiding unobligated funds at the end of the program year, given the provisions of the legislation.
4. Utilization data by service category, including client numbers and demographics for each service category and for mutually determined special populations requiring additional analysis (e.g., young MMSC {Male to male sexual Contact} of color; women over 55), to be provided [Semi Annually], including end-of-year data consistent with the Ryan White Services Report (RSR). Basic data will be provided within 30 days after the RSR is submitted; due dates for more complex analyses will be mutually determined annually.
5. HIV Care Continuum data for all PLWH in the jurisdiction and for Ryan White clients, as well as mutually agreed upon breakdowns by subgroups, to be provided annually in [May &June]. If data are obtained from the State, the Recipient will be responsible for arranging timely provision of these data.
6. Other performance and clinical outcomes data including HRSA/HAB-specific measures, collected by the Recipient, to be provided quarterly.
7. Information and recommendations requested as needed by the CARE Council to carry out its responsibility in setting priorities among service categories, allocating funds to those service categories, and providing directives to the Recipient on how best to meet these priorities. The content and format for this information will be mutually agreed upon each year, but will typically include epidemiologic data, additional cost and utilization data, and an estimate of unmet need for primary Health care among people who know their status but are not in care. In addition to providing the information in written form, the Recipient will participate in data presentations to the CARE Council at a mutually agreed upon date and time.
8. Information requested as needed by the CARE Council to meet its responsibility for assessing the efficiency of the administrative mechanism. The content and format for this information will be mutually agreed upon each year, but will typically include information from the Recipient on the procurement and grants award process; statistics (such as number of applications received, number of awards made, number of

applications from minority providers, number of new providers funded, and number of minority providers funded), and reimbursement procedures and timelines.

9. Carryover information as it becomes available. This includes the estimated carryover as submitted to HRSA/HAB at the end of the calendar year, the actual carryover from the Financial Status Report, the carryover plan submitted to HRSA/HAB, and the approved carryover plan. Each document will be provided to the CARE Council within five business days after it is submitted or received.

10. The Federal Financial Report (FFR) and other end-of-year reports including the Final Implementation Plan and Final Allocations Report, as submitted to HRSA/HAB in the final progress report each year, providing information on the number of individuals served and costs per client for each service category. CARE Council will receive this information within ten business days after the Recipient submits the final progress report to HRSA/HAB, based on the Conditions of Award, in time for use in priority setting and resource allocation.

When the CARE Council or a Committee requests special or additional information from the Recipient, the request will always be listed in the summary minutes of the meeting. In addition, CARE Council support staff will provide a list of requests in a follow-up e-mail to the Recipient, within two business days, with a copy to the Committee Chair or CARE Council Chair. The request will always specify the date by which the information is needed, and for what legislatively defined task, and Recipient will respond within five business days, indicating whether it can meet the request and by what date. The two parties will negotiate content and timing where required.

D. Documents and Information That will Not be Shared

In order to maintain the confidentiality of sensitive information, the following information will not be shared, subject to the requirements of Florida's Public Records Law, Chapter 119, Florida Statutes:

1. The CARE Council will not share information on the HIV status of members of the CARE Council who are not publicly disclosed as people living with HIV/AIDS. Except for individuals who choose to disclose their status, the HIV status of CARE Council members will not be shared with the Recipient or with other CARE Council members except those involved in the Membership Process.

2. CARE Council support staff will not inquire, interfere, or otherwise discuss needs of, or actual HIV services provided to, CARE Council members by the Recipient or Subrecipients. CARE Council support staff will instruct members to communicate directly with their service provider or the Recipient staff to address individual medical care and support service needs.

3. The Recipient will not share information about individual applicants for service sub recipient contracts or about the performance of individual contractors –

   Information will be shared by service category only. If there is only one sub recipient in a service category, the information will be shared, but without identifying information.

4. Information about the individual salaries of Recipient and CARE Council staff will not be shared beyond those with a direct need to know. The CARE Council will not have access to the Recipient's detailed budget other than the summary version submitted in the Part A Application. The Part A Program Manager will have access to the CARE Council's detailed budget as needed for the Part A application, Conditions of Award, and other HRSA/HAB requirements.

V. Settling Disputes or Conflicts

If conflicts or disputes arise with regard to the roles and responsibilities specified in Section II of this Memorandum of Understanding, the parties will use the following procedures to resolve them:

1. Begin with a face-to-face meeting between the parties to attempt to resolve the situation, within five working days after the issue or dispute arises.
2. If the situation cannot be resolved by these parties, hold a meeting of representatives of both parties, along with the Recipient staff supervisor and the Chair of the CARE Council, to discuss the issue and reach resolution if possible, within ten working days after the initial meeting.
3. If the situation still cannot be resolved, the two parties will be removed from the discussion and the mutual decision of the Recipient staff supervisor and Chair of the CARE Council will be final.

VI. Responsible Parties and Contact Information

The following are the parties to this MOU and the parties' representatives at the time this MOU is adopted. Any notice or communications required to be sent by this MOU shall be sent to the parties' representative at the email provided.

The MOU will continue in effect regardless of changes in the individuals who hold these positions. Their successors will be expected to follow the MOU.

For the Recipient:

- Part A Program Manager, Dr Casey Messer, cmesser@pbcgov.org

For the CARE Council:

- CARE Council Chair, Chris Dowden, cdowden@midwaycare.org

VII. MOU Duration and Review

A. Effective Date

The MOU will become effective once all the authorized individuals representing the Recipient and CARE Council sign it.

B. Duration

The MOU will remain in effect for 5 years unless or until the parties take action to end it or The Recipient no longer receives Part A funding for the EMA/TGA.

C. Process for Reviewing and Revising the MOU

The MOU will be reviewed and revised annually, with the involvement and approval of all parties. Reviews will occur:

1. Following each reauthorization or legislative revision of the Ryan White legislation by the U.S. Congress, to ensure that the MOU remains fully appropriate, updated, and reflective of the Act.
2. At least once every year at the first meeting of the parties to this MOU.

VIII. Signatures

Casey Messer 5/26/22

Casey Messer, DHSc, PA-C, AAHIVS
Ryan White Program Manager

Chris Dowden, PharmD, BCPS, AAHIVP
CARE Council Chair