

Greater Baltimore HIV Health Services
Planning Council

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Planning council Chair Debbie Rock (center) leads applause for Lt. Gov. Michael S. Steele at the council's August 2003 priority-setting conference, while Vice Chair Lena Franklin looks on approvingly.



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MISSION

The mission of the Greater Baltimore HIV Health Services Planning Council is to provide comprehensive, high-quality services to people living with the HIV disease in the greater Baltimore eligible metropolitan area (EMA), regardless of their ability to pay.

The planning council will plan for and ensure access to culturally sensitive, high quality, cost-effective services in collaboration with local authorities, service providers and consumers of HIV-prevention and care services. This system includes a plan to expand capacity, as well as monitor and evaluate services.

The planning council and its advisors will act in a timely and unbiased manner when setting priorities to allocate resources.



EXECUTIVE SUMMARY

The Greater Baltimore HIV Health Services Planning Council and the Baltimore EMA have had a lot to be thankful for during the year 2003. Highlights of the year include:

- ◆ Receiving a funding increase from \$17,986,832 for fiscal year (FY) 2002 to \$21,458,791 for FY 2003, the largest proportional increase ever in the history of Ryan White Title I funding for any EMA. The EMA also planned for \$769,944 in FY 2002 to FY 2003 carryover funds.
- ◆ Organizing successful EMA and counties priority-setting conferences that for the first time involved planning for three different grant award outcomes.
- ◆ Developing a priority-setting training manual that was distributed to all planning council and Counties Committee members.
- ◆ Completing the planning council section of the FY 2004 EMA application.
- ◆ Completing the revision of eight service category standards for HIV/AIDS services in the Baltimore EMA and reorganizing the *Standards of Care: Fiscal Year 2004* manual.
- ◆ Organizing a successful counties community forum and conducting focus group surveys in the EMA to solicit information from providers and consumers of Ryan White Title I CARE Act and other funding-stream services regarding barriers to accessing HIV/AIDS treatment.
- ◆ Developing a tool to assess the administrative mechanism of the administrative agency.
- ◆ Establishing a stand-alone Needs Assessment Committee. Previously, needs-assessment activities were the responsibility of a work group under the Comprehensive Planning Committee.
- ◆ Meeting ethnic/racial reflectiveness and non-conflicted PLWH/A membership targets for planning council membership.
- ◆ Carrying out elections for the chair and vice chair of the planning council.



PLANNING COUNCIL MEMBERS

Debbie Rock, *Chair*

Sheila Ashley

Wanda Belle

Dale Brewer

Cheryl Chambers

Laurence Chapman

Tracey Chunn

Lynn Creditt

Grace Daniels

Steven Dashiell

Iris Davis

Betty Flint

Bryna Grant

Tyrone Gray

Lenwood Green

Bertha Greene

Nancy Guest

Michelle Holloway

Louinda House

Sophia Jones

Lena Franklin, *Vice Chair*

Willislee B. Jones

Jean Keller

Daphne Lane

Donald Maynor

Wendy Merrick

Jeanne Morris

Michael Obiefune

Ann Price

Brenda Ross

Raymond Shattuck

Kimberly Smolen

Walter Samuel

Synthia Smith

Carnell Thomas, Jr.

Bernice Tucker

Greg Upton

Pierre Vigilance

David Waller

IN MEMORIAM

Adam Davis



MESSAGE FROM THE PLANNING COUNCIL CHAIR



Photo: Carnell Thomas, Jr.

Planning council
Chair Debbie Rock.

As we come to the end of 2003, I look back over my first year as your chair and reflect on our work together. I believe we have come a long way.

Our committees have strong leaders and, with their guidance, have taken bold approaches to the work of the council. We have seen an increase in our committee attendance and membership. We have seen committees generate work groups so that care standards could be reviewed and revised to meet broad planning deadlines. We have seen committees take on new processes and procedures to help the planning council achieve its mandates from the Ryan White CARE Act itself.

The number of professionals and community experts who joined us in the development of this year's *Standards of Care: Fiscal Year 2004* manual was truly amazing. These individuals were generous in sharing their service knowledge, were flexible with their schedules and were committed to seeing that our EMA had the best standards that could be produced.

The level of participation from the HIV-infected and -affected community has increased so much that we have had to move meetings from the main planning council support office building to larger quarters. We know that there are several reasons for this increase and I would like to highlight some. First, planning council members have spread the news about the work of the council. The media campaign devised by InterGroup Services (IGS), our contracted support provider, has put the name of the planning council out at community fairs, on radio shows and in public service announcements. In addition, Title I program support activities have taken the message about HIV planning and services into all of our EMA suburban counties and into numerous neighborhoods of Baltimore City.

I want to acknowledge the contributions of our partners at the Baltimore City Health Department (the grantee) and Associated Black Charities (the administrative agency). We have developed an admirable working partnership — resulting in our grant increase to over \$21 million this year. We have improved our planning because our partners have provided more and better data. Our partners have been active on our committees and have participated in the development of many of our planning processes.

In the next year, council Vice Chair Lena Franklin and I are dedicated to continuing to expand the public's participation on committees, to inviting more of the



public to attend our council meetings and planning activities, and to building collaborative partnerships with the Maryland AIDS Administration, the Maryland Community Planning Group for HIV Prevention, the Mid-Maryland Consortium and the Regional Planning Group so that our efforts to prevent the spread of HIV and our work to support the availability of the highest quality of HIV treatment and supportive services grow.

Thank you for your dedication and your hard work. I feel honored to have been elected by you and am privileged to serve as your chair.

— Debbie Rock

ABOUT THE PLANNING COUNCIL

The planning council was first established in 1991 when Baltimore became a Ryan White-eligible metropolitan area, in need of funding for HIV/AIDS services. The planning council is a 40-member body appointed by the mayor of Baltimore City. The racial makeup of the planning council is 90 percent African-American and 10 percent white. Nearly 50 percent of planning council members are persons living with HIV/AIDS (PLWH/A), 15 of whom have publicly disclosed their HIV status. The planning council sets service priorities for the allocation of Ryan White Title I funds within the EMA, develops a triennial comprehensive plan, and assesses the efficiency of the administrative mechanism in rapidly allocating funds for HIV/AIDS services.

Ryan White Title I funds paid for services for 9,488 individuals living with HIV/AIDS in the Baltimore EMA in 2002. The planning council works closely in partnership with the grantee and the administrative agency to assess service needs within the EMA and to develop a continuum of care for people living with HIV disease and for their families. The planning council assesses the effectiveness of services in meeting identified needs.

To ensure that comprehensive planning is carried out and that the needs of all HIV-infected and -affected individuals living in Maryland are identified and planned for, the planning council participates with the Maryland AIDS Administration in a statewide coordinated statement of need. This three-year plan, required by the Ryan White CARE Act, is only one of the council's collaborative activities with HIV planning and service entities. To see that services for HIV consumers are planned and coordinated, the council also

Planning Council Fast Facts

- ♦ Five of our planning council members have changed jobs in the past year.
- ♦ Six physicians served on the planning council during FY 2003.
- ♦ Thirteen of our FY 2003 planning council members are Leadership, Empowerment, Advocacy and Participation (LEAP) graduates.
- ♦ Seven of our PLWH/A members are staff at direct service provider programs.
- ♦ Four of our PLWH/A members are leaders of consumer advisory boards (CABs).



works with planners from the AIDS Administration's HIV Prevention Bureau, HealthChoice managed-care organizations and providers receiving funding from the U. S. Substance Abuse and Mental Health Services Administration.

ABOUT THE BALTIMORE EMA

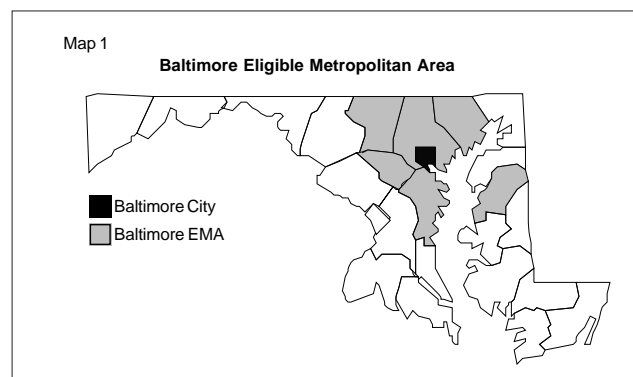
The Baltimore EMA is home to 2.5 million people, representing 48 percent of Maryland's population. The EMA consists of Baltimore City and its surrounding counties: Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's. Geographically, the region encompasses an area of 2,609 square miles.

The population density of the EMA ranges from 109 persons per square mile in Queen Anne's County to 8,039 persons per square mile in Baltimore City.

The EMA is very diverse in terms of socio-economic status, living conditions and access to care. As a whole, 67 percent of the population are Caucasian, 27 percent African-American and 5 percent other ethnicities. African-Americans make up 64 percent of the residents of Baltimore City. Poverty rates, as federally defined, vary considerably, from 4.4 percent in Howard County to 24 percent in Baltimore City.

Current HIV/AIDS surveillance data indicate that the Baltimore EMA is ranked third in the nation for AIDS cases, compared to eighth in 2000. The data also indicate that, while the number of new cases has been declining, the number of PLWH/As continues to increase in the EMA, indicating increased longevity among the previously infected. Approximately 6,000 HIV-positive clients who know their status are not in primary medical care.

The incidence of HIV continues to rise among intravenous drug users (IDUs), who are the driving force behind the epidemic in the Baltimore EMA. Epidemiological data show that HIV disease continues to have greater impact on the African-American population: African-Americans are most likely to be affected by HIV and to know about their infection status yet not seek medical care or social support services immediately. The HIV-positive homeless population is growing: data indicate that one third of the homeless population is HIV positive and as many as 49 percent of those are AIDS defined. Some of the barriers to care





for HIV-positive homeless clients are: lack of access to pre- and post-HIV testing, lack of medical insurance, unstable living situations, inaccessible service systems, competing priorities such as food and shelter, misdiagnosis and stigma or provider bias.

The Baltimore EMA is known to provide excellent primary medical care and research expertise. Fourteen primary medical sites provide care, including two pediatric primary care clinics and one adolescent clinic.

PLANNING COUNCIL ACCOMPLISHMENTS IN 2003

Following are summaries of the planning council's accomplishments for 2003.

Funding

In proportion to last year's budget, the Baltimore EMA received the largest funding increase ever in the history of Ryan White Title I funding. The 21 percent increase brings the 2003 funding total to \$21,458,791.

With input and hard work from BCHD, ABC and the planning council, the greater Baltimore EMA funding application for FY 2004 was completed and submitted to the U.S. Health Resources and Services Administration (HRSA). This annual competitive application is the means by which federal Title I grant funds are sought and then awarded. The application is reviewed and graded at the federal level on how well it explains the EMA's severe need for funding, how the EMA has used funding in the past, and what a loss of funding would mean to the HIV-positive people who depend on the services that the funds make possible.

The application is the culmination of the efforts of all Ryan White partners during the course of the fiscal year. It represents the collaboration of many people who research information, create data tables, and provide writing and editing services, all with the shared goal of creating a cohesive document that accurately represents the state of the HIV epidemic in the EMA. The document synthesizes epidemiological data from the state of Maryland, statistical data from the U.S. Centers for Disease Control and Prevention (CDC) and data on other funding streams to make the compelling case that the Baltimore EMA needs Ryan White Title I funds because of the complexity of the EMA's particular HIV epidemic.

The application was submitted in October 2003; the announcement of awards is expected in January 2004. The planning council's hope is that as a result of all of our efforts, the EMA will repeat this year's success by again being awarded a significant increase in funding.

This year, the Baltimore EMA received the largest proportional funding increase ever in the history of Ryan White Title I funding.



Planning

In 2003, for the first time, the planning council planned for three grant award contingencies for FY 2004. Allocations of funds were projected based on decreased, level and increased funding. The decision to plan for multiple contingencies was a reaction to serious discussion in Congress of a reduction in Ryan White funding; the planning council had to be prepared for the possibility of a funding decrease. However, the fact that historically the Baltimore EMA has received funding increases made increased funding a reasonable contingency too. And even if the award were the same as the previous year, the planning council could not assume that the Baltimore EMA's needs were the same; level funding would require as much planning as a change in funding.

To assist with planning for each of the three contingencies, the planning council and its work groups — with input from the grantee and the administrative agency — guided the support office's development of a performance-based scoring matrix for 26 HIV / AIDS service categories in the EMA. The matrix provided a way for the planning council and the administrative agency to assess and score the performance and achievement not only of each service category as a whole, but also, for the first time, of the providers in each service category. The ability to compare the data at that level of detail gave the planning council more flexibility in deciding how to allocate funds across and within categories.

The planning council's hope is that the EMA will repeat this year's success by again being awarded a significant funding increase in FY 2004.

The planning council used the matrix scores during the 2003 priority setting and allocations process for FY 2004; the administrative agency will continue to use the matrix throughout the year to assess EMA service providers.

The planning council completed the assessment of the administrative mechanism, a task required by the Ryan White CARE Act, to ensure that funds are getting to the communities and populations most impacted by the epidemic. This year, the planning council completed the assessment using a new tool — the Baltimore EMA version of the Sacramento planning council's assessment tool. Adapting the tool for use in the Baltimore EMA required the collaboration and hard work of the planning council and the administrative agency: the group tasked with modifying the tool met at least a dozen times in a three-month period. The group had to be sure that the tool reflected the way that services are delivered in the Baltimore EMA, accounting for the fact that administrative responsibilities are divided between two agencies, BCHD and ABC, both of which needed to be assessed.

Priority Setting

The Baltimore EMA and counties priority-setting conferences were organized by the IGS planning council support office under the direction of the council. Activities at both the EMA and counties priority-setting conferences resulted in

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the establishment of service category rankings and funding allocations for each ranked service and formed the basis of the projected service continuum for FY 2004.

The Baltimore EMA-level priority setting and allocations process took place over two days in August 2003. Underscoring the importance of the planning council's work to Baltimore City, Mayor Martin O'Malley and Baltimore City Council President Sheila Dixon attended the first day of the conference. Mayor O'Malley talked about the problem of substance abuse in Baltimore City and its role in the HIV epidemic, while President Dixon spoke on the work of the Baltimore City Council Commission on HIV/AIDS Prevention and Treatment.

On the second day of the conference, Lieutenant Governor Michael Steele, the first statewide elected official to attend a planning council event, addressed the planning council and other conference attendees. Lieutenant Governor Steele spoke about a recent *Washington Post* article about African-American men on the "down low," a term used to describe men who do not consider themselves to be gay or bisexual yet who have sex — often unprotected — with other men. These men do not tell their wives or girlfriends about their behavior, which puts the women at increased risk for HIV. In fact, a 2001 report by the CDC identified these men as greatly impacting the transmission of HIV to heterosexual women, particularly women of color. The lieutenant governor's comments at the priority setting informed the scope of the council's African-American Men's Health Survey, which will be completed in early 2004.

A quorum of planning council members was in attendance on both days of the EMA-level conference. Only those members attending both days were eligible to vote on service rankings and allocations. Prior to determining the priorities and allocations, the planning council required those eligible members to review all data presented to them impacting the provision of services. Eligible members had to justify their decisions by identifying the sources of information used to make those decisions.

On the first day, more data were presented to the council, including: data on trends in HIV therapy, the most recent epidemiological data for the EMA, data on new HIV testing methodology and its impact on identifying new HIV-positive clients and bringing them into care sooner, service and expenditure information from the past year, data on the homeless population, demographics for those



Photo: Cornelia Thomas, Jr.

Mayor Martin O'Malley and planning council Chair Debbie Rock at the August 2003 priority-setting conference.



receiving services and other data on the needs of the HIV consumers.

Following the data presentations, service categories were ranked. With the rise in the number of people living with HIV and the number of clients living longer through the use of highly active antiretroviral therapy (HAART) and new medications, it is no surprise that primary/ambulatory medical care was again rated the top ranked service priority with the highest percentage of award for FY 2004 (25.06 percent of service dollars). Substance-abuse treatment also continues to be a high priority for the planning council: it was once again ranked number two on the service category list. All three subcategories under the category of substance-abuse treatment (SAT-outpatient, SAT-residential and SAT-alternative therapy) received increased funding in this year's priority allocations process.

The results of the ranking were immediately provided to the planning council members to be used for the allocation process. A performance-based matrix

scoring of all the service categories was also provided to guide decisions on allocations based on an assumption of decreased funding.

On the second day, allocation exercises took place for, first, level and, second, increased funding in FY 2004. Each service category was discussed and a dollar-amount allocation selected. The dollar amount allocated to each service category was later converted to a percentage allocation and presented to the planning body for final approval. This process enabled planning council members to see the allocations in dollars planned, percentages planned and percentages remaining to be planned. This process was adopted for all three contingencies — decreased, level and increased funding — until all funds were accounted for in all service categories that received funding.



Photo: Cornell Thomas, Jr.

Lieutenant Governor Michael Steele with planning council Chair Debbie Rock during the second day of priority setting.



Photo: D. P. Munn

City Council President Sheila Dixon with Joseph Boyd, ABC senior accountant, during priority setting.



Training

The planning council instituted ongoing training, through a series of presentations, on topics that impact the planning process, such as medical trends and outcomes, expenditure service delivery reports and narratives, epidemiological and unduplicated client data, treatment adherence, needs-assessment data, summary information of each service category, capacity building and community education reports, committee directives, and client services continuum data.

Each of the presentations was intended to provide council members with in-depth information to aid them in planning. For example, ABC conducted training on the services provided under each HIV-funded service category in the EMA, while IGS staff trained new planning council members and Counties Committee members in preparation for priority setting.

In April 2003, the council's priority-setting work group, under the auspices of the Comprehensive Planning Committee, took the recommendations of council members and developed a training curriculum to help fellow members plan for funding the most needed services for people living with HIV and AIDS in the EMA. As directed by the work group, the IGS planning council support office developed a priority-setting training manual.

The planning council instituted ongoing training on topics that impact the planning process. Presentations on each topic are intended to provide council members with in-depth information to aid them in planning.

Quality Improvement

BCHD's quality-improvement program (QIP) involves activities aimed at determining whether, or how well, service providers have met the minimum standards of care within the EMA. BCHD conducts site visits to providers' establishments, and BCHD staff or consultants review samples of client charts to determine compliance with current standards of care for the Baltimore EMA. BCHD has conducted QIP reviews for primary medical care, primary medical care (co-morbidity), case management, treatment adherence, substance-abuse treatment services, mental health (children and adolescents), mental health (adults), and client advocacy. The reports from these reviews proved useful as planning tools in a number of planning council committee meetings in 2003.

The IGS planning council support office had its site visit from BCHD, the grantee, in November. The site visit was very successful, with the site visit team making only one or two very minor suggestions and going out of its way to compliment the professionalism of the support office staff.

Needs Assessment

The planning council successfully organized a counties community forum and conducted focus group surveys to find out why people who know their



HIV/AIDS status are not in care. The data gathered provided the council with an understanding of the needs of the various HIV communities as they planned for services. Additionally, due to the large number of needs-assessment activities conducted by the planning council each year, the council made a strategic decision to create a stand-alone committee from the needs assessment work group under the Comprehensive Planning Committee. The new Needs Assessment Committee has already started addressing the processes for collecting needs-assessment data, including unmet need for FY 2004.

Membership

The planning council met all its CARE Act-required reflectiveness targets. Reflectiveness means that the racial/ethnic and gender demographics of the council mirror the demographics of the HIV epidemic. For the fourth year since this condition of grant award was instituted by HRSA, the council has exceeded its requirement that at least 80 percent of its membership reflect the populations most affected locally.

COMMITTEE ACCOMPLISHMENTS IN 2003

Following are highlights of the accomplishments of each of the planning council's committees.

By-laws Committee

The By-laws Committee reviewed the by-laws that govern the planning council and developed committee membership criteria.

Comprehensive Planning Committee

The Comprehensive Planning Committee's needs-assessment work group was expanded into a separate, stand-alone committee. As a result, the Comprehensive Planning Committee and the new Needs Assessment Committee worked to clarify and delineate their different responsibilities and activities.

In the early part of the year, the Comprehensive Planning Committee's priority-setting work group reviewed the ground rules and processes that were later used to make the 2003 priority-setting activities more efficient. Additionally, to assist planning council members in participating at the 2003 priority-setting process, the priority-setting work group recommended mandatory priority-setting training. The priority-setting work group also dedicated July's planning council meeting for data presentation to all planning council

Due to the number of needs-assessment activities each year, the planning council made a strategic decision to create a Needs Assessment Committee.



members to allow more time for deliberations and analysis of information before voting on funding.

The committee's Minority AIDS Initiative (MAI)/carryover work group planned for carryover in the amount of \$769,944 (FY 2002 to FY 2003).

The committee developed directives for capacity building and community education, and is currently reviewing the goals and objectives in the comprehensive plan.

Counties Committee

The Counties Committee increased its number of consumer members from 5 to 12. The committee also improved dialogue between providers and consumers. Providers have begun to share their knowledge of services and issues at the meetings with other committee members, which is vital within the committee for better planning for services for HIV-positive clients in the counties.

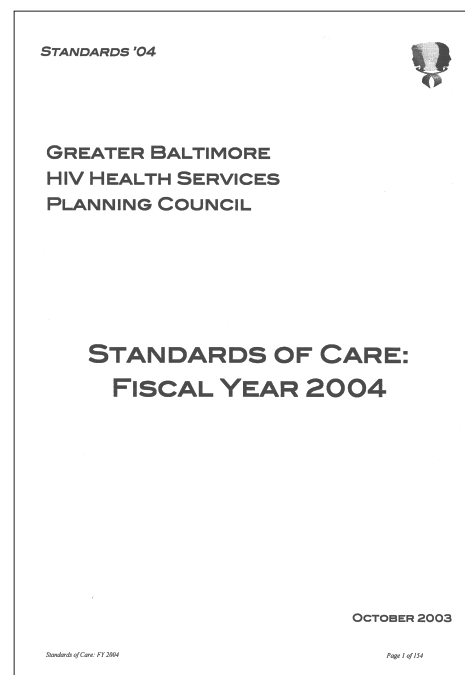
Evaluation Committee

The Evaluation Committee developed a new tool and process for evaluating the administrative mechanism. The committee adapted the assessment tool used by the Sacramento planning council to measure service delivery in the Baltimore EMA. The Sacramento tool had been identified by HRSA as an excellent model at the All Titles Conference in Washington, D.C. in 2002.

Health Services Committee

The Health Services Committee incorporated the BCHD QIP recommendations into the standards for primary medical care. The committee also developed standards for drug reimbursement, substance abuse and primary medical care (co-morbidity). In addition, the committee oversaw the publishing by the support office of a revised standards manual, *Standards of Care: Fiscal Year 2004*, in October.

The committee developed directives that were forwarded to the administrative agency for incorporation into the FY 2004 Title I funding application.



The cover of the recently revised Standards of Care: Fiscal Year 2004 manual.



Nominating Committee

The Nominating Committee worked diligently throughout the year to recruit, interview and nominate members to the planning council. For the third consecutive year, the planning council has been able to retain 33 percent of its membership from the non-affiliated PLWH/A community. This means that one third of the council's membership is made up of Title I consumers who have no relationship with Title I providers (other than receiving services).

PLWH/A Committee

The PLWH/A Committee is instrumental in recruiting members for the planning council and its committees. As active participants in all planning council committee meetings, the PLWH/A committee membership has assisted with focus groups, community forums, task groups and recruitment of 25 percent of planning council members and 35 percent of committee members.

The committee drafted three position papers, which included issues affecting HIV clients and service delivery: "Impact of Funding Reduction," "Challenges in Changing and Revising Case Management" and "Community Education: How to Educate the Community about HIV Services." These position papers have been distributed to all planning council committees with the goal of helping those committees consider ideas from the HIV-positive community when discussing issues.

Support Services Committee

The Support Services Committee reviewed standards for case management, buddy/companion services, enriched life skills, legal services, nutritional counseling and psychosocial support services. The committee also incorporated the QIP recommendations in the case management standards.

COLLABORATION ACTIVITIES IN 2003

With the collaboration of BCHD, ABC, IGS planning council support staff and the Evaluation Committee, the Sacramento planning council's assessment tool was adapted to measure service delivery in the Baltimore EMA. The new tool was used to conduct the assessment of the administrative mechanism. The assessment questionnaire was used to assess the procurement process, fiscal monitoring, tracking systems, contract development, allocations and priority setting, communication reporting, barriers and concerns, timeliness, and flexibility of the administrative mechanism in implementing the mandates of the Ryan White CARE Act. The assessment data also included results of a survey of providers regarding the



Photo: D. P. Manno

Partnership in action: Baltimore City Health Commissioner Peter Beilenson and planning council Chair Debbie Rock.

request-for-proposals (RFP) process, the contracting process, monitoring and site visits. Both BCHD and ABC scored very high marks when assessed.

As a result of joint efforts between BCHD, ABC and the IGS planning council support office, a carry-over request application was submitted to HRSA so that an additional \$769,644 was available in 2003 for special projects or to expand services to serve newly diagnosed HIV-infected individuals. Use of carryover dollars was planned for projects in primary medical care capacity building, primary medical care community education, short-term emergency housing, substance-abuse treatment for services to surrounding counties and substance-abuse treatment for Baltimore City residents.

With collaborative efforts from the council and ABC, all Ryan White Title I funds were allocated for service priorities established by the planning council.

With input from BCHD and ABC, and under the auspices of the council, the planning council support office organized very successful EMA and counties priority-setting conferences. Representatives from BCHD, the state AIDS Administration and ABC provided data for the three contingency scoring matrices that had been developed by the planning council to determine allocations of funds during priority setting. The Counties Committee members stated that August 2003's priority setting was the best ever.

A carryover request application was submitted to HRSA so that an additional \$769,644 was available in 2003 for special projects or to expand services.

Due to improved communication between BCHD, ABC and the planning council support office, the committees received timely feedback on reports and issues discussed at meetings, which helped them plan and evaluate service delivery in the Baltimore EMA.

In addition to collaborating with BCHD, ABC and IGS, the planning council collaborates with numerous other agencies, organizations, and institutions. A partial list of the council's other collaborative partners are: the Baltimore City Council's Commission on HIV/AIDS; the University of Maryland; the AIDS Administration's AIDS Resource Center for Epidemiology & Health Services Research; Johns Hopkins University; the Office of Congressman Elijah E. Cummings on the Maryland Partners United to Stop HIV (PUSH) initiative; and the Maryland Pharmacy Association. For research expertise, the planning council

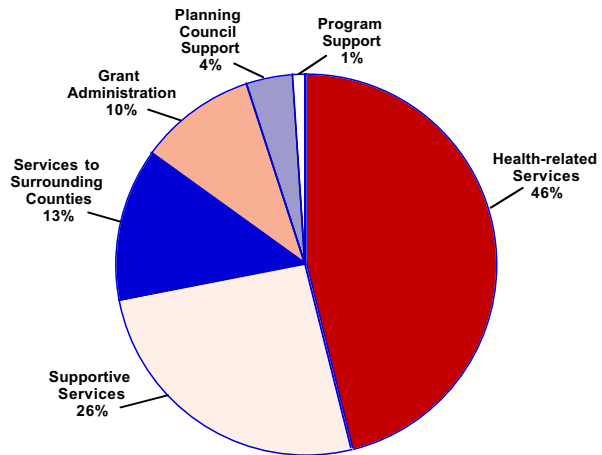


has relied on AIDS Administration epidemiological and unmet needs data presented at the priority setting; Housing Opportunities for Persons With AIDS (HOPWA); individuals receiving and administering funds through Titles II, III and IV of the Ryan White CARE Act; Medicaid; the Veterans Administration; the Deaf AIDS Project; the Prisoner's Aid Association of Maryland; and our provider partners who lent their expertise to revise the standards manual, *Standards of Care: Fiscal Year 2004*.

FUNDED SERVICES: 2003

To the right are the percentage allocations for FY 2003, as submitted by the Baltimore EMA for FY 2004 in the HRSA application. The total sum from which these categories are reported as shares is \$21,458,791, of which \$1,997,668 are MAI dollars. The total sum does not include carryover dollars from FY 2002.

Percentage Allocations for Services Funded in FY 2003



Source: Associated Black Charities, Inc. 2003. The Ryan White Comprehensive AIDS Resource Emergency Act: Title I HIV Emergency Relief Grant Program. Baltimore, Md.: ABC, Table 11.

OTHER NEWS FROM 2003

The planning council revised the by-laws that govern it by establishing criteria for committee membership for people who are not serving on the council.

In an effort to support the availability of excellent HIV/AIDS services in the EMA, the planning council invited 16 experts from the community, such as social workers, case managers, and physicians, to participate in revising and developing the standards of care for some service categories to meet higher standards of professionalism that will be applicable to service delivery.



As part of its commitment to provide support to the planning council, the council's support staff at IGS:

- ♦ Launched a planning council recruitment campaign on March 1, 2003.
- ♦ Participated in a Radio One People's Expo to distribute information on HIV/AIDS and planning council functions.
- ♦ Launched the first radio scripts of HIV/AIDS messages for FY 2003, which aired in the Baltimore EMA on Radio One, Magic 95.9 and Heaven 600 throughout the year. Planning council members (particularly Lennie Green) and planning council support staff (particularly Nicole Curtis) participated in crafting the scripts and lending their voices. The final radio script aired November 24 through December 1, 2003.
- ♦ Conducted two needs assessments: for BCHD, IGS researched the needs of buddy/companion program clients; for ABC, IGS researched the needs of deaf people with HIV.

In addition to these accomplishments, members of the IGS planning council support office were invited to Douglas Memorial Baptist Church and Heaven 600 to educate the community about the HIV epidemic and the roles and responsibilities of the planning council.

ON THE HORIZON FOR 2004

The Comprehensive Planning Committee will review and make adjustments to the *Comprehensive Plan for HIV Service Delivery* in the Baltimore EMA. For the next three years, the committee will continue to make changes to the plan, as new or more accurate information about the epidemic requires different planning strategies.

The planning council continues to recruit and retain members, guided by the reauthorization of the Ryan White CARE Act. It is essential to maintain the expertise necessary to carry out the activities needed for effective planning.

Planning council committee work plans, work products and deliverables will be developed to ensure that the CARE Act requirements and supportive activities are carried out and that the work of the council moves forward.

The planning council and its partners will collaborate with the AIDS Administration for the assessment of unmet need in the EMA.

The EMA-wide consumer survey will be completed and made available in FY 2004. The survey seeks to identify service gaps and barriers to care and determine met and unmet service needs.



In collaboration with its partner, BCHD, the council will continue to integrate data from the BCHD QIP into planning. The QIP will provide evaluation for the service delivery system and identify gaps, weaknesses or non-compliance with federal or local health supportive-service guidelines. Through the process of problem identification and corrective action, the overall service system for HIV-positive clients will be enhanced and improved.

The planning council will integrate the 2003 CDC prevention initiative, *Advancing HIV Prevention*, into its planning.

The EMA-wide consumer survey will be completed and made available in FY 2004. The consumer survey is a needs-assessment tool designed to determine the HIV services needs and access barriers of PLWH/As in the Baltimore EMA. The primary objective of the consumer survey is to provide the planning council with credible and sufficient data to inform their priority setting and fund allocation decisions. The consumer survey seeks to identify service gaps and barriers to care and determine the met and unmet service needs. Conducting the survey involves designing the survey instrument, recruiting and interviewing respondents, training providers and community participants on survey interviewing techniques, entering survey data in a database, and analyzing and reporting the results.

The planning council will continue to secure reliable data for making planning decisions. Until a reliable client-level data management system is in place that tracks clients' services across the system, there are some limits to the reliability of the planning data.

The methodology for allocating planning council funds during priority setting will continue to be reviewed as additional data become available.

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Planning council Chair Debbie Rock with
BCHD Assistant Commissioner of Health
Pierre Vigilance.

Photo: D. P. Marino

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Most of all, the planning council would like to thank all its committee members and volunteers who offer their time and expertise in making the planning process for HIV services in the Baltimore EMA a successful one. Thank you.

GREATER BALTIMORE HIV HEALTH SERVICES PLANNING COUNCIL

To provide comprehensive, high-quality services to people living with the HIV disease in the greater Baltimore eligible metropolitan area regardless of their ability to pay.

To plan for and ensure access to culturally sensitive, high quality, cost-effective services in collaboration with local authorities, service providers and consumers of HIV prevention and care services. This system includes a plan to expand capacity, as well as monitor and evaluate services.

The planning council and its advisors will act in a timely and unbiased manner when setting priorities to allocate resources.

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