



Greater Baltimore HIV  
Health Services Planning  
Council

**ANNUAL  
REPORT**

December 2004



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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 faced many challenges and achieved many successes during 2004. Among them were:

- Successfully managing and implementing programs and services, despite receiving the first funding reduction in the history of the Baltimore EMA. For fiscal year (FY) 2004, the EMA was awarded \$19,710,879 (including Minority AIDS Initiative funds), which is more than eight percent less than the FY 2003 award of \$21,458,791. Because the planning council had had the foresight to plan for the possibilities of increased, level, and decreased funding at its FY 2004 priority-setting conferences in summer 2003, the impact of the funding reduction was minimized. The EMA also planned for \$1,034,127 in FY 2003 to FY 2004 carryover funds.
- Organizing successful EMA and counties priority-setting conferences that continued the forward-thinking and beneficial strategy of planning for three different grant award outcomes.
- Designing and carrying out through its support staff one of the largest face-to-face consumer surveys in the nation. The Needs Assessment Committee designed the survey instrument, helped develop the process for administering the surveys and participated in the analysis of the survey data. Over 600 interviews were conducted throughout the EMA. The data gathered from this survey were used to help the planning council establish its service rankings and allocations for FY 2005.

- Continuing the reviews of service-category standards for HIV/AIDS services in the Baltimore EMA by the Health Services and Support Services committees following submission of the quality improvement program reports from the Baltimore City Health Department.
- Increasing participation of members of the HIV-infected and -affected community at all committee meetings and planning council meetings. Fifty percent of the planning council standing committees are chaired or co-chaired by people living with HIV or AIDS (PLWH/As). The planning council continues to meet and exceed its racial/ethnic reflectiveness and non-conflicted PLWH/A membership requirements.
- Developing a successful process for addressing a new U.S. Health Resources and Services Administration (HRSA) requirement that the planning council report any vacancy in its membership within 30 days. The new council process, created by the Nominating Committee, is called the “pool list.” It allows the council to approve applicants in advance of a vacancy and send the applicants’ names to the mayor in an expeditious manner.
- Carrying out successful elections for the chair and vice chair of the planning council, as well as chair and six members of the Nominating Committee.

## PLANNING COUNCIL MEMBERS

(AS OF SEPTEMBER 1, 2004)

Debbie Rock, <i>Chair</i>	Jeffrey Powell, <i>Vice Chair*</i>
Kate Allston	Sophia Jones
Sheila Ashley	Willislee B. Jones
Wanda Belle	Jean Keller
Dale Brewer	Daphne Lane
Herman Carter	Donald Maynor
Laurence Chapman	Wendy Merrick
Tracey Chunn	William Miller
Markton Cole	Michael Obiefune
Lynn Creditt	Ann Price
Steven Dashiell	Melanie Reese
Iris Davis	Jerry Rice
Betty Flint	Brenda Ross
Bryna Grant	Walter Samuel
Michael Graves	Alfredo Santiago
Tyrone Gray	Raymond Shattuck
Nancy Guest	Carnell Thomas, Jr.
Phyllis Hall	Bernice Tucker
Michelle Holloway	Pierre Vigilance
Loulinda House	David Waller

\* elected vice president on November 16, 2004

## MESSAGE FROM THE PLANNING COUNCIL CHAIR



Photo: Carnell Thomas, Jr.

*Planning council  
Chair Debbie Rock.*

We have come to the end of another successful year for the Greater Baltimore HIV Health Services Planning Council. There were unanticipated challenges for us this year. Nevertheless, the planning council members and the other volunteer committee members met the challenges.

For the past two priority settings, we have planned for level funding, as well as for funding increases and decreases. Although we were ready for it, this year's funding decrease still tested our planning processes and our service delivery system. We continue to hope for additional funds in FY 2005, yet we as planners recognize that numerous entities — nationally and internationally — are competing for funds. And because an increase in total CARE Act funding would not guarantee that our EMA would receive increased or level funding next year, it is critical that we continue to plan carefully as we make our voices heard about this important legislation.

Further complicating the situation, the CARE Act is due to be reauthorized this coming year, 2005. Although we have many allies and friends in Congress, many senators and congressmen and -women are not optimally informed about HIV and the importance of the CARE Act. The planning council as a body cannot lobby Congress for additional funding, but each of us who is knowledgeable about HIV/AIDS can make sure that our senators and congressmen and -women hear the facts about HIV in the Baltimore EMA.

As the epidemic continues to grow in our area, the planning council must be creative with its planning. We need to re-examine our systems and processes to ensure that we are effectively using our limited grant funds. We must use our intelligence and skill to continuously build a better service-delivery system. Our system must address those that have the greatest needs and the fewest resources.

Strategies such as self-management training for consumers and providers, or shifting our service-delivery system to a chronic-care model of treatment, must be part of our discussion and planning. We need to continuously evaluate our systems to make sure that they are as efficient and effective as possible. We need to bring into our partnership circle more service providers who are not funded by the Ryan White CARE Act but who work with our same consumer populations. These collaborations will benefit our consumers, improve the quality of life of the entire greater Baltimore community, and ensure that more HIV-positive individuals and those at risk of infection receive information that can change their lives.

Providers must continually renew their commitment to offering the highest standards of service by building into their programs an ongoing evaluation and quality improvement program. Consumers must take responsibility for working with providers to ensure that services are being used most effectively and for those with greatest needs.

The planning council has always been an agent for change. We are a dynamic, evolving entity, relying on each member, whether appointed by the mayor or volunteering on a committee, to keep faith with the mission while vigorously advocating for those who have great needs but cannot speak up for themselves.

Peace and blessings,  
*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 82.5 percent African-American, 15 percent white and 2.5 percent Hispanic/Latino. Nearly 50 percent of planning council members are PLWH/As, 7 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 10,572 individuals living with HIV/AIDS in the Baltimore EMA in 2003, a 9 percent increase over the number of individuals served the previous year. 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

### **PLANNING COUNCIL FAST FACTS**

- *Six physicians served on the planning council during FY 2004.*
- *Eleven of our FY 2004 planning council members are Leadership, Empowerment, Advocacy and Participation (LEAP) graduates.*
- *One of our planning council members got married in the past year.*
- *Three planning council members are pursuing academic degrees while serving on the planning council.*
- *Eleven PLWH/As have been elected to leadership positions for the planning council and its committees.*
- *Four committees are co-chaired by individuals who are not appointed members of the planning council.*
- *Forty percent of planning council members are non-aligned PLWH/As.*

their families. The grantee is the Baltimore City Health Department (BCHD). BCHD interprets and applies HRSA policy and directives, develops and carries out the quality improvement program (QIP), and oversees and monitors the planning council support and administrative agency contracts. The administrative agency is Associated Black Charities (ABC). Among its many responsibilities, ABC distributes funds in accordance with the planning council's priorities, provides the planning council with the information it needs for planning and to accomplish assessment and evaluation tasks, and establishes and monitors contracts with providers.

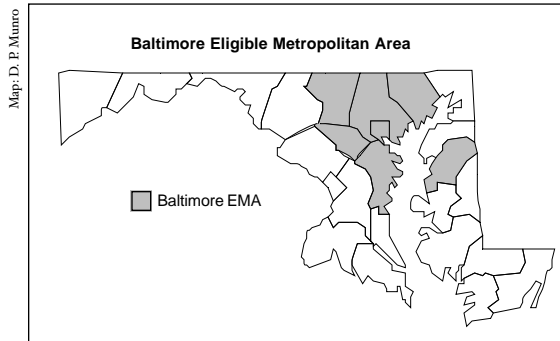
To ensure that comprehensive planning is carried out and that the needs of all HIV-infected and -affected individuals living in Maryland are identified and planned for, the planning council participates with the Maryland AIDS Administration in a statewide coordinated statement of need. This three-year 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 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 EMA is very diverse in terms of socio-economic status, living conditions and access to care. As a whole, 68 percent of the population are Caucasian, 25 percent African-American and 7 percent other ethnicities. African-Americans make up 65

percent of the residents of Baltimore City. Poverty rates, as federally defined, vary considerably, from 3.5 percent in Carroll County to 23 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. It is

estimated that over 8,000 HIV-positive clients in the EMA know their status but are not in primary medical care. Helping these clients access care is one of the most significant challenges that this EMA continues to face.

The incidence of HIV continues to rise among intravenous drug users (IDUs), whose behaviors are the primary means of transmission in the Baltimore EMA.

Epidemiological data also show that HIV disease continues to have greater impact on the African-American population: 85 percent of the EMA's PLWH/As are African-American. The HIV-positive homeless population continues to grow: 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. Fifteen primary medical sites provide care, including two pediatric primary care clinics and one adolescent clinic.

## PLANNING COUNCIL ACCOMPLISHMENTS IN 2004

Following are summaries of the planning council's accomplishments for 2004.

### FUNDING

For the first time in the history of Ryan White Title I funding in Maryland, the Baltimore EMA received a funding decrease. In proportion to last year's budget, the EMA's funding was cut by just over eight percent, which brought the 2004 funding total to \$19,710,879, down from \$21,458,791 last year. Although the decrease was disappointing, the planning council was proud of the work it had done during its FY 2004 priority-setting conferences to plan and prepare for just such a decrease. Because of the council's efforts, service continuity was maintained throughout the EMA.

With input and hard work from BCHD, ABC and the planning council, the Baltimore EMA funding application for FY 2005 was completed and submitted to 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 rep-

resents the state of the HIV epidemic in the EMA. The document synthesizes epidemiological data from 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 November 2004; the announcement of awards is expected in January 2005. The planning council's hope is that as a result of all of our efforts, the EMA will not experience another decrease in funding.

Photo: D. P. Munro



*Baltimore City Health Commissioner Peter L. Beilenson, M.D., discusses some of the planning challenges in the Baltimore EMA.*

#### 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 the establishment of service category rankings and funding allocations for each ranked service and formed the basis of the projected service continuum for FY 2005.

Once again, the council planned for three grant award contingencies. Although the Baltimore EMA has typically received funding increases, it was this multiple contingency process that prepared the planning council and the EMA to successfully weather the eight percent decrease received in FY 2004. For that reason, the council once again projected funding allocations based on decreased, level and increased funding.

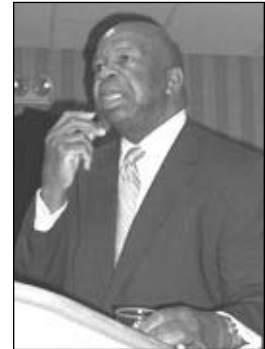


Photo: D. P. Munro

*The Honorable Elijah E. Cummings, U.S. representative, addresses planners at the 2004 priority-setting conference.*



Photo: D. P. Munro

*Planning council Chair Debbie Rock introduces Renee Cohen from the office of U.S. Representative Benjamin E. Cardin.*

The EMA-level priority setting and allocations process took place over two days in late July and early August 2004. Underscoring the importance of the planning council's work to the entire state of Maryland, several local and national policy makers were present to address the planning council and other conference attendees, including the Honorable Elijah E. Cummings, U.S. representative; Renee Cohen from the office of U.S. representative Benjamin L. Cardin; Dr. Peter L. Beilenson, Baltimore City health commissioner; Wanda Watts, director of community outreach for the office of the Honorable Sheila Dixon, City Council

president; and Terry T. Brown, co-chair of the Baltimore City Council Commission on HIV/AIDS Prevention and Treatment.

A variety of data had been presented to the planning council members during the July meeting of the full council. Additional data were presented to them on the first day of the conference, including data on service utilization for 2003 and the results of the 2004 consumer needs-assessment survey. The data presentations were critical because during voting, members would be asked to justify their decisions by identifying the sources of data they used to make those decisions.

Following the data presentations, voting on service category priorities took place. A quorum of planning council members was in attendance on both days of the



Photo: D. P. Munro

*A planning council member fills out a ballot during the 2004 priority-setting conference.*

EMA-level conference, and only those members who were present on both days were eligible to vote on service priorities and allocations.

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 2005. Substance-abuse treatment continues to be a high priority for the planning council: it was once again ranked number two on the service category list.

The results of the ranking vote were immediately provided to the planning council members to be used for the FY 2005 allocation exercises. During the exercises, each service category was discussed and a hypothetical 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.

The planners' hard work at the conference was recognized in a lengthy article in the August 11, 2004 issue of Baltimore's *City Paper*. The article, by Rebecca Alvania, detailed the "excruciating but highly charged" process that is voting on service priorities and funding allocations and acknowledged the many people throughout the EMA's political and health-care systems who are working to ensure that the region's PLWH/As receive the care that they need.



Photo: D. P. Munro

*Planning council Program Manager Kate Hale, and Darrell Wheeler, conference facilitator, strategize during the 2004 priority-setting conference.*

### QUALITY IMPROVEMENT

BCHD's quality-improvement program involves activities aimed at determining whether, or how well, service providers have met the minimum standards of care within the EMA. In FY 2004, BCHE conducted QIP reviews of the housing assistance, psychosocial counseling, oral health and outreach service categories.

### NEEDS ASSESSMENT

The planning council, with the guidance of the Needs Assessment Committee and the support of IGS, designed and carried out one of the largest interviewer-administered consumer surveys in the country. Over 600 interviews were conducted with PLWH/As to determine what their health care and service needs are and what barriers prevent them from receiving those services. Because of the way the data were collected, the planning council was also able to extract service priority rankings from the consumers' perspectives.

After reviewing the results of the survey, the Needs Assessment Committee has identified three avenues of additional research, and has applied for and received carryover funds to conduct three follow-up needs assessment studies. The results of those studies will be presented at the FY 2006 priority-setting conferences. More information about the outstanding efforts of the Needs Assessment Committee and the collaborative process they used to manage and implement the survey project is in the section, "Collaboration Activities in 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 in the EMA. For the fifth 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 2004

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

### BY-LAWS COMMITTEE

The By-laws Committee met and reviewed the by-laws and made changes that brought them in line with the HRSA requirement to include information about filing grievances.

The committee has been working to have the by-laws and grievance policy reviewed by an independent source to ensure that the content is appropriate and sufficient.

### COMPREHENSIVE PLANNING COMMITTEE

The Comprehensive Planning Committee took on a new task this year: it developed a format and process for completing directives from all planning council activities. The format, developed with input from the grantee and the administrative agency, includes: the directive's category, a brief statement of the issue or problem the directive intends to address, goals and/or objectives for the directive, the directive statement, the entity responsible for carrying out the directive, a schedule for reporting on the directive's progress, and the approximate cost of carrying out the directive in either in dollars or time.

The committee has begun the process of gathering information on trends, issues, barriers and strategies that will comprise the key chapter in the *Comprehensive Plan for HIV Service Delivery: Baltimore EMA 2006 – 2008*.

#### **EVALUATION COMMITTEE**

The Evaluation Committee completed revision of an assessment tool for the grantee, BCHD, and continued using the original tool to assess the administrative agency, ABC. Although data gathering was delayed due to changes within the AA (i.e., the administrative agency), the committee was able to complete its assessments of both the grantee and the AA by the extended due date.

The committee oversaw the expenditure and performance reports submitted by the AA and worked with the grantee and the AA to clarify the narrative portions to make them more useful to the planners.

#### **GRIEVANCE/CONFLICT OF INTEREST COMMITTEE**

The By-laws Committee is overseeing this committee's function, which is the development of grievance and conflict-of-interest policies. The By-laws Committee incorporated the grievance policy into the by-laws with the approval of the planning council.

#### **HEALTH SERVICES COMMITTEE**

The Health Services Committee reasserted its recommendation to screen for syphilis twice a year among the three population groups that have shown an increase in cases over the past two years, these being women between the ages of 15 and 25, sex workers and men who have sex with men (MSM).

The committee has revised the standards for oral health, primary care (pediatric), and mental-health services (children and adolescents), and is in the process of reviewing standards for mental-health services (adults).

#### **NEEDS ASSESSMENT COMMITTEE**

The Needs Assessment Committee helped design and carry out one of the largest face-to-face consumer surveys in the nation. For more information about this major accomplishment, see the next section, "Collaboration Activities in 2004."

### NOMINATING COMMITTEE

The Nominating Committee has continued to proactively recruit members for the planning council and for committees. The committee revised its screening tool and presented it to the council for approval.

With the FY 2004 grant award, HRSA introduced a requirement that the planning council report any vacancy in its membership within 30 days. The Nominating Committee has addressed this requirement by creating a process for filling council vacancies expeditiously. The process, called the “pool list,” allows the council to approve applicants in advance of a vacancy. The committee screens all applications as they are received and makes recommendations to the planning council for approval of qualified candidates even if there is no vacancy at the time of the application. The committee then adds approved candidates to the pool list until an appropriate seat becomes vacant.

*THE NOMINATING COMMITTEE HAS CREATED A FORWARD-THINKING TOOL CALLED THE POOL LIST, WHICH HELPS ENSURE THAT VACANT PLANNING COUNCIL SEATS ARE FILLED QUICKLY.*

### PLWH/A COMMITTEE

The PLWH/A Committee has completed two position papers this year — one about stigma and one about transportation. These position papers help PLWH/As as they participate in many activities of the planning council. They present issues and strategies to address problems so that, during discussions, the position of the HIV-infected community can be readily represented.

The committee has worked with staff from ABC’s Institute for Community Capacity Building and Community Education to complete a project to address gaps in basic knowledge about HIV disease. The project places video monitors and videotapes in targeted locations that serve the HIV-positive community or communities at high risk. The videotapes, which will be played for members of high-risk populations, contain educational information about HIV transmission and care. The facilities that receive the monitors and videotapes will perform pre-

and post-implementation testing to capture data about the effectiveness of this strategy in helping to inform HIV-positive individuals about seeking care.

#### **SERVICES TO SURROUNDING COUNTIES COMMITTEE**

The Services to Surrounding Counties Committee held a very successful priority-setting event. It planned for three possible grant award outcomes: a funding decrease, level funding and a funding increase. This type of contingency planning last year helped ensure continuation of services when the EMA received a funding decrease for FY 2004.

The committee also completed the first phase of its examination of the continuum of services available to county residents who are seeking substance-abuse treatment. As a result of its examination, the residential programs that serve Title I consumers are now open to residents of the entire EMA.

#### **SUPPORT SERVICES**

The Support Services Committee completed a review of the service standards for client advocacy. Currently, the committee is reviewing the service standards for housing assistance.

The committee also reviewed all the goals and objectives in the current comprehensive plan. It evaluated whether: 1) the goals had been met, 2) the objectives and strategies for the future needed to be revised and 3) whether there were new issues that needed to be identified for 2005 in an addendum to the plan.

## COLLABORATION ACTIVITIES IN 2004

The planning council cannot complete its work successfully without the assistance of its partners, the Baltimore City Health Department and Associated Black Charities. Although the council, the grantee and the administrative agent each have legislatively defined responsibilities, it is the interactive relationships among these three entities that ensure that the requirements of the Ryan White CARE Act are met.

Each year at priority setting, the planning council draws extensively on individuals with special expertise to present information about trends and issues for the direct service categories. It also works with the Maryland AIDS Administration and the state office for Medicaid to obtain data regarding the epidemic and medical insurance. BCHD provides data analysis, helps gather information from the Veteran's Administration and presents quality improvement findings. ABC provides fiscal and performance data and unduplicated client information for planning purposes. Representatives from BCHD and ABC also offer basic recommendations that the council uses in its deliberations about allocating funds.

This year the planning council conducted two special activities that required extensive collaboration — a program site visit for the planning council and planning council support office, and an EMA-wide consumer survey.

The program site visit required the input of non-planning council members who serve on council committees and providers' staff who attend meetings, lend their technical expertise to developing standards and agree to serve as proxies for council members who must miss a meeting. Twenty-five percent of the individuals who met with the site visit team were such volunteers. The program site visit and the

fiscal site visit that preceded it by a month are described fully in the section “Other News from 2004.”

The EMA-wide consumer survey carried out in 2004 was the most intensive consumer survey in the planning council’s history. The Needs Assessment Committee began working on the survey project about 12 months before it was completed in time for the 2004 priority-setting events. The committee, which was just a task group when the project began, determined that it would improve the quality of the data it gathered by conducting face-to-face interviews with all participants instead of distributing a self-administered survey. Once this determination was made, the committee began the process of developing a questionnaire.

*THE 2004 CONSUMER SURVEY WAS ONE OF THE LARGEST INTERVIEWER-ADMINISTERED SURVEYS IN THE NATION.*

Ten drafts of the questionnaire were reviewed and edited by members. A final draft of the questionnaire was sent to three independent researchers for review and additional suggestion about questions, format and process.

The planning council approved the final draft and IGS, following the guidance of the committee, developed a training manual for the survey interviewers, as well as a series of tools to aid them in administering the survey.

*OVER A 6-WEEK PERIOD, 13 INTERVIEWERS VISITED 48 DIFFERENT PROVIDER LOCATIONS AND INTERVIEWED 609 PLWH/AS.*

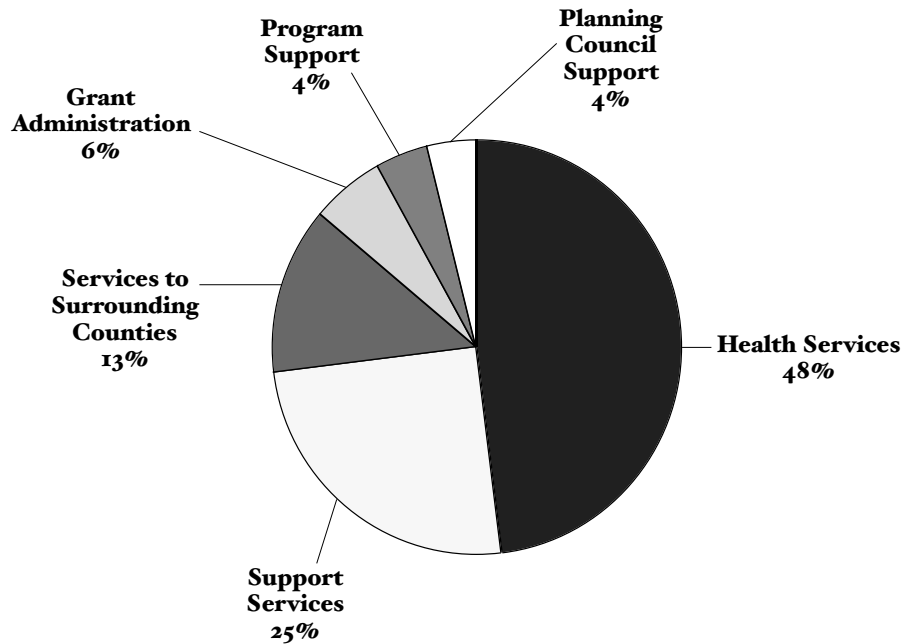
During a period of about six weeks, 13 interviewers went to 48 service provider locations throughout Baltimore City and the six surrounding EMA counties to conduct interviews. The providers agreed to supply private space in which the interviews could be conducted confidentially. They also assisted in scheduling consumers for interviews and helped identify additional sites where other interviews could be conducted. By the end of the project, over 600 individuals had been interviewed.

This effort would not have succeeded without the collaboration of the contact staff at the locations and the efforts of PLWH/As associated with the planning council who spread the word about the survey and helped individuals overcome their concerns about confidentiality and survey fatigue. Everyone associated with this activity should be proud of his or her part in making this a hugely successful needs-assessment activity.

## FUNDED SERVICES FOR 2004

Below are the percentage allocations for FY 2004. The total sum from which these categories are reported as shares is \$19,710,879, of which \$1,898,933 are MAI dollars. The total sum does not include carryover dollars from FY 2003.

### PERCENTAGE ALLOCATIONS FOR SERVICES FUNDED IN FY 2004



Source: Associated Black Charities, Inc. 2004. *FY 2004 Table 9 — Revised Allocation of Funds by Service Category, Baltimore EMA.* Baltimore, Md.

## OTHER NEWS FROM 2004

### PLANNING COUNCIL SUPPORT OFFICE SITE VISITS

On September 24, the IGS planning council support office had the first of two site visits in FY 2004. This first site visit was a fiscal site visit (the second within 10 months). On the 24th, a BCHD fiscal reviewer spent a good portion of the day examining financial files and extensively interviewing IGS's president, CFO and COO, Douglas P. Munro, and the office and business administrator, Daurice Y. Gorham. On the 27th, in a conference call between IGS and BCHD, the reviewer pronounced himself entirely satisfied with IGS's handling of the planning council's financial affairs. (The 2003 fiscal site-visit team members had also been very pleased with what they had seen financially at the council support office after their two-day stopover.)

One of the most important events of the past year just happened on November 15th, 16th and 17th. The Baltimore City Health Department Ryan White Title I Office contracted a national consulting firm to perform a site visit review of the programmatic portion of the planning council support office and the general functioning of the planning council.

The organization contracted to perform the review, Mosaica: The Center for Nonprofit Development and Pluralism, is a not-for-profit consulting firm that "provides tools to other nonprofits to build just, inclusive, and thriving communities and societies. Its special commitment is to strengthen and support entities committed to serving and empowering groups whose voices are least likely to be heard when public policies are adopted and resources allocated." Mosaica has served as a consultant for HRSA in providing training and organizational devel-

opment to planning councils across the country. The organization also helped write the CARE Act manuals that have been in use since 2000.

The president and founder, Emily Gantz McKay, led her team of five Mosaica staff members to perform the site visit. Planning for the visit began in September with a conference call that included grantee representatives, IGS staff and Mosaica principals. The general plan for the visit was discussed and a variety of materials were mailed from IGS to Mosaica in preparation for the visit. Items such as the grant application, the priority-setting notebook, annual reports, the comprehensive plan, by-laws and grievance procedures, lists of committee chairs, a roster of planning council members, standards of care, planning council minutes from the most recent meeting, a planning council mailing packet, and other documentation of the processes followed by the planning council and the support office were provided for review.

*THE SITE VISIT TEAM COMPLIMENTED THE PLANNING COUNCIL'S OPENNESS, COOPERATION, DEPTH OF KNOWLEDGE AND COMMITMENT TO ITS WORK.*

About a month before the actual visit, Mosaica staff members provided a list of groups and individuals that they wished to interview either individually or in groups. The schedule ensured that the site visit team would talk with more than 40 people about the planning council and planning council support. In addition to the full IGS staff and the full planning council staff, the site visit team interviewed the chair and immediate past vice chair of the council and all committee chairs and co-chairs. Several planning council members who are not chairs and non-appointed members who volunteer on committees also met with members of the site visit team. Also interviewed were several consumers, some of whom are appointed members of the council and some of whom are not appointed but serve on committees. A selection of providers who sit as council members, as well as some who serve only on committees were also interviewed. Finally, representatives from the grantee and the administrative agency were interviewed.

Three members of the Mosaica team attended the November planning council meeting and witnessed the entire process, from the presentation of committee reports through the election of new council leadership and the full Nominating Committee.

A written report will be forthcoming, but on November 17, 2004, three members of the site visit team met with the grantee representative and the entire IGS staff. During this exit conference, the team spoke about the strengths they had heard about and observed in the council and the planning council support.

They complimented the council on its openness and hard work in establishing a community-driven process. They noted the depth of information and understanding that the council members and other volunteers had about their committee responsibilities. Individuals spoke about having information or knowing where to find information, as well as knowing whom to contact for particular information in the IGS system.

*ALTHOUGH THE SITE VISIT TEAM WAS NOT WITHOUT SUGGESTIONS FOR IMPROVEMENT, THEY WERE IMPRESSED WITH THE CREATIVITY AND AVAILABILITY OF THE PLANNING COUNCIL MEMBERS AND SUPPORT STAFF.*

The Mosaica team was impressed with the dedication of the volunteers who serve on the council and on its committees. The strong, positive working relationship among council members and with the support staff was identified throughout the interviews. The availability of staff to meet the requests of the council was noted. The team commented on the creativeness of the council and IGS team for developing and implementing such forward-thinking process as the contingency matrix and the pool list.

Although there were no core weaknesses identified, the team did share some suggestions gleaned from the interviews. For example, the committee structure could be streamlined by folding some committees into each other, such as the By-laws and Grievance/Conflict of Interest committees; this would free up time and energy in both the council and the support office.

The team noted that the volume of information given to the council and to the public is both a positive and a negative. It is a positive in that individuals have plenty of information from which to draw conclusions and to help them understand the background of issues. However, the team suggested that it might be better to reduce the amount of time spent gathering information and the volume of data gathered, and concentrate more staff time on analysis so that members could make more use of information for planning.

It was suggested that the council tighten its conflict-of-interest policies so that proxies and alternates carry their own conflict of interest as well as pick up the conflicts for the person for whom they are substituting. The team also stated that some volunteers thought that they could benefit from the same training that is given to consumers.

Once the written report is received from Mosaica, IGS and planning council leadership will review the suggestions and discuss any changes with the Executive Committee and then the full council.

### COMMUNITY EDUCATION

Three key challenges make reducing the spread of HIV infection a daunting task. The first is ensuring that meaningful prevention information reaches individuals who engage in high-risk activities. The second is persuading individuals to both be tested and to receive the results of their HIV tests. The third challenge is making sure that those who test positive have the information and support needed to enter medical care.

One of the ways the Baltimore EMA tries to meet all of these challenges is through its annual CARE Fair. The EMA's community education coordinator (from ABC's Institute for Community Capacity Building and



Photo: Cyd T. Laamena

*BCHD Assistant  
Commissioner of Health  
Pierre Vigilance addressing  
the crowd at the 2004  
CARE Fair.*

Photo: C. T. Lacanienta



Former planning council member Grace Daniels and other staff from Family & Children's Services of Central Maryland, ready to assist visitors to the 2004 CARE Fair.

Community Education) plans the fair, which is held in an area of Baltimore City that has a very high rate of HIV infection. The fair brings together providers who offer prevention information and testing services and members of the community who need the information and services. The event also hosts treatment providers who can offer

appointments and clear links into services for those who know their status.

The photographs on these pages were taken at the 2004 CARE Fair, which was held at Mondawmin Mall. The photos show planning council members, community leaders and providers prepared to assist anyone in the mall with information about HIV testing, care and treatment. Individuals who wished to be tested could do so confidentially at the fair. With the development of the new oral test that returns a result in about 20 minutes, many more people were willing to be tested than at previous years' fairs.

The CARE Fair is made possible through funds that the planning council allocates for community education activities. The Baltimore City Health Department contracts with Associated Black Charities to



Photo: InterGroup Services, Inc.

IGS Chair and CEO Cyd Lacanienta, state Delegate Salima Siler Marriott, and Counties Committee Co-chairs Susan Kopins and Melanie Reese greeting visitors to the 2004 CARE Fair at Mondawmin Mall.

provide community education in the EMA and in surrounding counties. The planning council offers guidance to Associated Black Charities and the health department regarding the types of activities that could be carried out with the funds.

The 2004 CARE Fair was a success. Not only were more people tested than in previous years, but overall, over 400 people sought information and assistance.

## ON THE HORIZON FOR 2005

The CARE Act is scheduled for reauthorization by Congress in 2005. Individual members of the planning council and its committees will be visiting with our senators and congressmen and -women to be sure that they have a full understanding of how vital the CARE Act as structured is to meeting the needs of PLWH/As in the Baltimore EMA.

The Comprehensive Planning Committee will develop a new *Comprehensive Plan for HIV Service Delivery* in the Baltimore EMA. The plan will cover 2006 through 2008. The committee has already begun reviewing the final year of the existing plan and gathering data that will inform the new plan. As they move forward, they will be drawing on the resources of those who have the widest vision of the HIV epidemic in the EMA, such as state epidemiologists, service providers, and internationally renowned clinicians.

The planning council will continue to recruit and retain members, which is essential to maintaining the expertise needed to carry out the activities needed for effective planning.

In collaboration with its partner, BCHD, the council will continue to integrate data from the BCHD quality improvement program 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.

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 planning council will continue to secure reliable data for making planning decisions. A follow-up to the 2004 consumer needs assessment survey will be conducted in an effort to better understand consumer knowledge of available services. Two additional needs assessment studies will be done, one an analysis of service utilization by jurisdiction, and the other an analysis of service need trends.

## ACKNOWLEDGEMENTS

The planning council would like to thank its partners in Ryan White Title I planning, notably the outstanding contributions made by Dr. Pierre Vigilance, BCHD assistant commissioner of health, in leading the grantee and administrative functions throughout the year at the Baltimore City Health Department. In addition to being an effective leader, advocate and activist in the fight against HIV and the many co-morbid diseases that accompany it, Dr. Vigilance leads a strong team at the Ryan White Title I office. This team includes Richard Matens (program director), Ralph Brisueno (assistant program director), Evonne Nwankwo (QIP coordinator), Alberta Lin Ferrari (QIP clinician), Shazia Kazi (public health analyst), Page Gray (public health analyst), Shirley Marc (public health analyst), Kelly Stewart (community liaison) and Raven Jeffress (administrative assistant). David Klein (accountant supervisor) in Fiscal Services oversees the finances.

The council would also like to thank the staff at Associated Black Charities, headed by Barbara Blount Armstrong. Special thanks are due to Barbara Simpson Epps, senior program officer for the Ryan White Title I Program at ABC. Ms. Simpson Epps has picked up the leadership role and is moving forward with the development of the programmatic elements of the administrative mechanism. The Baltimore EMA is fortunate to have had a person with her experience in HIV services and planning council activities join the Ryan White team at ABC. (Ms. Simpson Epps comes to ABC from her own management consulting firm, Simpson Epps & Associates, and brings with her a wealth of experience that includes work in human resources, organizational development and nonprofit management, particularly with organizations serving the HIV/AIDS community.) The other members of the ABC Ryan White Title I staff are: Lillian Hardy,

Wanda Pigatt-Canty, Carl Hackerman, Marvis Patterson, Jonathan Truesdale and Siok-Bi Wee. Thanks are also due to ABC's fiscal team headed by Joseph Boyd (senior accountant), Lamont Keaton and Bertram McKeithen. At ABC, in the Institute for Community Capacity Building and Community Education, are several skilled staff who have been working diligently to improve the Ryan White Title I service continuum: Cleo Edmonds, Alice Poole-Davis, Patricia Ross and P.J. Gouldmann.

The planning council appreciates the efforts of Cyd Lacanienta and Douglas Munro of IGS for the long hours and dedication that they have put into assisting the council. Special thanks go to Daurice Gorham for outstanding office management and Paul Campbell for impeccable maintenance of the office. In particular, the planning council values the contributions of the IGS planning council staff, which was reorganized this year to make the support processes more efficient. Kate Hale continues to provide direction for overall planning council activities. Nicole Curtis and Lauren Koontz provide direct support to all of the committees and task groups of the planning council. With the addition of Evelyn Bradley as the deputy program manager for the day-to-day oversight and continued editorial and technical support from Rebecca Abernathy, the support office will be able to provide more analysis of the reports it receives for circulation to the planning council. In addition, there will be more opportunity for strategic and longer-range planning and technical assistance.

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.

*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, providers and consumers of HIV prevention and care services. This system includes a plan for expanded capacity, as well as monitor and evaluate services.*

*To act in a timely and unbiased manner when setting priorities to allocate resources.*



**GREATER  
BALTIMORE  
HIV HEALTH SERVICES  
PLANNING COUNCIL**

**Annual Report  
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**Prepared by InterGroup Services, Inc.**

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