



GREATER BALTIMORE HIV HEALTH
SERVICES PLANNING COUNCIL

ANNUAL REPORT

DECEMBER 2007

PREPARED BY INTERGROUP SERVICES, INC.



*FUNDED BY THE RYAN WHITE
PROGRAM THROUGH THE
BALTIMORE CITY HEALTH
DEPARTMENT*



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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 HIV disease in the greater Baltimore eligible metropolitan area, 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 and to 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

Each year, the Greater Baltimore HIV Health Services Planning Council faces new challenges and continues to evolve. This year proved to be particularly demanding, as a partial list of the year's developments will demonstrate:

- *Reauthorization of the Ryan White program.* As a result of the new legislation (Ryan White HIV/AIDS Treatment Modernization Act of 2006, P.L. 109-415), the funding-allocation requirements and the array of eligible service categories changed, requiring a revisiting of the FY 2007 priority-setting allocations. The new legislation places a greater emphasis on HIV medical services, mandating that no more than a quarter of direct service dollars can be allocated to support services. This change required an additional priority-setting operation tracking the proportion of allocations to core medical services and support services. Some service categories funded in previous years were eliminated because they were now ineligible for funding; meanwhile, new service categories were created to reflect the new requirements. Emergency priority settings were held early in 2007 to ensure that the council continued to be in compliance with federal requirements following the legislative changes. As well, a “regular” priority setting, planning for FY 2008, was held on schedule this past summer.
- *Tracking three separate funding streams.* Part A formula and supplemental awards, as well as the Minority AIDS Initiative (MAI) award, were distributed at different times during the year, with separate expenditure-tracking requirements. This was the first year of what will be an ongoing requirement that the MAI grant have its own priority setting and operate within its own funding cycle, separate from the Part A grant cycle.

- *Reorganization of the planning council's standing committees.* Committees were restructured to streamline their activities and reduce duplication of effort. The Support Services and Health Services committees merged to form the Continuum of Care Committee. The Needs Assessment Committee and By-laws Committee folded into the Comprehensive Planning Committee and the Executive Committee, respectively. The affected committees, as well as the entire planning council, collaborated on the decision to merge and on the restructuring process.
- *Preparations for the transition within the administrative mechanism.* In fall 2007, the grantee and administrative agent (AA) announced that they will be redefining their roles, including adapting the administrative mechanism to improve its ability to administer contracts and monitor services. As matters currently stand the grantee is the Baltimore City Health Department of behalf of the mayor of the city, while the AA is Associated Black Charities, responsible for both fiscal and programmatic monitoring of contracts with Ryan White Part A service providers. Under the new arrangement, which will start in fiscal year 2008, the health department will assume the program-monitoring element of the AA's current role.

The planning council and its administrative support office met these and other challenges, while continuing to improve the council's capacity to serve the community. Highlights of this year's achievements include:

- *Successful allocation of funding to provide services to over 10,000 Ryan White clients in the Baltimore EMA.* The EMA was awarded \$18,288,023 under Part A and \$2,100,038 under MAI, for a total of \$20,388,061.
- *Completion of two needs-assessment projects.* The consumer needs-assessment survey of 2007 was the largest ever conducted by the planning council and had 745 respondents. (We also believe this to be the largest ever face-to-face survey of HIV service consumers nationally.) Results of the survey provided a wealth of knowledge on the unmet service needs and barriers to care experienced by con-

sumers in the Baltimore EMA. Additionally, a special project analyzing the not-in-care population and evidence-based approaches to engaging these people in care was completed in August 2007.

- *Advanced Leadership Training.* A series of training workshops prepared by the planning council support office was offered to planning council members to enhance their leadership skills. This was the first training of its kind to be conducted with the planning council.
- *Planning work on the Comprehensive Plan for Service Delivery in the Baltimore EMA: 2009-2011 report.* The Comprehensive Planning Committee has created a work plan and organized a stakeholder forum to be convened in January 2008, the first steps in the yearlong process of completing this lengthy and complex deliverable.

The challenges faced this year were unusual, as this was a transition year for the Ryan White program; however, the road ahead holds new obstacles. The planning council will continue to evolve in response to future changes to Ryan White legislation while it works to meet the changing needs of Ryan White service consumers in the Baltimore EMA.

PLANNING COUNCIL MEMBERS

(AS OF DECEMBER 1, 2007)

| | | |
|------------------------------|--------------------------------|-------------------|
| Lennwood Green, <i>Chair</i> | Dale Brewer, <i>Vice Chair</i> | |
| Sheila Ashley | Rickie Green | Carolyn Massey |
| Dorcas Baker | Reginald Haden | Richard Matens |
| Michael Becketts | Phyllis Hall | Alice Middleton |
| Karen Bellesky | Carlisle Harvey, Sr. | William Miller |
| Rebecca Bradley | Dwight Henson | Gail Nelson |
| Herman Carter | Deborah Hunter | Michael Obiefune |
| Glenn Clark | Joseph Hurtt | Norman Robinson |
| Markton Cole | Regina Johnson | Walter Samuel |
| Denise Cooper | William Jones | Leroy Smith |
| Albert Foyles | Jean Keller | Bernice Thomas-El |
| Rowena Gore-Simmons | Jeanne Keruly | Bernice Tucker |
| Bryna Grant | Francis Lowman, Jr. | Joy Winslow |
| Michael Graves | Gregory Manigo | |

DEPARTING COUNCIL MEMBERS DURING 2007:

| | | |
|------------------|---------------------|------------------------|
| Katherine Alston | Tyrone Gray* | Melanie Reese |
| Lynn Creditt | Robin Hamlett | Hilton L. Roberts, Jr. |
| Iris Davis | Bettye Cheek Jones* | Kima J. Taylor |
| Nathalia Drew | Wendy Merrick | Scott Woods |
| Betty Flint | Darryl Payton | |

* Died while active planning council members.

MESSAGE FROM PLANNING COUNCIL LEADERSHIP

Photo: D.P. Munro



*Planning council Chair
Lennwood Green (right) and
Vice Chair Dale Brewer.*

Dear colleagues and friends,

Dale Brewer and I wish you the best as we enter a new year. Together, the planning council and its partners have made it through one of the most challenging periods in the history of the council. I will not recount all of the year's events here. Suffice it to say that, in one short year, we have staged multiple priority-setting events, helped draft two funding applications (Part A and the Minority AIDS Initiative) and are still working our way through the effects of the new Ryan White HIV/AIDS Treatment Modernization Act of 2006.

You have met each new challenge with inspiring dedication and spirit. In addition to the arduous tasks of planning and evaluation, you have worked to bring the community's voice to our elected officials, educating and advocating as planning council members are uniquely qualified to do. This effort on your part has not been without sacrifice. In particular, we would like to honor the efforts of those members who, despite serious health problems, continued to work without hesitation toward goals they believed in.

Similarly, we would like to point out how fortunate we are to have an organization like LifeLinc, whose volunteer members have gone above and beyond in keeping informed and making their presence known in Annapolis and Washington. Their continued efforts are crucial as the Health, Education, Labor and Pensions Committee of the Senate and the Energy and Commerce Committee of the

House of Representatives begin working on the next iteration of Ryan White legislation, which must be approved and signed before September 2009, when the current legislation sunsets.

As we continue to adapt to the changes wrought by the 2006 reauthorization, we look forward in the coming year to deepening and strengthening our partnership with the Maryland AIDS Administration as it works toward ensuring that the HIV names-reporting processes required by the 2006 Ryan White legislation are put in place and fully operational by the required deadlines. We also stand ready to assist in any way we can as the Baltimore City Health Department and Associated Black Charities step into new roles. Internally, we will continue our review of the council's structures so that we can continue to fulfill our duties as efficiently and effectively as possible. In particular, the cultivation and development of effective committee leadership under the oversight of the Executive Committee remains a priority of the council and its leadership.

We are about to start a new year filled with challenges both known and unknown. Thousands of our fellow citizens rely on the services we plan, and they must always be our priority. As a council, we must continue to keep pace with the epidemic in our EMA and strive to remain knowledgeable about the tools and partnerships we need to carry out our mission.

In all of the trials and difficulties of the last year, Dale and I were impressed — though certainly not surprised — by the conviction and strength displayed by council members and our friends and partners. It is our hope that we can accomplish just as much in the coming year, and Dale and I call on all council members to continue to give their best efforts. Our community deserves no less.

Warmest regards and best wishes,

Lennwood Green, Chair

December 2007

ABOUT THE PLANNING COUNCIL

The Greater Baltimore HIV Health Services Planning Council came into being in 1991. The council is a body of mayorally-appointed volunteers who are tasked with the annual planning and allocation of approximately \$20 million of Ryan White Part A (formerly Title I) funding to HIV-related service providers in the Baltimore EMA. Administered by the U.S. Health Resources and Services Administration (HRSA), the Ryan White Part A grant is a component of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (formerly known as the Ryan White CARE Act). It is intended to provide HIV-related services to

uninsured clients. These funds are distributed to “EMAs,” or regions with more than 2,000 cases of AIDS during the most recent five-year period and a population of at least 50,000 (HRSA 2007). The Baltimore EMA is comprised of Baltimore City and its six neighboring counties: Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne’s. The Baltimore EMA is currently 1 of 22 Ryan White Part A-eligible EMAs in the country.

SNAPSHOT OF MEMBERSHIP

- *52.5 percent men.*
- *47.5 percent women.*
- *80 percent African-American.*
- *15 percent white.*
- *5 percent Hispanic/Latino.*
- *60 percent PLWH/A.*

Baltimore’s planning council has expanded from 35 members in 1991 to become the 40-member body it is today. The race and gender demographics of the council membership reflect the diversity of the HIV epidemic in the EMA. Planning council membership includes people living with HIV/AIDS (PLWH/As) and representa-

tives from the affected community, local service providers, community-based and faith-based organizations, city and county health departments, state health planners and Ryan White Parts B and D. This diversity of membership strengthens the planning council by bringing myriad experiences, insights and types of expertise to the planning process.

The council has seen changes not just to the size of its membership but also to its committee structure over the years. Those associated with the council in the beginning realized that it could not meet its federal requirements acting as one single entity. In response to the emerging

needs of the community and council itself, committees were formed over the years, beginning with the By-laws Committee. By 2006, the planning council was managing 10 committees: By-laws, Comprehensive Planning, Evaluation, Executive, Health Services, Needs Assessment, Nominating, People Living with HIV/AIDS, Services to Surrounding Counties and Support Services. In an effort to streamline committee tasks and reduce the burden on volunteers, the planning council made the decision to merge several committees and their respective tasks this past year. As a result, the planning council now has seven standing committees: Comprehensive Planning, Continuum of Care, Evaluation, Executive, Nominating, People Living with HIV/AIDS and Services to Surrounding Counties.

The planning council could not accomplish its work without the assistance of several vital partners. Functioning as the Part A grantee for the Baltimore EMA, the

SNAPSHOT OF VOLUNTEER TIME

- *Number of planning council meetings: 12.*
- *Total number of regular committee meetings: 69.*
- *Days spent in priority-setting meetings: 7.*
- *Number of joint reprogramming meetings: 2.*
- *Priority-setting trainings: 1.*
- *Individuals who completed all 4 sessions of Leadership training: 10.*

Baltimore City Health Department (BCHD) is responsible for overseeing the EMA's Ryan White Part A grant. In addition to its current role as grantee, BCHD was also initially responsible for monitoring provider contracts (as the AA is now) and ensuring that the planning council met related federal requirements. During these initial stages of the planning council history, staff from the University of Maryland's School of Nursing provided the council's administrative and support services, a contract later turned over to Associated Black Charities (ABC). In 2002, BCHD turned its administrative-agent duties over to ABC, and contracted ABC's former planning council administrative, research and support operations to a Baltimore-based consulting firm, InterGroup Services, Inc. (IGS). Additional changes were made to the area's Ryan White administrative structure in fall 2007, when BCHD announced it would be reassuming some of the AA's duties. Regardless of this transition, the council knows that these three administrative bodies (ABC, BCHD and IGS) will continue to work well together, as they have for almost six years, to provide council members with the support they need to discharge their duties.

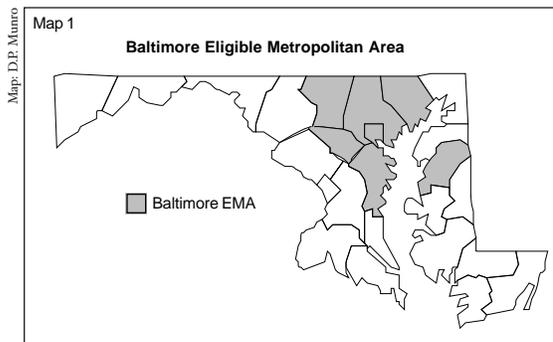
Other important partners include the Maryland AIDS Administration and the University of Maryland, which provide the council with epidemiological data to keep it abreast of local trends in the epidemic. These organizations have continued to support the planning council throughout the last 16 years by designating representatives to sit on the council, presenting data and serving as technical resources. These partnerships, as well as others established throughout the years, have proved to be valuable resources as the council continues to face changes in both the Ryan White legislation and the nature of the HIV/AIDS epidemic.

Much of the council's growth and success can be attributed to the organization's ability to adapt to change and anticipate future obstacles. However, the most important ingredient in planning council success is the dedication of the individuals who volunteer their time and energy working toward, and believing in, the goals of the council.

ABOUT THE BALTIMORE EMA

EPIDEMIOLOGY

The Baltimore EMA is composed of Baltimore City and its six surrounding counties, Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's. Nearly half of Maryland's residents, 2.63 million people, reside within this region and, according to the Maryland AIDS Administration, 20,208 of these people are living with HIV/AIDS, as of December 31, 2006. The vast majority, about 79 percent, of these PLWH/As reside in Baltimore City (DHMH 2005a). According to 2005 CDC data, Baltimore City has the second highest rate of new HIV infections in the nation (CDC 2006).



Comparison among the EMA's various jurisdictions reveals dramatic racial disparities within Baltimore's epidemic. A majority of the EMA population is composed of non-Hispanic whites, yet about 84 percent of those living with HIV/AIDS in the region are African-American.

While Hispanics account for only about 1 percent of the HIV/AIDS cases in the EMA, prevalence among Hispanics is substantially higher than among non-Hispanics (249 cases per 100,000 Hispanic population compared to 158 cases per 100,000 general population). Furthermore, data from the Maryland AIDS Administration also suggest

that Hispanics are more likely to first enter treatment at more advanced stages of the disease, indicating that this population tends to delay seeking care (DHMH 2005a).

HIV/AIDS continues to disproportionately affect men in this EMA; however, the gap between men and women has gradually narrowed over the years (DHMH 2005b). As of 2005, about 62 percent of prevalent HIV cases in the EMA were men and around 38 percent women (Flynn 2007). Across all races/ethnicities, HIV prevalence is significantly greater among males than among females, but the difference is decreasing, especially among African-Americans (DHMH 2005b).

Injection drug use (IDU) continues to plague the Baltimore EMA and is its number-one HIV-transmission mode. The proportion of HIV cases caused by IDU exposure varies among jurisdictions, from as high as 46.5 percent of cases in Baltimore City to less than 15 percent in Howard County. Men who have sex with men (MSM) account for only 18.1 percent of the EMA-wide cases, yet this mode of exposure shows up in nearly half (43.1 percent) of Howard County's cases. However, the HIV epidemic is not confined to small subpopulations, like IDUs and MSMs. Heterosexual HIV exposure accounts for 29.0 percent of cases throughout the entire Baltimore EMA; in one county, Queen Anne's, heterosexual sex is the mode in about half of all cases (DHMH 2006).

The diversity in modes of exposure necessitates a variety of targeted approaches to outreach. The planning council currently allocates funding to early intervention services (EIS) and attempts to increase identification of HIV-positive IDUs early in their disease progression through innovative outreach programs with referrals to treatment and services. Additionally, approximately eight percent of service dollars are allocated to substance-abuse-treatment service categories. In response to the dramatic increase in HIV incidence in the population of MSMs of color, all Ryan White funding parts (formerly titles) are collaborating to maximize efforts to reach this population. The planning council recognizes that coop-

eration between these various funding streams, as well as among service providers, is required for establishing effective outreach programs with linkages to core medical services.

Baltimore's current continuum of care integrates primary medical care with support services, which are essential for retaining PLWH/As in care. Part A Ryan White grant money funds approximately 21 percent of the total HIV/AIDS service funding for the Baltimore EMA. In 2007, this funding was allocated to 18 service categories, both core medical and support services. These funds continue to provide an essential safety net for uninsured and underinsured populations living with HIV/AIDS.

HIV/AIDS POLICY CHANGES IN MARYLAND

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 mandated that, beginning in 2007, Ryan White funding would be based on the number of HIV cases reported by name. Up to this point, Maryland had used a code-based system to report HIV data and a names-based system for AIDS cases. Given the extent of the epidemic in Maryland, the state could not risk potential reductions in federal funding resulting from non-compliance with the HIV names-reporting mandate. Therefore, state legislators found it necessary to immediately consider revising the state's regulations for reporting HIV information. The state legislature passed the Maryland HIV Reporting Act in April 2007 to require that HIV cases, in addition to AIDS cases, be reported by name. This legislation ensured that Maryland would be in compliance with the new federal law and allows HIV and AIDS data to be reported in a consistent manner (DHMH 2007a).

Another new development in 2007 resulted from the fact that the U.S. Centers for Disease Control and Prevention (CDC) revised its recommendations concerning HIV testing and counseling in September 2006. These recommendations do not currently concur with Maryland's laws on the subject, quite the opposite. While Maryland law requires patients to request and give specific consent for

HIV screening, as well as receive pre-test counseling, the CDC now recommends HIV screening — with no pre-test counseling — as a default for all patients in health-care settings unless they specifically opt out (DHMH 2007b).

The incongruence between Maryland law and CDC guidance led state legislators and area service providers to conclude that the law should be reevaluated. Legislation was passed in April 2007 that required the Maryland AIDS Administration to form a work group that would be tasked with reviewing the CDC recommendations, as well as current research and data on counseling and testing, to consider whether changes to Maryland law are needed. Numerous townhall meetings were held, and the AIDS Administration accepted public comments on the possible changes. The work group's report will be reviewed by the Maryland General Assembly early in 2008.

PLANNING COUNCIL ACCOMPLISHMENTS IN 2007

FUNDING

The FY 2007 Ryan White Part A formula award was granted to the Baltimore EMA in March of 2007. It totaled \$13,101,233, an increase over the FY 2006 formula award. The formula award is based on the number of people living with HIV/AIDS for the most recent calendar year. The supplemental award, announced several weeks later, totaled \$5,186,790, based on the EMA's demonstrated need for additional funding and the availability of services to expend the extra funds, among other criteria. It also helped considerably that Baltimore's grant application had earlier received the second highest score among all EMAs nationwide, a testament to the dedication and expertise of each and every person involved in the EMA's Part A continuum of care. The Baltimore EMA also received \$2,100,038 in MAI funding, which targets racial/ethnic minorities. This was more money than was requested by the Baltimore EMA and was the fourth largest MAI grant award in the nation. A subsequent request for carryover funds from FY 2006 was also approved, in the amount of \$908,888 for 20 initiatives.

NAVIGATING THE REAUTHORIZATION

The planning council faced many challenges in adjusting to the changes that resulted from the new Ryan White legislation. Before even considering all of the major modifications that occurred with service categories and funding streams, council members first had to adapt to many terminology changes. For one, the name of the program changed with the reauthorization, from the Ryan White CARE Act to the Ryan White HIV/AIDS Treatment Modernization Act. Also,

the funding components of the act changed names, from titles I-IV to parts A-D. The council, as well as everyone who delivers or receives Ryan White services, had to ground themselves in these and many other vocabulary changes before being able to grapple with the more substantive changes.

Advancements in the treatment of HIV/AIDS enable PLWH/As to live longer lives than ever before. The new legislation reflects this change by altering policies concerning how Ryan White funds are to be disbursed. One change is the requirement that all Ryan White Part A EMAs allocate at least 75 percent of total funding into “core medical services” and no more than 25 percent into “support services”; in this EMA, this change meant somewhat reducing the proportion of funds in support services, compared to past years. The council had to put a great deal of thought into meeting this new requirement while maintaining a continuum of care that continues to meet the needs of Ryan White clients in the Baltimore EMA. The council’s innovative strategy of funding many of the former support services through MAI has minimized disruptions in service delivery.

The reauthorization also redefined what can be considered a support service, with the result that several service categories that had existed in the past were no longer eligible to receive funding. The new definition of support services states that “a [support] service must be necessary for the improvement of the HIV-related clinical status of the consumer” (KFF 2006). Therefore, services such as client advocacy and treatment adherence are no longer eligible for funding as stand-alone categories. Instead, like several other support-service categories, they were merged to form subcategories under the core medical categories of early intervention services, outpatient and ambulatory health services (OAHS), and medical case management. Outpatient ambulatory health services (OAHS) also includes the subcategories of primary medical care, co-morbidity, viral load testing and emergency financial assistance. Early intervention services (EIS) include client advocacy, legal services, outreach and primary medical care, while medical case management (MCM) includes case management, psychosocial support and treatment adherence. The council was successful in developing a creative process that fully utilized

its core medical service dollars to fund multiple services that would otherwise have been ineligible for funding as stand-alone services.

Other major shifts that the council had to negotiate involved the disbursement and monitoring of the Part A and MAI awards. Whereas expenditures of both the formula and supplementary portions of the Part A grant were previously monitored together, the reauthorization now requires a separate reporting process for each. And this year, the MAI grant was awarded on an entirely different schedule from the Part A grant, a cycle that will continue in subsequent years. The new MAI funding cycle does not correspond with the Part A fiscal year and the disbursement of the formula and supplemental awards; therefore, the planning council must devise a separate priority setting and allocation process for the MAI categories. In 2007, the federal government did not disburse the MAI grant until August, which caused service providers to close programs funded with MAI dollars until the grant was received.

The council was also faced with new procedures related to carryover dollars. This year, the council's request for over \$900,000 in carryover funds was approved. However, the EMA will not receive as much in the future. Under the new legislation, only one year of carryover will be available and the maximum amount allowed for each EMA will be two percent of the formula award. This means that all EMAs will be required to expend at least 98 percent of their formula awards by the close of FY 2007. For the Baltimore EMA, no more than roughly \$260,000 in carryover will be available. The EMA will be penalized for unobligated formula funds beyond two percent, and, although there is no specified penalty for unspent supplemental funds, a record of under-spending may affect the amount of supplemental funds awarded in subsequent years.

Throughout all of these changes, council members strived to stay abreast of new information by utilizing all available resources. The new regulations underscore the need for the planning council to receive timely, accurate data on expenditure

patterns so that it can make intelligent decisions in the allocation and reprogramming of funds throughout the year. Council members are acutely aware of this and will be monitoring the administrative mechanism and other technical resources even more closely than usual as they work to maintain an effective continuum of care.

MULTIPLE PRIORITY SETTINGS

Each year, the planning council meets to rank each service category and set spending priorities for the upcoming fiscal year's Ryan White Part A grant to the Baltimore EMA. This process, in which council members decide how much of the grant will be allocated to each of the eligible service categories, is also referred to as priority setting. The actual amount of the grant is never known at the time of the meeting, so the council plans in terms of percentages of the eventual award, preparing different plans for the possibilities of an increased, decreased or level award. To plan for services provided within the Baltimore EMA's six counties, the planning council treats the counties as a single category (called "services to surrounding counties" or STSC) and allocates a lump proportion of the award to it. In the days following the EMA's priority setting, the STSC Committee holds a separate priority setting (also referred to as the counties priority setting), in which it allocates this lump sum among its own prioritized service categories in the same way that the planning council does for the EMA as a whole. Prior to 2007, then, there had always been just two priority-setting events each year, one for the EMA and one for STSC, around July or August of the year prior to the fiscal year for which the planning was being done.

The reauthorization, ratified in December of 2006, presented numerous challenges for this existing priority-setting procedure. Among other things, the legislative changes affected the way that service categories were classified and the way that MAI funds were distributed. During the "regular" FY 2007 priority setting in the summer of 2006, the planning council had planned and allocated according to what was then anticipated to be the new language in the reautho-

rization legislation. For example, even though they were not yet required to do so, the council grouped the service categories into the two new service groups, “core medical services” or “support services,” in hopes of avoiding needing to revisit the process after the legislation passed. However, certain additional unanticipated changes were contained in the final version of the reauthorizing legislation. Because some of these changes were effective immediately, the council had to conduct an emergency priority setting for FY 2007 funds in January 2007 to keep the EMA in compliance. This, in turn, triggered an STSC priority setting for the same purpose, held in March 2007.

As noted earlier, the reauthorization legislation also requires the EMA to conduct a separate planning process for MAI funds. Per this mandate, the planning council conducted priority setting for the MAI grant during an extended May 2007 planning council meeting. One difficulty was the last-minute federal requirement that the allocation of MAI funds to its own medical and support categories not, when factored mathematically into a hypothetically combined Part A/MAI award, drag the overall allocation to medical services below 75 percent of the combined Part A/MAI service award. This is a cumbersome requirement, the point of which it is hard to fathom, given that Part A and MAI are now on separate funding schedules and so in reality never are combined.

The council was also reminded that it could not plan for service categories that had newly been disallowed by HRSA. Council members rose to meet all these challenges, however, successfully completing no fewer than five separate priority-setting meetings between August of 2006 and May of 2007.

Even as these emergency priority-setting events proceeded, preparations were already underway for the FY 2008 priority setting that would be held in August of 2007. The council’s Needs Assessment Committee (which had been folded into the Comprehensive Planning Committee partway through the year), guided IGS in identifying and recruiting presenters on medical trends and outcomes, needs

assessment, alternative funding streams and new issues affecting the continuum of care. Each year, the council uses data from such presentations, as well as presentations from the grantee, the AA, Part B and Part D program representatives, the Clinical Quality Management (CQM) program, IGS, and its own committees to make educated funding-allocation decisions at priority setting.

This year, the council chose to receive its data presentations throughout the several months leading to priority setting, beginning in March, as opposed to its past practice of hearing all data presentations during one extended meeting just before priority setting. The impetus for this change came from suggestions made in previous years by council members on improving priority-setting processes. Over the course of these months, representatives from the Maryland AIDS Administration presented current epidemiological data, the latest prevention programs and initiatives, as well as information regarding the Maryland AIDS Drug Assistance Program (MADAP) and the administration's other insurance programs. The council received additional presentations from local organizations, including Baltimore Homeless Services, Baltimore Substance Abuse Systems, Inc., Housing Opportunities for People with AIDS (HOPWA) and the Baltimore Human Relations Commission. Additionally, the council received reports on medical trends, the service continuum and a consumer needs assessment conducted by IGS.

In addition to receiving information through presentations, council members were supplied by IGS with binders overflowing with data, regulations, definitions and other relevant information. Included in each binder were service-category "scorecards," a tool created by IGS in FY 2005 to assist the council in its analysis of the expenditure and performance history of each service category. Included on each scorecard are relevant comments from the expenditure and service-delivery (ESD) reports provided to the council throughout the year by the grantee as well as a five-year trend analysis. Council and STSC Committee members who intended to vote at priority setting were required to attend a priority-setting training

session that included a tutorial on how to use the scorecards. Attendance was also required at the July planning council meeting, which included the final data presentations and the service-category ranking exercise.

Having already conducted multiple priority settings to reconsider FY 2007 priorities, planning council members were familiar with the new requirements and were well prepared for the FY 2008 priority setting in August, the first “regular” priority setting under the reauthorization. The council members, proxies and visitors gathered in west Baltimore, at the Potter’s Place conference center. The planning council support office, IGS, contracted a professional facilitator, Dr. Darrell P. Wheeler, to assist the members through the formal procedures necessary to complete the funding-allocation exercises. Throughout the process, council members received data, technical support and recommendations from the AA, grantee and IGS staff.

The event opened with introductory addresses from Dr. Michelle A. Gourdine, deputy secretary for public health at the Maryland Department of Health and Mental Hygiene, and Heather Hauck, director of Maryland’s AIDS Administration. The council and conference attendees also heard from Baltimore City Health Commissioner Joshua M. Sharfstein. Council members were greatly buoyed by this display of support from EMA public-health leaders, especially during the at times arduous priority-setting conference.

The counties priority-setting meeting was held at the Howard County Department of Health one week following the EMA conference. The planning council had allocated approximately 10 percent of its core medical service funds and 3.1 percent of its support service funds to the STSC category during the EMA priority setting. STSC Committee members, proxies and visitors gathered at the health department to plan for the allocation of these funds to 13 STSC service categories. Dr. Peter L. Beilenson, health officer of Howard County, addressed the

conference, as did Baltimore County Health Officer Pierre N.D. Vigilance, a former council member himself.

As always, both the EMA and STSC priority settings began with an overview of the process, as well as a description of the materials provided. Conflicts of interest were reviewed and members were reminded of the procedure for making and discussing motions. This year, the AA not only verbally presented its allocation recommendations, but also distributed binders (separate from the IGS-compiled binders) that included their recommendations and a trend analysis for each service category. The contingency exercises planned for a five percent increase and five percent decrease of the grant award. For both funding scenarios, the council planned allocations for core medical services first, to ensure that it had met the mandatory 75 percent allocation, before distributing the balance among support service categories. The council was reminded that many of the support services that the EMA had historically funded with Part A dollars were now funded under MAI, but that, although FY 2008 MAI allocation priorities are expected to be conducted in February 2008, the council needed to remain aware that MAI allocations would have to balance with Part A allocations to maintain the mandated ratio of core medical services to support services.

CHANGES IN QUALITY ASSESSMENTS

The planning council follows a four-year schedule for reviewing and updating standards of care for each service category. This schedule corresponds closely with the BCHD Continuous Quality Management (CQM) program's schedule for reviewing service categories. CQM was formerly known as the Quality Improvement Program, or QIP; following reauthorization, QIP was transformed into CQM in an effort to stress clinical outcomes in quality assessments, as it is now mandated that funded support services demonstrate clinical outcomes. The primary goal of the CQM program is to assess the extent to which providers are meeting minimum local standards of care, as established by the planning council. Their findings are reported to the planning council, but the CQM staff members

serve primarily as a technical resource for the Continuum of Care Committee since they are tasked with reviewing each provider according to the standards of care developed by that committee.

With the realignment of service categories and the addition of subcategories due to the new legislation, new standards of care had to be created for some categories. This meant that the Continuum of Care Committee and the CQM staff had to revise their schedule for review of services and standards. This year, the Continuum of Care Committee developed standards of care for the new service categories, including early intervention services, health insurance premiums and cost sharing, and outpatient ambulatory health care. The committee will be creating the medical case management standard and then resuming its scheduled review of established standards of care in 2008.

NEEDS ASSESSMENT ACTIVITIES

Planning councils are required to factor needs-assessment research into their planning of HIV-related services and allocation of Ryan White Part A funds. The Needs Assessment Committee, which was folded into the Comprehensive Planning Committee partway through this year, oversaw two significant needs-assessment projects that provided the council with a wealth of information used to strengthen the HIV/AIDS continuum of care in the EMA. The Needs Assessment Committee requested carryover funds from FY 2006 to fund a “not-in-care” research project and the FY 2007 consumer needs assessment.

The not-in-care project compiled and analyzed research on locating and engaging PLWH/As who are not receiving care for their HIV disease. Guided by outlined objectives formulated by the Needs Assessment Committee, an IGS policy analyst studied peer-reviewed articles and other research reports, as well as interviewing some local outreach providers, concerning best practices for reaching and retaining this population in care. The council hopes to utilize the recommendations and findings from this project to establish new evidence-based strategies for

locating the not-in-care population and further reducing unmet need in the Baltimore EMA.

The other major needs-assessment project completed in FY 2007 was the consumer needs-assessment survey, a federally mandated research project that has been conducted triennially in the Baltimore EMA since 1998. The assessment seeks to analyze unmet service need and understand more fully the barriers of care that exist within the EMA. Results from the needs assessment are used by the planning council to help guide its priority-setting and planning decisions throughout the year. In 2004, the Needs Assessment Committee, in conjunction with contracted researchers and IGS, developed a more extensive survey instrument and methodology by which to conduct the needs assessment. Slightly modified versions of the 2004 survey instrument and methodology were used to conduct the needs assessment in 2007. From January 16, 2007 to February 28, 2007, a total of 14 trained interviewers administered the one-on-one, confidential survey to 745 respondents (730 of them residing in the Baltimore EMA) at 38 locations. The results of the survey were presented at the July planning council meeting in preparation for the upcoming priority setting.

COMMITTEE ACCOMPLISHMENTS IN 2007

In addition to — indeed, partly in response to — the many changes described earlier in this report, there were also modifications to the council’s committee structure in 2007. In January of 2007, the planning council was operating with 10 standing committees. Throughout 2007, the council and its committees analyzed the existing committee structures and worked to streamline them in an effort to make meetings more efficient and, therefore, less time consuming for volunteers. After much deliberation, the Support Services Committee combined with the Health Services Committee to form the Continuum of Care Committee. The By-laws Committee was subsumed into the Executive Committee. Finally, the Needs Assessment Committee fell under the umbrella of the Comprehensive Planning Committee, reducing the number of standing committees to seven.

COMPREHENSIVE PLANNING COMMITTEE

The Comprehensive Planning Committee increased in size and responsibility in spring 2007 following the absorption of the Needs Assessment Committee. Before assuming the responsibilities of the Needs Assessment Committee, the Comprehensive Planning Committee worked closely with policy analysts from IGS to conduct the 2007 consumer survey. The results, which included information on consumer need and barriers to care, were presented to the planning council prior to priority setting and have already been utilized for both allocation and reprogramming events. The Comprehensive Planning Committee will be assuming the responsibility for organizing this triennial survey in the future.

With guidance from the grantee and the support office, the committee developed recommendations for the use of \$908,888 in carryover funds, or dollars that went unspent in FY 2007. Some of the capacity-building projects that were proposed to utilize these funds included the implementation of an electronic case-management documentation system, provision of pillboxes and diaries to improve treatment adherence, distribution of toiletries to improve quality of life and development of new outreach interventions. The committee also received the IGS report on not-in-care PLWH/As mentioned earlier, *Engaging PLWH/As in Care: Lessons*

Learned for the Baltimore EMA, which was paid for with FY 2006 carryover funds.

**THE COMPREHENSIVE
PLANNING COMMITTEE
DEVELOPED RECOM-
MENDATIONS FOR THE
USE OF \$908,888 IN
CARRYOVER FUNDS.**

The Comprehensive Planning Committee also assisted in organizing priority-setting-related activities. Planning the data presentation schedule and priority-setting training were among the logistical tasks undertaken by the committee. The commit-

tee reviewed and revised the FY 2008 directives that were developed during priority setting. This fall, following the EMA and counties priority settings, the committee organized a review group to assess the processes of priority setting. Requests brought forward by the review group, as well as from evaluation forms completed by participants at each priority-setting event, are used to alter priority-setting processes to accommodate the changing needs of council members. For example, requests from the review group in 2006 led to data presentations being given throughout the year, rather than condensed in one planning council meeting. The recommendations from this year's review group will be presented to the council in January 2008.

The committee is currently preparing for the development of the *Comprehensive Plan for HIV Service Delivery in the Baltimore EMA: 2009-2011*, its largest deliverable. The last few months of 2007 have been spent laying the foundation for this process, including organizing a group of local stakeholders in the HIV/AIDS field

to generate concepts and strategies to be addressed by the planning council over the upcoming years. The comprehensive plan will be written throughout 2008.

CONTINUUM OF CARE COMMITTEE

The merging of the Health Services and Support Services committees resulted in the creation of the Continuum of Care Committee. Over the course of several months, the council and both of the two original committees discussed the merger and outlined the responsibilities of this new committee. The purpose of the Continuum of Care Committee is to (1) identify service gaps, (2) formulate service definitions and priorities, (3) develop and enhance performance standards and quality-assurance criteria, (4) monitor the implementation plan and (5) serve as a technical resource to the planning council on all funded categories.

SHORTLY AFTER ITS FORMATION, THE CONTINUUM OF CARE COMMITTEE BEGAN WRITING AND REVIEWING NUMEROUS STANDARDS OF CARE.

Shortly after its formation, the committee began writing and reviewing numerous standards of care.

Several new or overhauled service categories, such as early intervention services (EIS), emergency financial assistance (EFA), and health insurance premiums & cost sharing required brand new standards; others, such as adult primary medical care, needed only revisions and updates. The committee will continue editing these and other standards in 2008, as well as continuing to establish its practices for carrying out its other designated responsibilities.

EVALUATION COMMITTEE

Unlike some of the other committees, the Evaluation Committee did not undergo any internal changes throughout the year. However, the committee did remain responsible for monitoring the transitions that occurred within the grantee and the administrative agent.

The committee worked with the grantee and AA to refine the tools used to assess the administrative mechanism and had IGS hire a consultant to formally conduct the data gathering. Equipped with the data collected from the consultant, the committee performed its annual assessment of the administrative mechanism. The assessment was completed in September 2007, in time for inclusion in the Part A grant application.

FULFILLING ITS ROLE AS THE COUNCIL'S FISCAL MONITOR, THE EVALUATION COMMITTEE LED THE JOINT REPROGRAMMING SESSION FOR THE COUNTIES AND THEN CONVENED SEPARATELY TO CONDUCT THE EMA-WIDE REPROGRAMMING.

In September and November, the committee met jointly with the Services to Surrounding Counties Committee for the reprogramming of FY 2007 funds. Fulfilling its role as the council's fiscal monitor, the committee led the joint reprogramming session for the counties and then convened separately to conduct the EMA-wide reprogramming. The planning council voted to approve the reprogramming recommendations from the Evaluation Committee and STSC Committee during its

November meeting. As changes occur within the administrative mechanism in the upcoming year, the committee will be working closely with the grantee to ensure that the ESD and reprogramming reports are comprehensive, timely and accurate.

EXECUTIVE COMMITTEE

The Executive Committee is composed of the chairs or co-chairs of each of the standing committees of the council, two members-at-large from the PLWH/A Committee, representatives of the Part B and Part D programs, the representative of the mayor and health commissioner of Baltimore City, and the representative of the Baltimore County executive and health officer. In case of an emergency, the planning council by-laws grant the committee the authority to act on the behalf of the full planning council.

Responsible for assisting the council's chair and vice chair in managing the overall performance of all the standing committees, the Executive Committee plays an important role in maintaining council efficiency. In addition to setting the agenda for upcoming planning council meetings, all work products from each standing committee are reviewed by this executive body before being presented to the council for approval. The Executive Committee has veto power, so it can send unclear or incomplete products back to their respective committees for revisions. This process of checks and balances ensures that the work products approved by the council are of the highest quality. It also serves to minimize repetitive discussion around each item at the planning council.

In yet another committee transformation, the By-laws/Grievance Committee was folded into the Executive Committee. As of 2007, the Executive Committee will convene a task group to review and recommend by-laws changes when necessary.

NOMINATING COMMITTEE

As the overseer of planning council membership procedures, the Nominating Committee continued to strengthen its role of monitoring committee membership and attendance, as well as ensuring the council's compliance with related federal requirements. These tasks may sound rigid and mundane; however, the committee continues to swiftly adapt to changes in the legislation and create novel recruitment strategies. Furthermore, the composition of the committee itself evolves annually, as elected committee membership changes to reflect the will of the council. The committee lost its valuable chair in the summer of 2007, but a strong replacement was appointed for the interim and the committee continued to efficiently carry out its responsibilities.

In 2006, the Nominating Committee brought forward the recommendation that council members must attend 66 percent of their committees' meetings. This year, the committee incorporated an attendance-tracking timeline into an addendum to the bylaws, along with the stipulation that attendance will be tracked once

a person has become a voting member. Additionally, the committee enforced relevant bylaws on council members who had not chosen a primary committee or who had otherwise failed to promptly fulfill their membership obligations.

Early in the year, new council-membership requirements were propagated by HRSA, including mandates that planning councils must now have a representative infected with either hepatitis B or C and, if applicable, a representative of the local Native American population. In response, the committee reviewed the planning council application and revised it to incorporate questions pertaining to the new requirements.

As evidenced by the caliber of individuals sitting on the council, as well as those waiting on the pool list, the Nominating Committee has continued to excel in screening applications and selecting individuals who believe in the planning council's mission and vision and are passionate about advocating for the PLWH/A community.

PEOPLE LIVING WITH HIV/AIDS COMMITTEE

PLWH/A Committee members functioned deftly in this year's highly charged political atmosphere, actively embracing their role as a strong voice representing the EMA's Ryan White service consumers. For example, committee members attended the Maryland AIDS Administration townhall meeting that was convened to hear public comments on the CDC's new recommendations concerning counseling and testing for HIV (mentioned earlier). The committee expressed support for the CDC's recommendations that every patient in a health-care setting be tested for HIV unless he or she specifically requests not to be, at which time the patient would have to sign a form stating that he or she opted out of testing. The committee also voiced its support for the elimination of pre-test counseling, but added its own recommendation for post-test counseling and referrals to medical services for those who test positive for HIV. Finally, the committee recommended that health education and prevention information be given to

patients who received the test, especially those who tested negative for HIV, so as to minimize their risk of contracting the disease. The task force working to revise Maryland's law commended the committee for its insightful recommendations and will be updating the committee as the legislative process continues in 2008.

In an effort to achieve a balance between the needs of the underinsured consumer and the reality of limited resources, the PLWH/A Committee worked throughout the year to develop two position papers. The first position paper, "Transitioning off of Ryan White and into Long-term Services," was developed in response to the increasing lifespan of PLWH/As and the mandated shift away from using Ryan White dollars to fund support services. The paper discussed the need for consumers to transition from reliance on Ryan White services to permanent, long-term services. The PLWH/A Committee also began composing another position paper, which focuses on the identification of what they deem the most essential core medical and support services for consumers. These position papers provide a means for educating both the planning council and state/federal legislators and officials on consumers' opinions and needs.

***THE PLWH/A
COMMITTEE
LAUNCHED A CAM-
PAIGN TO RECRUIT
COUNCIL AND COM-
MITTEE MEMBERS
FROM THE SUR-
ROUNDING COUNTIES.***

Planning council and committee recruitment continues to be a goal of the PLWH/A Committee. This year, the committee launched a campaign to recruit new members from the surrounding counties. Committee representatives have begun presenting information on the planning council and various standing committees at meetings of HIV-service consumer advisory boards (CABs) and support groups. The first presentation was held in Howard County in November and the project will continue into 2008.

SERVICES TO SURROUNDING COUNTIES COMMITTEE

The STSC Committee continues to represent the six surrounding counties of the Baltimore EMA in its committee and collaboration activities. Seven members of this committee currently sit on the full planning council and several more actively represent the counties through their service on other standing committees. The committee partnered with the Comprehensive Planning Committee to streamline the priority-setting process, as well as to make recommendations for FY 2008 directives and the use of FY 2007 carryover funds. Currently, members of the committee are working with the PLWH/A Committee to identify counties-based support groups where the PLWH/A Committee can make recruitment

***THE STSC COMMITTEE
PARTNERED WITH THE
COMPREHENSIVE
PLANNING COMMITTEE
TO STREAMLINE THE
PRIORITY-SETTING
PROCESS.***

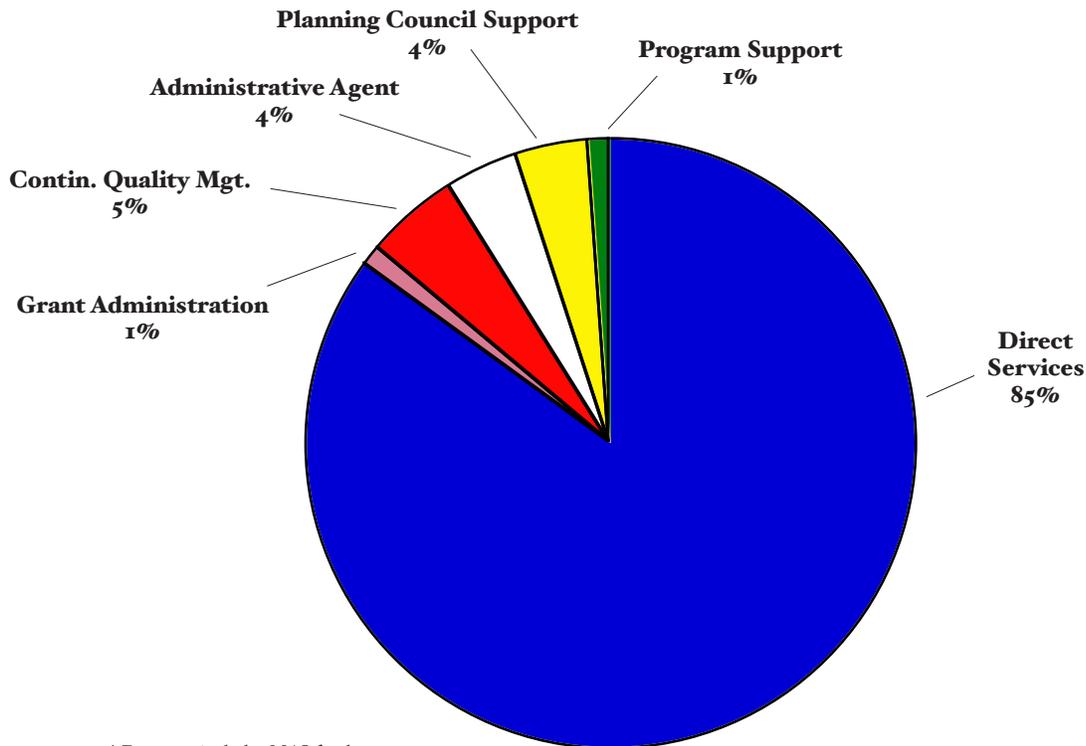
presentations. The Howard County community advisory board (CAB) was the first to hold a recruitment presentation this fall, and it is hoped that other county CABs will soon follow its lead.

The STSC committee is responsible for allocating the Part A funds that the council has designated for use in the surrounding counties. In preparation for the STSC priority setting, the committee members attended the council's data presentations and a priority-setting training session in July. Additionally, the committee met with the Evaluation Committee for joint reprogramming sessions in September and November. During these sessions, the committees received the ESD report and reprogramming recommendations from the AA.

FUNDED SERVICES FOR 2007

Below are the allocation percentages for FY 2007. The Part A grant award for the Baltimore EMA in FY 2007 totaled \$18,288,023. The first graph below shows the breakdown of the total grant, and the second graph displays the distribution of direct services.

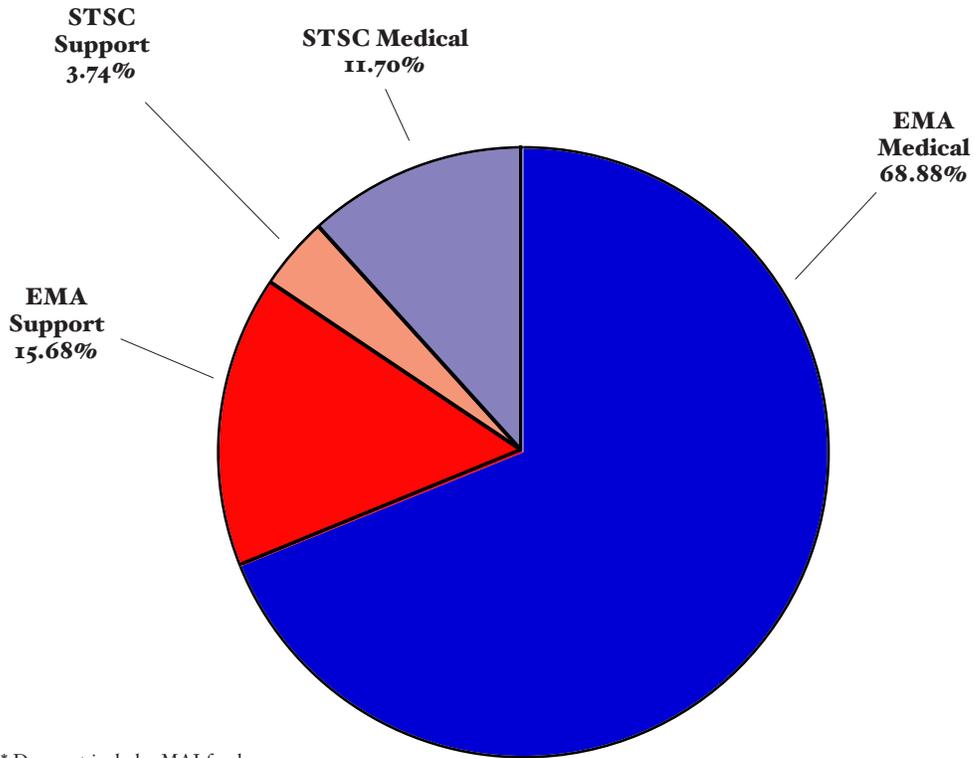
FY 2007 TOTAL PART A AWARD (\$18,288,023)*



* Does not include MAI funds.

Source: Associated Black Charities, Inc. (ABC). 2007. *FY 2007 Table 9 — Allocation of Funds by Service Category, Baltimore EMA*. Baltimore, Md.: ABC, May.

FY 2007 PART A SERVICE AWARD (\$15,544,820)*



* Does not include MAI funds.

Source: Associated Black Charities, Inc. (ABC). 2007. *FY 2007 Table 9 — Allocation of Funds by Service Category, Baltimore EMA*. Baltimore, Md.: ABC, May.

COLLABORATION ACTIVITIES IN 2007

GRANTEE AND ADMINISTRATIVE AGENT

The planning council and its support office, IGS, work very closely with the grantee and AA. Looking back over the last year, it would be difficult to list all of the cooperative projects that these entities engaged in. Some of the highlights include the grant applications (Part A and MAI), priority setting and reprogramming.

IGS, the grantee and the AA collaborated to write the applications for both the Ryan White Part A and the MAI grants, which received the second highest score for applications among all EMAs in the country, an outstanding achievement. The planning council is grateful for the hard work that went into this accomplishment, work vital to ensuring that the EMA continues to receive adequate funding.

Priority settings, as well as the five- and seven-month reprogramming processes, are essential yet complicated exercises for all parties involved. The planning council relies heavily for its fiscal decision-making on the recommendations presented by the AA, as well as the data collected and presented in the ESD report. The planning council and IGS work with the grantee and AA to confirm that voting members are supplied with all the information required to make their data-based decisions.

PEER REVIEW OF STANDARDS OF CARE

The council reviews standards of care for funded service categories on a four-year schedule. As mentioned, the Continuum of Care Committee leads these reviews;

however, the committee receives input from CQM and experts in the delivery of that particular service. The merging and creation of new service categories following the reauthorization required the committee to consult all available resources when creating the new standards of care. The planning council approved the newly established EIS category's standard this fall. Two additional standards of care, health insurance premiums/cost sharing and outpatient ambulatory health care, are in the final stages of revisions and will be finalized early in 2008.

PRIORITY SETTING

Priority setting is the most critical of the planning council's responsibilities and could not be successfully carried out without help from all of its partners. As noted previously, the grantee, AA and IGS provide tremendous support to the council for this activity. Additionally, the council calls on other HIV/AIDS-service planners to ensure that, when planning for the allocation of funds, the council can successfully avoid duplication of, or gaps in, service. In 2007, the council received information by means of reports and presentations from representatives of the Ryan White Part B and D programs, Maryland AIDS Administration, Baltimore Substance Abuse Systems, Inc., Baltimore Homeless Services, Johns Hopkins Medical Institutions, Maryland Department of Health and Mental Hygiene, and Medicaid.

NEEDS ASSESSMENT

Both 2007 needs-assessment projects, the not-in-care research report and the consumer needs assessment, involved much collaborative work. The Needs Assessment Committee worked with IGS policy analysts to design and plan both projects. To conduct the needs assessment, 14 interviewers were hired and trained to administer the one-on-one, confidential survey. Four of these interviewers had participated in the 2004 consumer survey. A total of 745 consumers were interviewed (730 residing in the Baltimore EMA) at 38 sites, which included community-based organizations, health departments, hospitals, substance-abuse treatment facilities and support-group providers. Neither project could have been successful-

ly conducted without the cooperation of both the consumers and HIV-service providers in the Baltimore EMA.

MARYLAND AIDS ADMINISTRATION REGIONAL ADVISORY COMMITTEE

The Maryland AIDS Administration has revitalized the Regional Advisory Committee (RAC), an organization that was established to share information and receive assessments of HIV/AIDS services in Maryland. Feedback generated at RAC meetings is used to assist the AIDS Administration in the development and implementation of HIV/AIDS programs in the community.

In 2007, several members of the planning council, as well as the PLWH/A Committee and the support office, began regularly attending central Maryland RAC meetings. Two planning council members were recently elected as co-chairs to this local RAC. With the recent appointment of planning council members to this leadership position and the growing number of council-associated individuals attending these meetings, the council is optimistic that there will be future collaboration opportunities as this organization progresses.

LEADERSHIP, EMPOWERMENT, ADVOCACY, PARTICIPATION

The Gay Family Foundation, Inc. (GFF) has been awarded the Part A capacity-building contract for the past few years. Under this contract, GFF leads numerous seminars, with the Leadership, Empowerment, Advocacy, Participation (LEAP) program being the one that most directly affects the council. Now in its eleventh year, this program is well-established as a successful way to introduce the planning council and its activities to PLWH/As in the community. Over half of the LEAP 11 graduating class has attended planning council meetings; three are currently on the pool list and two have already been appointed to the planning council. Greater communication between the Nominating Committee and those developing future LEAP curriculums would only continue to increase the number of capable, enthusiastic applicants for council membership.

ON THE HORIZON IN 2008 AND BEYOND

TRANSITION WITHIN THE ADMINISTRATIVE MECHANISM

The grantee announced this fall that, effective March 1, 2008, the respective responsibilities of the grantee and AA would be changing. Programmatic and data-related oversight will be assumed by the grantee, while the AA will act primarily as the fiscal agent. The administrative bodies have begun planning for as smooth a transition as possible, but there will no doubt be a few bumps in the road during this first year.

Therefore, the planning council will remain engaged in the progress of this administrative conversion and concentrate on the direct and indirect effects this change will have on council activities and deliverables. Members are already considering questions such as the type and quality of data they would like to receive for priority setting and reprogramming, the content of monthly reports, and how the change will affect the implementation of council directives and timeliness of reporting. The council plans to help as much as possible with the transition, with the goal of achieving the most effective administrative mechanism possible.

THE COMPREHENSIVE PLAN FOR 2009-2011

The Comprehensive Planning Committee will be overseeing the development of the planning council's comprehensive plan for 2009-2011. It is the planning council's largest deliverable and the writing and revising of this document will take almost all of 2008 to complete before submission to HRSA in January 2009.

A stakeholder forum, to be convened in January 2008, will launch the development of the plan. In addition to planning council members, community members and

local advocates are encouraged to attend this meeting to impart their assessments of local service delivery and their predictions of trends in the populations affected by the disease. Interviews will be conducted following this forum to obtain additional information that can be used to formulate the plan. The Comprehensive Planning Committee, with IGS assistance, will be composing and revising the plan throughout 2008. Planning council members will have numerous opportunities to contribute ideas for the plan's objectives and are already thinking about issues they think may arise in the coming years.

SUNSET OF THE RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT

The planning council also must begin thinking seriously about the implications of the end of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, as the legislation virtually dies September 30, 2009. This means that the law cannot be reauthorized again, but rather will either be abolished altogether or rewritten completely. Either way, this could seriously affect the way in which Ryan White dollars are disseminated at the federal and local level. Some of the same obstacles that were faced in the past will resurface, regardless of previous victories. While current legislation requires that a minimum of 75 percent of the grant award be allocated to core medical services, the council worries that there may be pressure to increase the requirement or to disallow funding of support services altogether. Another potential threat would be the elimination of planning councils entirely. And these are just some of the problems that may come up.

Thus, the planning council will take every opportunity to educate legislators of the vital need for Ryan White services in the vulnerable community of uninsured PLWH/As. The council will continue to assess and advocate for the needs of the HIV/AIDS community in the Baltimore EMA, demonstrating along the way the important role that can be played by an active planning body such as the council.

PLANNING COUNCIL LEADERSHIP

Planning council leadership will be experiencing a turnover, as the chair's and vice chair's terms come to an end in 2008. Lennwood Green and Dale Brewer have led the council through some complex times and are now experienced with leading the council in the political and media arena. Given the uncertainty of the future of Ryan White legislation, planning council leadership will be more important than ever before. It will be critical that those members considering running for leadership positions in 2008 establish working relationships with current council leadership and administration. Additionally, those interested persons, not to mention the rest of the council, must remain cognizant of the looming challenges on the federal, state and local levels.

LEADERSHIP FOR THE FUTURE

A prevailing theme throughout the final months of 2007 was the need for planning council members to evaluate and improve their leadership skills and participation levels. All planning council members are leaders to some extent, if only by virtue of their representation of specific constituencies to the council and committees. However, it is critical for all members to periodically assess their individual leadership-related strengths and weaknesses and work to strengthen their skills. If nothing else, members with a strong understanding of good leadership will be better able to hold planning council and committee chairs and co-chairs to a high standard.

With the end of the terms of current planning council leadership and the conclusion of the reauthorization approaching, council members are forced to begin assessing the direction of the council. Consideration as to how potential changes could impact the council's ability to work toward its mission and vision must be analyzed. The urgent need for planning council members to begin assessing the capacity and future direction of the council prompted IGS to prepare a series of leadership-training workshops for planning council members.

ADVANCED LEADERSHIP TRAINING

All planning council members were encouraged to enroll in IGS's first Advanced Leadership Training series. The course was intended to provide a combination of personal leadership skills, planning council-specific leadership skills and knowledge of the planning council as an organization.

The four sessions, conducted in October and November, were interactive classes that built upon one another, beginning with a self-assessment of individual leadership skills and ending with an analysis of the planning council and related factors. The sessions were not lectures; instead, participants were expected to actively engage in group activities and conversations. Former planning council chair Debbie Rock, IGS Chairwoman and CEO Cyd Lacanienta and current planning council chair Lennwood Green were guest speakers and contributed to the training sessions, offering invaluable insight into their individual experiences as leaders within the planning council and the community. After completion of the four sessions, participants left with a better understanding of the council and their ability to influence its course through effective leadership.

ADVANCED LEADERSHIP TRAINING GRADUATES

| | |
|-----------------|----------------|
| Sheila Ashley | Deborah Hunter |
| Karen Bellesky | Carolyn Massey |
| Rebecca Bradley | William Miller |
| Herman Carter | Gail Nelson |
| Denise Cooper | Joy Winslow |
| Albert Foyles | |

PLANNING COUNCIL TRIVIA

HOW WELL DO YOU KNOW THE COUNCIL MEMBERS?

Complete the following sentences to see how well you know your fellow planning council members.

(Answers below.)

Which planning council member...

1. ...has a son on the honor roll this year?
2. ...baked 100 rum cakes to be shipped to troops in Iraq this December?
3. ...has been on the Billboard Top 20 Dance list?
4. ...won a state roller-skating championship at 11 years old?
5. ...lived in the Czech Republic for two months?
6. ...recently visited two countries that he wanted to explore since age 10?
7. ...will be getting married in the upcoming year?
8. ...enjoys playing the piano and organ?
9. ...is a golfer?
10. ...is a new grandmother?

Answers:

1. Denise Cooper, 2. Karen Bellesky, 3. Herman Carter, 4. Jeanne Keruly, 5. Alice Middleton, 6. Lennwood Green, 7. Norman Robinson, 8. Dorcas Baker, 9. Reginald Haden and 10. Gail Nelson.

PLANNING COUNCIL WORD SEARCH

Answer the following questions and then locate the answers in the word search. Answers may be written forward, backward, upward, downward or diagonally.

(The solutions can be found on the page after the word search.)

1. The Health Services and Support Services committees merged to form what new committee?
2. Once a motion is made, someone must _____ it before it can be voted upon.
3. Planning council meetings are held on the third _____ of each month.
4. Under the reauthorization, at least 75 percent of Part A dollars must be allocated to _____ services.
5. Maryland recently switched to _____-based HIV reporting.
6. The Baltimore EMA is made up of Baltimore City, Baltimore County, Queen Anne's County, Carroll County, Anne Arundel County, Harford County and _____ County.
7. What is the acronym for the federal agency that administers Ryan White funding?
8. _____ is held every summer to allocate Ryan White Part A funds.
9. Members of the _____ Committee are elected annually by the planning council.
10. The planning council is composed of _____ members.
11. The Baltimore City Health Department acts as the _____ for Ryan White Part A in the Baltimore EMA.

12. A main task of the Continuum of Care Committee is the review of _____ of care.
13. The _____ survey of the Baltimore EMA is a needs-assessment project conducted every three years.
14. _____ of funds occurs every September and November under the direction of the Service to Surrounding Counties and Evaluation Committees.
15. Which committee is made up of committee co-chairs, Part B and D representatives, Baltimore City and Baltimore County representatives, and two members at large from the PLWH/A Committee?
16. The _____ Plan for HIV Service Delivery for 2009-2011 will be written in 2008.
17. The planning council and committees require a majority of members, or _____, in order for motions to be made.

H I R D K R I F R H C S D F G O K J E C
C O N S U M E R T F D B F L J Z S X F R
O O G R F V H O W A R D N F V K J Y R D
R G N I T T E S Y T I R O I R P H E N G
E T I T T G F G H G F V M V B Y I V P O
M U M D I D V Q E R T Y I D H J B I M J
E Z M V G N B S D R A D N A T S I T T Y
D U A E R O U T T Y B D A T Y U O U N M
I Y R Q C C X U R T Y Y T N M U I C O P
C X G E R E Y E M P U I I R E X V E M M
A U O R E S W S N O R T N T U H V X N M
L Y R U I H N D N M F V G R A N T E E B
M N P R E S T A X C B C M N F J I U F C
U H E F O R T Y B Q G H A T Y I O B P N
G H R S A E S G V U S D X R N M U R W C
Y T X F S K L I U O R E A S E M A N P O
Y N D W R X A F T R Y I P Y V D X A H E
T Q B F H K D C I U Y T B M N H G D P O
U G D G N V W C O M P R E H E N S I V E
P H F R K G C W D H K L O Y R E D B N X

Solution:

C O N S U M E R
O O G H O W A R D N
R G N I T T E S Y T I R O I R P E
E I T M V
M M I D I I
E M N S D R A D N A T S T
D A O U T A U
I R C U T C
C G E E M I E
A O S S O N X
L R D F G R A N T E E
 P A C
 E F O R T Y Q A
H R S A U R
 O S E M A N
 R
 U
 C O M P R E H E N S I V E

Word puzzle devised by Michelle L. Komosinski, Committee Policy Analyst, InterGroup Services.

ACKNOWLEDGMENTS

The planning council's achievements are attributable to the robust network of hard-working members, volunteers, partner organizations, HIV-service providers and other agencies. The ongoing support proved to be advantageous as the planning council maneuvered the numerous legislative and administrative changes throughout the year. It would be impossible to identify everyone who has contributed to the council throughout 2007, but there are some contributions that should be highlighted.

Despite ongoing shifts in administrative responsibilities, BCHD and ABC continue to provide exceptional support to the council, most notably in their ability to keep the council informed of new legislative changes. The council was fortunate to have experienced leadership in the grantee's office, with Ralph S. Brisueno acting as the program director of the Ryan White Part A Office, to guide it through these changes. Additionally, BCHD's CQM staff supplies the planning council and its committees with expertise and insight into HIV-service delivery in the EMA and the council would like to thank Jesse Ungard and his outstanding team: Steven Dashiell, Alberta L. Ferrari, Deepa Ganachari, Joy Johnson, Shazia Kazi and Lauren E. Koontz. The planning council also depends on the fiscal and performance data analyzed by ABC and is thankful for its hard work in preparing reports for the council. The council thanks Program Officer Guy Weston and Senior Accountant Sonney Pelham for leading an excellent staff including: Cleo Edmonds, Rian Ellis, Adesola Gbadamosi, Lamont Keaton, Andrea Knox, Boatemaa Ntiri and Danella Scruggs.

The planning council also wishes to thank the staff of IGS, who provide the primary administrative and research-related support for the council. Despite many personnel changes throughout 2007, IGS continued to meet the council's needs under the leadership of Cyd Lacanienta and Douglas Munro, who devote many hours to researching legislation and policy, overseeing the planning council support team and generally ensuring high-quality planning council deliverables.

Regrettably, Editor and Senior Policy Analyst Sutton Stokes, Policy Analyst Jill Boesel, and Program Specialists Nicole Curtis, Ramelle McCall and Jenna Miller departed IGS this year. However, the council was appointed a new deputy program manager, Natalie Lewis, as she was promoted from her previous position as policy analyst; and Michelle Komosinski was hired as the new committee policy analyst to round out the team. Both the latter have adapted to the council's needs like fish to water — and Michelle draws up a mean word puzzle!

Senior Technical Advisor Kate Hale continues to provide the planning council with technical support, Office and Business Administrator Daurice Gorham maintains records and arranges logistics for the planning council meetings and events, and James Salvador keeps the offices in good condition.

The planning council appreciates the individuals who volunteered time to compile data and present information that would improve the council's ability to make educated allocation decisions at priority setting. The planning council thanks the following individuals who gave data presentations to the planning council throughout 2007:

- Angie Allen, Maryland AIDS Administration (prevention).
- John Bartlett, M.D., Johns Hopkins (medical trends).
- Mary Lee Bradyhouse, Baltimore Homeless Services (HOPWA and housing issues).
- Adam Brickner, Baltimore Substance Abuse Services, Inc. (addictions and treatment).

- Glenn Clark, Maryland AIDS Administration (MADAP; Parts B and D services).
- Rosemarie Downer, Ph.D., Precise Research & Evaluation, Inc. (Baltimore County needs assessment).
- Rian Ellis, Associated Black Charities, (service category definitions).
- Colin Flynn, Maryland AIDS Administration (epidemiology).
- Jeanne Keruly, Johns Hopkins (continuum of care).
- Natalie Lewis and Sutton Stokes (2007 consumer survey).
- Alice Middleton, Department of Health and Mental Hygiene (Medicaid).
- William Miller and Joy Winslow, Planning Council (PLWH/A position paper on transitioning to long-term services).
- Veronica Thomas, Baltimore Human Relations Commission.
- Jesse Ungard, Baltimore City Health Department (Clinical Quality Management 2006 reviews).

The planning council appreciated the community support during its most important events, the EMA and STSC priority settings. At the EMA priority setting, the council was honored to have as guest speakers Diane Bell-McKoy from Associated Black Charities, Dr. Michelle Gourdine from the Department of Health and Mental Hygiene, Maryland AIDS Administration Director Heather Hauck and Baltimore City Health Commissioner Joshua Sharfstein. The STSC Committee thanks Howard County Health Officer Peter Beilenson and Baltimore County Health Officer Pierre Vigilance for addressing the committee at the STSC priority-setting conference in August. The planning council also wishes to acknowledge members of the community who attended the EMA or STSC priority-setting events as visitors: Andre Brewer, Anita Courtney, Anthony E. Leverette, Caroline Orwenjo, Carolyn Nganga-Good, Carrie Goines, Donald Brown, Everett Walker, Fahd Habeeb, Greg Schmitt, Jerome Gore, Krista Kocherhans, Latell A. Carlos, Manissa Massey, Pat Hawkins, Ralph Black, Richard Rubino, Shannon Cosgrove, Tanita Johnson and Tim Townsend. The

event can be rather difficult and tiresome; therefore, the council greatly appreciates all who attend and demonstrate interest in the council's work.

One of the largest planning council deliverables this year was the 2007 consumer needs-assessment survey. This survey would not have been possible without the support and assistance of the interviewers, HIV-service providers and, of course, the interviewees. The council would like to commend the 14 interviewers for their hard work in completing the survey: Veronica Barnwell, M. Lydia Berry, Terri Davis, Millie Fields, Greg Grenier, Christina Homa, Karen Horton, Doris Kelly, Michael Knipp, Michael Middleton, Kori Pilkins, Jessica Turrall, Nadja Vielot and C. Antoinette Volley. The council thanks all 745 consumers who participated and the providers who enabled the survey to be conducted:

- AIRS (AIDS Interfaith Residential Services).
- Anne Arundel County Health Department.
- Baltimore County Health Department.
- Baltimore Pediatric HIV Program/Johnson Square Day Care.
- Carroll County Health Department.
- Chase Brexton Health Services.
- Family Health Center of Baltimore.
- Glenwood Life Center.
- Harford County Health Department.
- HAVEN.
- HERO.
- Howard County Health Department.

- Johns Hopkins University — Comprehensive Care Practice.
- Johns Hopkins University — Moore Clinic.
- Man Alive.
- Manna House.
- Moveable Feast.
- New Vision House of Hope.
- Park West Medical Center.
- People's Community Health.
- Project PLASE.
- Queen Anne's County Health Department.
- Right Turn of Maryland
- STAR (Sisters Together and Reaching).
- Total Health Care.
- Tuerk House.
- University of Maryland — Denistry PLUS Program.
- University of Maryland — Evelyn Jordan Center.
- University of Maryland — Jacques Initiative.
- University of Maryland — Maryland General.
- WAR (Women Accepting Responsibility).

All planning council members are required to sit on at least one standing committee. However, with the exception of the Nominating Committee, committee membership is not limited to planning council members. In fact, committees encourage other community members to volunteer to provide their expertise and input in deliverables, such as the standards of care. The council would like to recognize and thank those non-planning council members who have participated in committees throughout the year: Stephanie Alston, Felecia Bailey, Patricia Balducci, Lynda Bayliss, Chanel Brown, Anne Burke, Vernetta Burrell, Garry Cannady, Phillip Church, Luana Clark, Michael Cole, Grace Daniels, Russell Disharoon, Rowdelle Echols, Adoenna Emeyi, Michelle Emerson, Shelly Ernest, Will Fenwick, Michael B. Flint, Bill Frank, Brian Fitzsimmons, John Gerwig, Christopher Gibson, Diane Goforth, P.J. Gouldmann, Lisa Green, James Gresham, Nancy Guest, Patrice Henry, Laura Herrera, Marlyn Jews, Brian Knight, Susan Kopins, Joyce Levy, Shannon Lunnen, Suzanne Matsko, Kibibi Matthews, Nola Korsch, Mary Mazzuca, Debbie Middleton, Richard Parrish, Stephanie Pons, Ken Ruby, David Shamer, Raymond Shattuck, Synthia Smith, Jami Stockdale, Carnell Thomas, Jr., Lucy Wilson and Mary Yancey.

Thank you again to everyone who has contributed to the planning council; it has been a great year. We look forward to working with you in 2008!

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GREATER BALTIMORE HIV HEALTH SERVICES PLANNING COUNCIL

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MISSION



To provide comprehensive, high-quality services to people living with 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 to expand capacity and to 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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