Greater Baltimore HIV Health Services Planning Council

Annual Report

December 2006

Prepared by InterGroup Services, Inc.

Funded by the Ryan White CARE Act 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 (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 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

The Greater Baltimore HIV Health Services Planning Council and the Baltimore Title I eligible metropolitan area (EMA) have faced many challenges and achieved many successes during 2006. Highlights of the year include:

- *Successfully managing and implementing programs and services for the Baltimore EMA's approximately 10,000 Ryan White CARE Act clients.* For fiscal year (FY) 2006, the EMA was awarded $20,628,895 (including Minority AIDS Initiative funds), a more than 7 percent increase over the FY 2005 award of $19,179,964.
- *Extensive efforts to monitor and respond to the pending reauthorization of the Ryan White CARE Act.* Hopeful that Congress would pass CARE Act reauthorization legislation by the end of 2006 (the CARE Act reauthorization of 2000 having expired), the council devoted much of its time this year to researching the changes that would likely be mandated as part of the reauthorization, including an apparent requirement that 75 percent of an EMA's total grant award be used for what Congress called "core medical services." This would have involved a dramatic shift in funding from support to medical services though, as it turned out, the very final version of the CARE Act bill merely required that 75 percent of *service* funds — not 75 percent of the *entire* award — be devoted to medical services. Still, not knowing this at the time, council members as well as the staffs of the support office, the grantee and the administrative agent worked hard to understand and minimize the effects of this shift on the service continuum. This past summer, the council structured its annual priority-setting conference so that the results would comply with the anticipated new legislation. Though the 75 percent mandate did not turn out to be strict as as anticipated,

the effort was not in vain. The bill as passed still classifies all services as "core medical" or "support," in a manner that the 2000 law did not. Having planned for this classification at priority setting, the EMA is now ahead of the game as we prepare to move into FY 2007.

The CARE Act bill — H.R. 6143 — eventually passed in the waning hours of the 109th Congress. Though passage of the bill has improved the EMA's funding prospects for FY 2007, cuts are still likely. The summer 2006 priority-setting conference only planned for cuts of up to 10 percent. Since there is a very real possibility of a cut of this magnitude or more (and it would have been larger still had the CARE Act not been reauthorized), the council must reconvene in January for another priority-setting event, this one designed to plan for a hypothetical cut of 20 percent. In this respect, the council is hoping for the best but planning for the worst.

- *Continuing to refine and improve the processes used at priority setting, the most significant task performed by the planning council each year.* The service-category scorecards, a planning tool introduced at the summer 2005 priority-setting conference, were further improved this year and were also available for this fall's reprogramming meetings for the first time. At priority setting, a two-tier voting process, necessary for compliance with the reauthorization legislation, was adopted this year, along with new techniques to streamline discussion and deliberation.
- *Delivering the* Comprehensive Plan for Service Delivery in the Baltimore EMA: 2006-2008 *to HRSA.* In addition to the grantee and the administrative agency, more than 40 health planners, prevention planners, service providers, consumers and epidemiologists provided input on this triennial deliverable, which is the council's most complex and lengthy product.
- *Designing and initiating, through its support staff, two needs-assessment projects.* The FY 2007 consumer survey project has already been started. Also, a special carryover project designed to gather and report on current knowledge related to the not-in-care HIV-positive population is now underway.

Planning Council Members

(as of September 1, 2006)

Lennwood Green, *Chair*

Dale Brewer, *Vice Chair*

Kate Allston
Sheila Ashley
Dorcas Baker
Herman Carter
Markton Cole
Lynne Creditt
Nathalia Drew
Bernice Thomas-El
Betty Flint
Albert Foyles
Bryna Grant
Michael Graves
Tyrone Gray
Reginald Haden
Phyllis Hall
Robin Hamlett
Dwight Henson
Regina Johnson
Bettye Cheek Jones
Sophia Jones
Jean Keller
Jeanne Keruly
Gregory Manigo
Carolyn Massey
Daniel McKelvin
Wendy Merrick
William Miller
Gail Nelson
Michael Obiefune
Darryl Payton
Melanie Reese
Hilton Roberts, Jr.
Walter Samuel
Alfredo Santiago
Raymond Shattuck
Kima Taylor
Bernice Tucker
Scott Woods

Message from Planning Council Leadership

Photo: D.P. Munro

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

This past year has been one of the most challenging in the history of the council, and Dale and I want to thank you for your perseverance and support. We have watched Congress struggle through 2005 and 2006 to craft a reauthorization bill for the Ryan White CARE Act. Efforts have been directed toward assuring the continuation of vital services while imposing tighter controls through prescriptive language and the phasing in of an HIV names-based reporting system for funding-formula purposes. Maryland's code-based HIV reporting system has not mattered previously because the formula has been based solely on AIDS caseload, not HIV and AIDS caseloads combined. In Maryland, as elsewhere, AIDS cases are already reported to the federal government by name.

As events unfolded in 2006, the community of consumers of Ryan White-funded HIV services joined with allies across the country to educate legislators about HIV and AIDS. They also stressed how the disease impacts the lives of individuals and the importance of the configuration of services and costly treatments that are necessary to save lives. Everyone in the Baltimore EMA who is concerned about the epidemic owes a debt to those volunteers who raised their own funds to travel to Washington and Annapolis to speak with legislators and staffers. These visits dramatically raised awareness and provided essential facts about the epidemic and what is necessary to keep those infected with HIV healthy and productive.

The issue was of vital concern, particularly for Maryland. The expiring CARE Act (the version reauthorized in 2000) required names-based HIV case reporting beginning in 2007. Maryland does not have an HIV reporting system in place that is acceptable to the federal agencies overseeing the HIV epidemic and the CARE Act funding system. Fortunately, the CARE Act as reauthorized this December supercedes this names requirement, giving states like Maryland an additional three years to convert to names reporting. Without this extension, Maryland and the Baltimore EMA would have been in a very precarious fiscal situation. Council leadership continues to work with the Maryland Department of Health and Mental Hygiene (DHMH) to address this issue and ensure a smooth conversion to names reporting by the end of FY 2009 (the new federal deadline).

Also during 2006, the council continued with its work of monitoring service-category performance and expenditures, reviewing and revising standards of care, recruiting and training new members, analyzing trends in the epidemic and developing strategies to keep pace with changing service demands and needs.

Although we begin 2007 with many unanswered questions regarding what our grant award will be, there are some things that are certain: first, that you will continue to advocate for those who have no voice or representatives who speak for them; second, that Dale and I will continue to work on your behalf with our partners to improve the quality of our care continuum and to expand services wherever possible; and last, that — together — we will build the best EMA in the country.

Happy holidays and peace in the coming year,

Lennie Green (Chair) and Dale Brewer (Vice Chair)

About the Planning Council

The Greater Baltimore HIV Health Services Planning Council is a 40-member, mayorally-appointed panel responsible for allocating about $20 million in annual federal grants for HIV-related services in the Baltimore area. These grants are made under Title I of the Ryan White CARE Act (RWCA), a piece of federal legislation first passed in 1990 to assist areas particularly hard hit by HIV; the CARE Act is administered by the U.S. Health Resources and Services Administration (HRSA). Recognizing that HIV disease knows no borders, CARE Act grants are directed not to one particular jurisdiction but to what the CARE Act terms "eligible metropolitan areas" (EMAs), usually consisting of a city and several surrounding counties. Nationwide, there are 51 EMAs, each with its own planning council. The Baltimore EMA comprises the city of Baltimore and six neighboring counties: Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's.

The Baltimore EMA, which celebrated its fifteenth anniversary this year, was recognized as eligible for Title I CARE Act funds in 1991. That year, the then mayor of Baltimore City, Kurt L. Schmoke, created a 35-person planning council and appointed as members various state health planners, HIV service providers, representatives of the other CARE Act titles and advocates for and from the HIV/AIDS-infected community. (The CARE Act requires that planning councils' memberships include representatives of each of these constituencies.) The Baltimore City Health Department (BCHD) was designated to administer the CARE Act grant award and to work with the planning council in meeting federal reporting requirements. University of Maryland School of Nursing staff initially provided administrative and other support services to the council.

The first years of the council's existence were devoted to regaining ground in the face of a fast-growing public-health emergency. The council worked with its partners to respond to the epidemic with an appropriate configuration of services, based on epidemiological data from within its own membership, the University of Maryland, and the Maryland AIDS Administration. As the council began to find its legs, it experienced the growing pains of any newly formed group that must create its own policies and processes at the same time that it is carrying out its mandated duties. The council recognized that it could not serve as a "committee of the whole" and still meet the CARE Act's requirements, so it created committees from its membership. These committees were designed to address the various tasks the council was required to carry out and to make recommendations to the council.

Planning Council Fast Facts

- Two council members had babies in 2006.
- Two members are studying for advanced degrees.
- Two members are working on a special HIV/AIDS project in Africa.
- Five out of 13 LEAP 9 (class of 2005) graduates are council members, and the rest are committee members.
- Eight members are graduates of past LEAP classes.

Among the first committees created by the council was the By-laws Committee. This committee was tasked with developing and formalizing the council's rules and procedures. The council also created a Comprehensive Planning Committee to analyze the trends and broad issues of the epidemic, and to provide the council with a big-picture view to guide planning. This committee was also responsible for ensuring that the planning council had available all the needs-assessment data it required to make its planning decisions. The Evaluation Committee was created to monitor and report on whether or not CARE Act-funded services were performing according to plan and to assess the effectiveness and efficiency of the system for funding services. To ensure the consistency and quality with which funded services are deliv-

ered, the council established two committees, Health Services and Support Services, and populated them with members qualified to develop health-care-delivery standards for each funded service category. The Nominating Committee was created to coordinate council elections and identify individuals to be recommended to the mayor for appointment as new members.

Recognizing that many of its infected/affected members were intimidated by the credentials and technical expertise of some other members, the council created a People Living with HIV/AIDS (PLWH/A) Committee so that new consumers joining the council could learn the processes, procedures and skills needed to fully participate in council meetings. The PLWH/A Committee is also responsible for bringing the perspective and voice of the infected community to committee and council meetings as decisions are made that affect service consumers.

Since the inception of the planning council, consideration has been given to ensuring that consumers in the six suburban counties of the EMA have access to all needed services. Recognizing that geography, stigma and the limited number of AIDS-service organizations in the counties would be barriers to care for counties residents, the council created a service category, "services to surrounding counties" (STSC), to provide funds for seropositive clinics in each of the counties. The council also created the STSC Committee to ensure that the needs of counties HIV-positive individuals would be identified, brought to the council and appropriately addressed through the services funded in the STSC category.

As the council matured, it refined its processes and procedures and created tools for carrying out its mandated tasks. As data requirements became more complex, the council created a Needs Assessment Committee to shoulder some of the responsibilities that had been held by the Comprehensive Planning Committee. The council also opened its committees to individuals who were not planning council members so that there would be an ever-increasing diversity of opinion and input from the larger community. In 2002, the contract for the planning council's administrative, research and other support was assumed by InterGroup

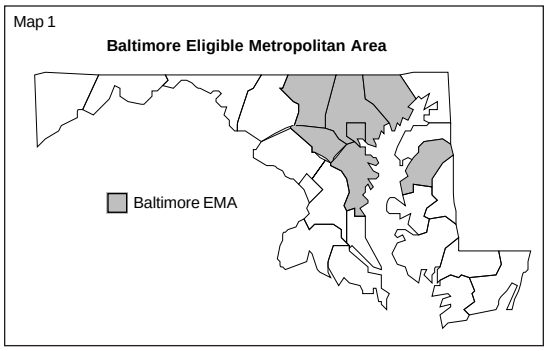
Services, Inc. (IGS), also referred to as the planning council support office (PCSO). That same year, Associated Black Charities (ABC) won the contract to act as BCHD's administrative agent (AA), overseeing and monitoring provider contracts.

Today, the planning council has 40 members; its membership reflects the diversity of the HIV epidemic in the Baltimore EMA. As of September 1, 2006, the council is 82.5 percent African-American, 15.0 percent white and 2.5 percent Hispanic/Latino; about half of the council's members are PLWH/As. Each year, over 200 volunteers work with the council on special projects, serve as members of committees, and provide input for standards of care, the comprehensive plan, priority-setting needs-assessment data, and other council activities. Through their efforts, over 10,000 PLWH/As received services in the Baltimore EMA in 2006.

About the Baltimore EMA

The Baltimore EMA consists of the city of Baltimore and six surrounding counties — Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's. Geographically, the region encompasses an area of 2,619 square miles; it contains 48 percent of Maryland's population.

It would be easy to assume that, because the EMA jurisdictions are geographically close, they are more similar than they are different. However, the jurisdictions of the Baltimore EMA are actually quite diverse, especially in terms of socio-economic status, living conditions and access to care. In the EMA as a whole, 68 percent of the population is Caucasian, 25 percent African-American and 7 percent other ethnicities. In Baltimore City itself, however, African-Americans make up about 65 percent of the residents. Poverty rates also vary considerably, from 3.4 percent in Howard County to 22.6 percent in Baltimore City.



According to current HIV/AIDS surveillance data, the Baltimore EMA's AIDS rate ranks fifth in the nation, compared to eighth in 2000. It is estimated that 35 percent of HIV-positive clients in the EMA know their status but are not in pri-

mary medical care. Bringing these clients into care is one of the most significant challenges that this EMA continues to face.

The epidemic in the EMA continues to be about four-fifths African-American, concentrated among those 30-50 years of age. Injection drug use is still a common exposure mechanism, particularly in Baltimore City, but transmission through heterosexual sex is increasing. The rate of increase in the incidence of HIV and AIDS has slowed, and infected individuals are living longer and healthier lives. While these are good trends, one result is an ever-increasing number of Baltimore EMA residents needing care.

Baltimore's current continuum of care is both broad and deep. Primary medical care is supported by a wide range of other services, including substance-abuse and mental-health treatment services, case management, oral health, housing, transportation, and other supportive services essential to keeping PLWH/As in care.

Planning Council Accomplishments in 2006

Following are summaries of the planning council's accomplishments in 2006.

Funding

The Baltimore EMA received a funding increase for FY 2006 after two straight years of reductions. The initial grant award of Title I and Minority Aids Initiative (MAI) funds for FY 2006 was $20,628,895, an increase of 7.6 percent from FY 2005. (As an aside, HRSA rated the Baltimore EMA's FY 2006 grant application the second best in the nation.) A carryover request for 22 projects was submitted to and approved by HRSA; this request added $626,517 to the initial grant award, for a final FY 2006 award of $21,255,412.

Priority Setting

Each summer, the planning council meets to set spending priorities for the upcoming fiscal year's CARE Act Title I grant to the Baltimore EMA, i.e., what percentage of the grant will be allocated to each possible service category. Since the actual amount of the upcoming year's grant is never known at the time of this meeting, the council must consider what it will do in the event of increased, decreased or flat funding. One of the service categories that the council can fund is services to surrounding counties. Each summer, after the full council has set the EMA's spending priorities for the upcoming fiscal year, the STSC Committee meets, separately, to set spending priorities for the funds that the council has allocated to the STSC category. (The full council's priority-setting meeting is also known as the EMA priority setting; the STSC Committee's is also known as the counties priority setting.)

Photo: S.R. Stokes

On behalf of Sen. Barbara A. Mikulski, Keysha Brooks-Coley accepts an award from council Vice Chair Dale Brewer as Chair Lennwood Green looks on.

The EMA and counties priority-setting meetings are quite formal parliamentary proceedings. IGS contracts with professional facilitators who guide the council's members in following their established processes, completing the service-category ranking and funding-allocation exercises, and issuing any special instructions for the grantee or AA concerning the delivery of services. Council and STSC Committee members are supported throughout their respective priority settings by AA, BCHD and IGS staff, who provide data, technical support and recommendations.

For this year's priority-setting process (i.e., planning for FY 2007), the council and the STSC Committee were faced with a complication. The Ryan White CARE Act, which must periodically be reauthorized by Congress, was due for this reauthorization before FY 2007. By the time of the priority-setting meetings, however, reauthorization had not yet occurred. This meant that, in addition to the usual uncertainty as to the precise size of the upcoming grant, planners were also in the position of attempting to comply with proposed changes to the CARE Act — changes that were not yet final.

The two most important of these potential changes, from a planning perspective, were (1) the realignment of service categories into two newly defined, broad classes, "core medical services" and "support services" and (2) the requirement that EMAs allocate at least 75 percent of their *total* grant awards to said core medical services. (This was later changed just to 75 percent of the *services* award, but the council did not know this at the time.)

As a first step toward meeting the latter requirement, before the priority-setting meetings the council met with advisors from its support office as well as from the AA and BCHD to examine the definitions of the two new classes of service categories and determine if components of certain categories that had previously been considered "support" might now qualify as "core medical." Also, to ensure maximum flexibility in maintaining the local continuum of care, the council established new — for this EMA — service categories, such as health insurance and early intervention services (both core medical services), which could absorb certain functions of some of the old support-service categories.

These shifts were not sufficient to accomplish the then goal of allocating 75 percent of total grant funds to core medical services, however. Therefore, the FY 2007 priority setting was structured so that funds would be shifted away from support-service categories as necessary to result in core medical being allocated what at the time was anticipated to be the required 75 percent. Because of the negative effect that reserving 75 percent of funds for core medical services would have on support services, the council decided to expand the array of services that could be funded by the MAI portion of the grant award. The Baltimore EMA had previously used MAI funds — which are intended for targeted additional support for minorities affected by HIV — for only four service categories. Since over 85 percent of new HIV cases in this EMA are African-American, the council, on the advice of the grantee, decided that MAI funds could be used for most of the old support-service categories (which would otherwise suffer as the result of the transfer of funds to the medical class of services).

Another pre-priority-setting activity was the presentation of planning data to the council by various local health officials and providers. Because of the volume of data that the council requires to perform its service rankings and funding-allocation exercises at priority setting, the entire July 2006 planning council meeting was given over to these data presentations. Additionally, two presentations were given at the June council meeting.

The council's Needs Assessment Committee guided IGS in identifying and requesting the data that council members most needed in order to make the best possible planning decisions. Information about the latest treatment trends and new issues confronting primary medical care providers was presented. Council members received handouts about other sources of funding for area HIV-related services, such as the Veterans Administration, the U.S. Substance Abuse and Mental Health Services Administration, and Medicaid. Title III of the CARE Act is used to fund early intervention programs, so data concerning this resource were of particular interest given the council's increasing emphasis on identifying and bringing HIV-positive individuals into primary medical care. Information about HRSA Special Projects of National Significance grants in the Baltimore EMA was also provided to council members. Maryland AIDS Administration representatives made presentations of epidemiological data, and representatives of CARE Act Titles II and IV activities in Maryland presented information about the total funds awarded and the services that received the funds. Other presentations concerned the Maryland AIDS Drug Assistance Program (MADAP), insurance programs funded through MADAP, and the state's new Primary Adult Care Program.

Photo: S.R. Stokes

Maryland state Deputy Health Secretary Michelle A. Gourdine addresses the 2006 priority-setting conference.

The full planning council's priority-setting meeting was held at the Best Western Conference Center on O'Donnell Street in Baltimore on July 28 and 31, 2006. Thirty-six members and proxies as well as nearly 50 visitors attended the EMA conference. Visitors included representatives from HRSA,

who observed the two-day conference, met with key members of the council and IGS staff regarding the processes and procedures used at priority setting, and shared the latest information from Washington regarding reauthorization.

Photo: S.R. Stokes

Baltimore City Health Commissioner Joshua M. Sharfstein discusses the reauthorization of the CARE Act at the EMA's conference.

The council was also pleased to have Baltimore City Health Commissioner Dr. Joshua M. Sharfstein, and HRSA's Johanne Messore (chief of the Division of Service Systems, Southern Branch, HIV/AIDS Bureau), address the conference. Attendees also heard from Dr. Roberto Nolte, the HRSA project officer for the Baltimore EMA. Dr. Michelle Gourdine, the deputy secretary of the Maryland Department of Health and Mental Hygiene, spoke about the state's plans for implementing an HIV names-based reporting system.

The counties priority-setting conference was held at the Baltimore County Department of Health August 7-8, 2006, to plan for the funds that the full council had allocated the STSC service category. Nineteen voting members and/or proxies of the STSC Committee were present. Dr. Pierre N. Vigilance, the Baltimore County health officer, addressed the counties conference.

Both the EMA and the counties priority-setting meetings began with an overview of what council members could expect during the course of the two-day events, including the research and voting materials that would be used. Throughout the conferences, members were reminded of the process for handling conflicts of interest, as well as rules for making and discussing motions. Also, since the council had committed itself and the STSC Committee to planning based on infor-

mation drawn from the proposed reauthorization legislation, the members received detailed information about the realignment of 2006's service categories into the expected new 2007 "core medical" and "support" services classes.

Various technical improvements made last year by the support office to the priority-setting voting process and reference materials were continued and further refined this year. One of these was the use of labels printed with the names of service categories; these labels could be affixed to members' voting cards, as opposed to the old process of members' writing these names in by hand. This innovation ensured that IGS vote-counting staff assigned all voting cards to the correct category, in addition to expediting the counting of votes by eliminating handwriting and spelling ambiguities. Since in FY 2007 there will be two classes of categories, core medical and support services, the voting was done in two stages.

Photo: S.R. Stokes

HRSA Project Officer Roberto Nolte in discussion with Commissioner Sharfstein at priority setting.

Another of last year's innovations, the "service-category scorecards," remained in use at this year's conference. The scorecard is a tool that provides a summary of the expenditures and performance of each service category funded through Title I. Scorecards also present digested comments from the AA's and/or grantee's expenditure and service-delivery (ESD) reports as well as a five-year trend analysis of clients served and funds spent. The cards show the gap between services needed and services provided in a category, based upon data from the most recent triennial consumer survey. Information

about other funding sources that support each service category is also included. IGS, as technical support, provides an analysis of the category's fiscal and service performance and offers questions to consider when planning allocations. Since scorecards summarize most of the data that members need to consider when setting allocations, they allow the council to have more time for discussion and deliberation.

Several categories that had been funded in past years were not funded for FY 2007. For example, hospice care was not ranked by the EMA priority-setting voting and so cannot be funded in FY 2007 (although the STSC Committee did vote to fund hospice care under the STSC category). Substance-abuse treatment (residential) appears no longer to be a fundable category under the new reauthorization legislation. Buddy/companion services were not funded at the counties priority setting.

Due to what until the second week of December was the great uncertainty surrounding the RWCA reauthorization, the planning council had earlier established plans for reconvening and reconsidering FY 2007 priorities. The summer 2006 priority-setting conference only planned for a cut of up to 10 percent. Even with reauthorization, the EMA may suffer a cut larger than this and the council must plan accordingly.

Quality Improvement

The planning council has developed a four-year schedule for reviewing and updating the standards of care for each service category. This schedule corresponds as closely as possible with the BCHD Quality Improvement Program's (QIP) plan for reviewing service categories. The intention of this schedule is not only to allow the Health Services and Support Services committees to have the benefit of the QIP findings when reviewing the council's standards of care but also to make known in advance which standards are due for review so that any special expertise necessary for reviewing a particular category can be identified and brought

into the process. By incorporating suggestions from QIP, the council's standards are improved and the service-delivery system continues to develop. This year, the council has approved revised standards for direct and indirect transportation, hospice care, substance abuse, emergency financial assistance and home health.

With the realignment of service categories under the new reauthorization legislation, it has become even more important for QIP to provide information concerning the overall performance of service categories. Technical assistance from both the AA and QIP will be critical in ensuring that the quality of realigned services continues to meet the council's standards of care for each of the newly merged service categories.

Needs Assessment

Two Needs Assessment Committee-requested carryover projects were completed in 2006: a study of the effects on local Medicaid beneficiaries of their forced switch to the Medicare Part D prescription-drug program, and an on-line inventory of HIV-related services and providers in the Baltimore EMA.

In 2005, the Needs Assessment Committee developed a carryover project to respond to the changes in Medicaid prescription-drug coverage triggered by the federal legislation that created Medicare Part D — specifically, those changes affecting a class of beneficiary known as "dual eligibles" (DEs). DEs are people who qualify not only for Medicare (on the basis of age or illness/disability), but also for Medicaid, the state- and federally funded health-insurance program for people with low incomes. Prior to January 1, 2006, DEs received a prescription-drug benefit through Medicaid. After January 1 of this year, however, this benefit was no longer available to them: in order to continue receiving prescription drug coverage after that date, DEs were required to enroll in the new Medicare Part D prescription-drug program.

Concerned that these DEs might face higher out-of-pocket costs as a result of this change, the Needs Assessment Committee commissioned a study by the planning council support office; this study was completed and the results presented in early 2006. The study found that MADAP was positioned to absorb most of whatever additional costs Maryland's PLWH/A DEs might face. However, the council did put in place a "safety net" at priority setting by ranking — but not funding — its AIDS Drug Assistance Program (ADAP) service category, so that if funds are needed to supplement MADAP's efforts, the council will have the option to contribute.

The second carryover project completed in 2006 was an on-line, searchable directory of HIV-related service providers in the Baltimore EMA. The goal of this project was to meet the HRSA requirement that EMAs complete resource inventories of HIV-related services in their jurisdictions, as well as to make the results of this inventory available to PLWH/As, providers, policy makers and anyone else who might be able to use this information. The inventory, available through the planning council's web site (www.baltimorepc.org) supports queries by provider name, location, services offered, and other search terms.

Committee Accomplishments in 2006

Following are highlights of the accomplishments of each of the planning council's committees during 2006.

By-laws Committee

The By-laws Committee is responsible for maintaining and updating the council's operating rules and procedures. The council's bylaws were last ratified in March 2004. This year, together with the Nominating Committee, the By-laws Committee reviewed section 7.8 of the bylaws and secured council approval for clarifying language concerning committee-meeting attendance requirements. Since not all committees meet an equal number of times per year, the rule was changed from requiring members to attend a minimum *number* of meetings each year to a minimum *proportion:* now, members must attend two thirds of a committee's meetings annually in order to remain members of that committee. Under the council's newly developed bylaws-addendum process, the council published this change in memo form on the council's web site without having to revise/republish the entire text of the bylaws.

Comprehensive Planning Committee

The Comprehensive Planning Committee completed its *Comprehensive Plan for HIV Service Delivery: Baltimore EMA, 2006-2008* and submitted it to HRSA early this year. (The comprehensive plan is a recurring council deliverable, due triennially.) HRSA's project officer for the Baltimore EMA, Dr. Roberto Nolte, found the plan to have no weaknesses at all. As an ongoing task, the committee monitors service delivery to ensure that the plan's objectives are being met.

After submitting this plan, the committee turned to other pressing 2006 tasks, such as overseeing its Carryover Task Group. This task group convenes annually to plan the request for carryover funds from HRSA. (With HRSA's permission, grant funds not spent during one fiscal year may be "carried over" to the next for special projects.) The task group worked with representatives of the AA and grantee, as well as members of other committees, to identify special projects or service categories that could absorb additional funds for activities meeting HRSA requirements for the use of carryover dollars.

The Comprehensive Planning Committee submitted the new comprehensive plan, one of the council's most complex and lengthy deliverables, to HRSA earlier this year.

This year, the task group developed a carryover request for $626,517; HRSA approved the request, which included five special projects. One of these projects is the Early Intervention Initiative, which will fund a campaign in the EMA's suburban counties publicizing the availability of various HIV-related services. Another approved carryover project is the design and launch of an on-line reporting system that will track RWCA service delivery, allowing the council to analyze patterns of service utilization and plan more effectively in response to shifting demand.

The final major tasks of the committee were compiling FY 2007 directives and conducting a comprehensive review and reassessment of outstanding 2000-2005 directives.

Evaluation Committee

The Evaluation Committee performs the council's fiscal oversight, monitoring grant-fund expenditures and the AA's performance. This year, the committee completed its assessment of the administrative mechanism in September 2006, in time for the results to be included in the FY 2007 grant application. BCHD and

the AA each received high scores. The committee also updated its assessment tools for FY 2007.

The Evaluation Committee changed its reprogramming-meeting process in order to reduce the number of times that the AA must present similar information to various council committees. (Reprogramming occurs when the ESD report shows that providers in a given service category are missing or exceeding projections; based on the AA's and grantee's recommendations, funds may then be moved from one category to another to ensure that as much of the grant as possible can be spent effectively by the end of the fiscal year.) Prior to this year, the AA and grantee typically met separately with the Evaluation, STSC, Health Services and Support Services committees to make reprogramming recommendations. Under the new system, these committees meet jointly in September and November to receive and decide on reprogramming recommendations. Both of these joint reprogramming meetings occurred this fall, and funds were reallocated in several categories.

The Evaluation Committee has refined a joint meeting process to make reprogramming more efficient.

Executive Committee

The Executive Committee, comprising the heads of all other council committees, is responsible for overseeing the activities and functioning of all of the council's committees. In addition, this year the committee found itself heavily involved in monitoring and reacting to new developments surrounding the pending CARE Act reauthorization. Related to the reauthorization, one of the committee's most challenging tasks of the year was helping to shape the council's response to the new legislation's restructuring of service categories; the committee's goal was to protect the service continuum and ensure that the EMA's PLWH/As would continue to have access to life-saving services.

With the guidance of the council chair and vice chair, the Executive Committee continues to assume more general oversight of the functioning of the council in addition to building closer, more integrated working relationships among the committees.

Health Services Committee

One of the Health Services Committee's primary, ongoing responsibilities is updating the council's standards of care for the EMA's health-service categories. Throughout 2006, the committee worked hard to ensure timely review and publishing of updated standards. To streamline this process in future years, the Health Services Committee joined with other council committees to form the Joint Common Language Task Group; the task group devised and received council approval for a standards-of-care template. This template, which standardizes certain language common to all of the council's standards, will speed the revision process and increase consistency across all standards.

Another committee project this year was the enhancement of the central lab testing list, with the result that tests to confirm initial positive STD (sexually transmitted disease) and hepatitis tests are now available to all providers. Also, through a word-of-mouth, peer-to-peer publicity campaign, the committee succeeded at increasing the numbers of providers and consumers sitting on the committee and/or attending committee meetings.

Needs Assessment Committee

As mentioned earlier, this year, the Needs Assessment Committee completed two carryover projects: an on-line inventory of the EMA's HIV service providers and a study of how the new Medicare Part D prescription-drug benefit would affect EMA PLWH/As who receive Medicare and Medicaid benefits (a population also known as dual eligibles). Both projects were well received.

Much of the committee's time was devoted to the issue of unmet need, a term that refers to people who know that they are HIV positive but are not in care. The committee worked with the Maryland AIDS Administration on improvements to the state's unmet-need calculation. The committee also proposed and received HRSA approval for a carryover project studying the best strategies for linking not-in-care PLWH/As to care; the project commenced in October 2006.

The Needs Assessment Committee completed two needs-assessment projects and initiated two more during 2006.

Finally, due to uncertain funding in FY 2007, the committee decided to begin its triennial consumer survey during FY 2006. The committee devoted two regular meetings and a special session to reviewing and updating the survey instrument used in 2004; meanwhile, the support office has begun searching for and hiring survey interviewers.

Nominating Committee

The Nominating Committee ensures the council's compliance with HRSA regulations concerning council membership, including how new members are identified and appointed. This year, the committee instituted new processes to improve the council's membership-related operations and ensure its continued reflectiveness of constituent communities. (In addition to requiring that planning council memberships reflect the ethnic, racial, gender and other demographics of the communities they serve, HRSA regulations also state that certain proportions of council seats must be reserved for providers, government officials and members of the infected/affected community.)

The committee maintains a "pool list," a pre-selected list of people who meet the requirements for council membership and may be considered for appointment in the event of a vacancy. In 2006, the committee increased its recruitment efforts with assistance from the council as a whole and the PLWH/A Committee specif-

ically. This campaign included billboard advertising and radio public-service announcements. As a result of the campaign, the pool list now contains more qualified potential council members than ever before.

PLWH/A Committee

The PLWH/A Committee's main focus this year has been monitoring the CARE Act reauthorization and analyzing the restructuring of service categories that the new legislation will require. Another area of committee interest has been the Maryland AIDS Administration's plans for shifting from a code-based HIV case-reporting system to names-based reporting. To reassure community members about this coming development, the committee published a position paper addressing concerns about the potential for loss of patient confidentiality under names-based reporting.

The PLWH/A Committee's focus this year has been monitoring reauthorization and analyzing the restructuring of service categories that the new legislation will require.

The committee has also further increased its efforts to connect with and mentor graduates of Leadership, Empowerment, Advocacy and Participation (LEAP), a training program currently administered by the Gay Family Foundation, Inc. (GFF) and intended to prepare PLWH/As for council and/or committee membership.

Services to Surrounding Counties Committee

The Services to Surrounding Counties Committee now has at least one representative sitting on every council committee to act as a conduit for critical information regarding issues and trends in the counties. As well, the committee is developing strategies to increase consumer participation in the committee's meetings, including the possibility of video conferences, among other ideas.

The committee is also working with the grantee to generate ideas for the Early Intervention Initiative, an information campaign publicizing the availability of various HIV-related services in the counties. To aid the initiative, the committee prepared a list of ZIP codes and locations where at-risk populations might be contacted. Targeted locations include malls, provider offices, beauty salons and transportation hubs. The grantee is working with a contractor to design and execute this project.

The STSC Committee now has at least one representative sitting on every Council committee as a conduit for information on counties needs, issues and trends.

The STSC Committee is also responsible for prioritizing the funds allocated to the STSC service category. Members of the committee attended the July data presentations and priority-setting training session in order to prepare for August's counties priority-setting conference; at their conference, the committee successfully allocated funds for FY 2007.

Support Services Committee

In June, the Support Services Committee received a tentative draft of the reorganization of service categories in the then pending RWCA reauthorization legislation. This draft of the legislation required EMAs to allocate 75 percent of each year's total grant award to what were now defined as "core medical services"; in addition, support services would have had to demonstrate that they were essential to improving clients' health. The committee consulted extensively with the AA, the grantee and support-office staff over the summer in order to analyze and plan for these changes. While, as matters have turned out, the version of the CARE Act as finally passed contains a less stringent set aside for medical services, the committee's efforts were not wasted. The legislation does retain the grouping of services into two broad classes — "core medical" and "support" — and so the fact that the EMA has planned for this in advance is beneficial.

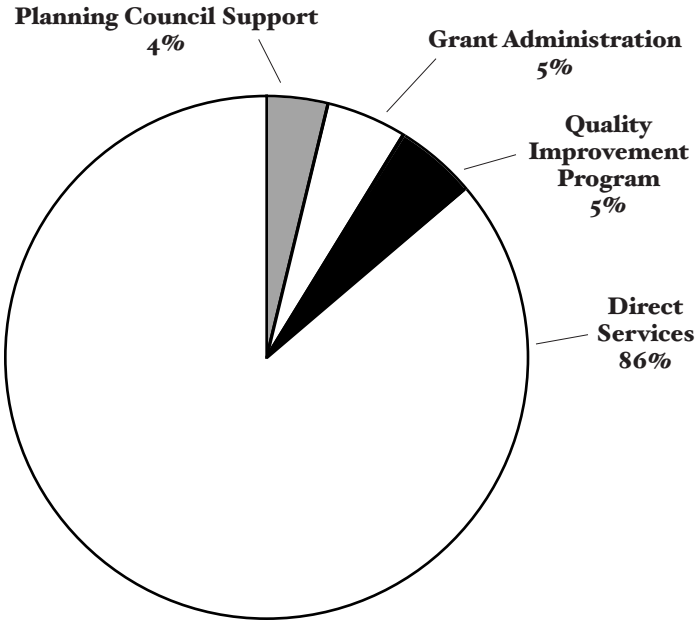
The committee also worked with Health Services and other members of the Joint Common Language Task Group to create a new standards-of-care template. The new format streamlines the organization and language of standards, making them easier to read, use and review. The committee forwarded revised versions of the emergency financial assistance and transportation (direct and indirect) standards to the council for approval and is currently working to devise three outcome measures for each MAI-funded category.

The Support and Health Services committees created a template for service-category standards that will speed review and improve consistency.

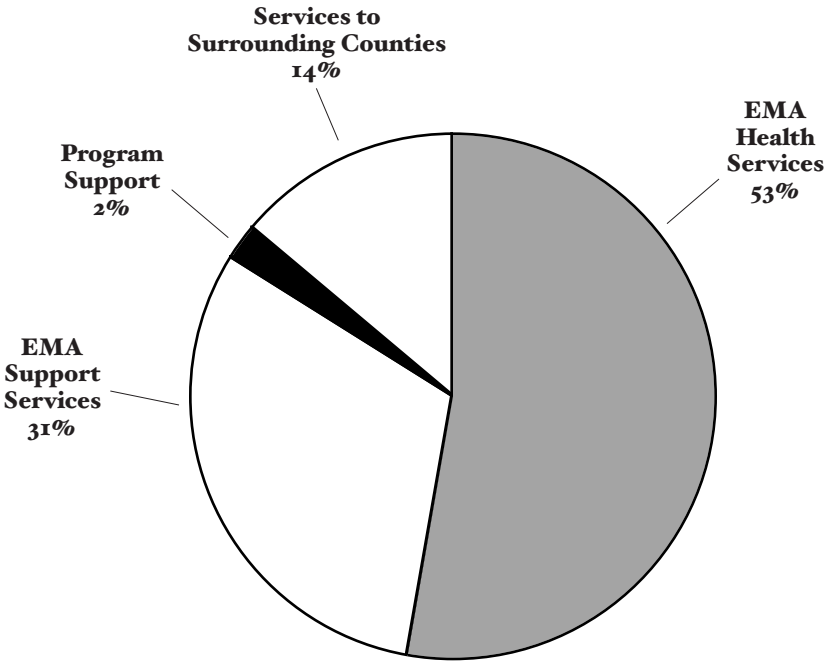
Funded Services for 2006

Below are the allocation percentages for FY 2006. The EMA's total grant award was $20,628,895, of which $1,652,985 was MAI funding. (The total award does not include carryover funds.) The first graph shows the breakdown of the entire award; the second graph shows the breakdown of the funds — out of the total award — allocated for direct services.

FY 2006 Total Award ($20,628,895)



FY 2006 Direct Services ($17,889,617)*



*Includes direct services paid for with MAI funds.

Source: Associated Black Charities, Inc. (ABC). 2006. *FY 2006 Table 9 — Allocation of Funds by Service Category, Baltimore EMA*. Baltimore, Md.: ABC, May 15 (rev. May 25).

Collaboration Activities in 2006

The planning council could accomplish nothing without its numerous partners. This section describes some of the council's collaborations during 2006.

Peer Review of Standards of Care

Each year the council collaborates with numerous service providers to review and revise those of its standards of care that are up for review. Approximately one third of the council's standards come up for review each year. Upon receipt of the QIP report on a given service category, the Health Services or Support Services committee (as appropriate) seeks out experts in the delivery of that particular service and solicits comments on the existing standard. During 2006, these two committees worked with experts in six different service areas in the course of reviewing and updating standards.

Priority Setting

In preparation for priority setting each year, the council works with various state, federal and local entities to gather data about the amount and kind of funding that is available for treating and/or serving HIV-positive individuals in the Baltimore EMA. In 2006, the council worked with representatives of Titles II and IV, the Maryland Alcohol and Drug Abuse Administration, Maryland Medicaid, DHMH and other organizations to make sure that, as Title I funds were planned for FY 2007, duplication of or gaps in services were not overlooked.

Needs Assessment

Turning to needs-assessment activities, IGS researchers had many contacts with — and much assistance from — state Medicaid and MADAP representatives in order to sort through the likely impact of Medicare Part D on dual-eligible (i.e., eligible for both Medicaid and Medicare) PLWH/As served by Ryan White. The other special needs-assessment project for 2006, the on-line, searchable resource inventory, was the culmination of a huge collaborative effort between the council and the more than 300 agencies that provided information.

Grantee and Administrative Agent

The council's most extensive collaboration each year is its ongoing one with the Baltimore EMA's Ryan White Title I grantee and administrative agent (the Baltimore City Health Department and Associated Black Charities, respectively). The council and its support office are in constant contact with the grantee and AA in the course of routine and special collaborative projects too numerous to list here.

Other News from 2006

This year also saw new developments in the areas of community education and capacity building.

Community Education

In 2006, the contract for the community education service category was competitively bid. Gay Family Foundation, Inc. was the successful bidder and assumed responsibility for carrying out the community-education plan developed by BCHD and the council. The main deliverables for GFF under this contract are seven "positive self-management training seminars" as well as targeted health fairs in ZIP codes with high HIV incidence in the city, Baltimore County and Anne Arundel County.

Capacity Building

The 2006 capacity building contract was also awarded to GFF. Under this contract, GFF led provider seminars on cultural competency and co-morbidity. Both activities offered participants new knowledge and techniques for improving service delivery. Other capacity-building activities scheduled for FY 2006 are consumer-advisory-board training sessions, a seminar on women's health issues and a resource-sharing workshop for providers.

Another important capacity-building activity — now in its tenth year — is the LEAP training program. LEAP has gone through many changes during its 10 years and has come to be regarded as a successful and beneficial activity for PLWH/As interested in joining the planning council or its committees. The curriculum, overseen by the planning council's PLWH/A Committee, includes training in public

speaking, writing, HIV-disease information, the Ryan White CARE Act, and planning council operations.

The LEAP class of 2006 graduated in November. Several members began attending council and committee meetings early in the year and have already applied for council membership.

Acknowledgments

The planning council depends on the hard work and dedication not only of its members and volunteers but also the staff members of countless providers, agencies, organizations and other partners. Day after day, these individuals rise to the often frustrating and draining challenge of ensuring access to care for the EMA's PLWH/As. We wish we could thank everyone by name, but there are just too many. In this section, we single out a few of the people whose efforts have contributed so much.

Despite many recent personnel changes, BCHD and ABC (the EMA's grantee and AA, respectively) continue to provide rock-solid support to the council. At BCHD — in his first year as the Baltimore City health commissioner — Joshua Sharfstein worked tirelessly with planning council chair Lennwood Green to coordinate the council's and city's response to various reauthorization-related issues. The council would like to express its sincere appreciation to Dr. Sharfstein and to BCHD's invaluable assistant commissioner, Dr. Kima Joy Taylor. The council is also grateful for the continued experienced leadership at BCHD's Ryan White Title I Office: Program Director Richard W. Matens and Assistant Program Director Ralph S. Brisueno bring dedication, perseverance and hard-won knowledge to everything they do. The council has come to depend on the expertise of BCHD's QIP staff as well, and wishes to thank coordinator Jesse Ungard and his team: Alberta Lin Ferrari, David Klein, Shazia Kazi, Lauren Koontz, Steven Dashiell and Raven Jeffress.

At ABC, then interim director Barbara Blount Armstrong showed herself to be a valuable ally to the council. The council was sorry to see ABC's Gail Williams-

Glasser, Bertram McKeithen and Siok-Bi Wee depart; these individuals were generous with their time and effort and clearly put their all into ensuring excellence in the EMA's service delivery. The council considers itself fortunate that experienced ABC staff members Michael LaBua, Rian Ellis, Cleo Edmonds and Patricia Kelly are still members of the Ryan White team, though they have left ABC as full-time employees and now work as contractors. Other ABC staff members also continue to give above and beyond the call of duty: new Program Officer Guy Weston and new Senior Accountant Sonney Pelham join Lamont Keaton, Ade Gbadamosi, Lillian Hardy and Ericka Porter to round out the team.

The planning council also wishes to thank its own support-office staff. Regrettably, Deputy Program Manager Evelyn Bradley, Editor and Senior Policy Analyst Rebecca Abernathy, and maintenance staff members Paul Campbell and Mitchell Peterson departed IGS this year; all will be missed. The council is fortunate to receive the continued support of IGS's principals, Cyd Lacanienta and Douglas Munro; both have spent many volunteer hours assisting with reauthorization-related research and analysis, in addition to their usual work helping the council achieve its goals and produce high-quality deliverables. Program Manager Kate Hale and Project Specialists Jenna Miller and Nicole Curtis work in direct support of the council's day-to-day operations and are the main points of contact for all 40 council members and over 200 committee volunteers. Their contributions include regulatory research, administrative support and recruitment drives; the council simply could not function without them. Sutton Stokes, who has been with IGS since 2004, replaced Rebecca Abernathy as editor and senior policy analyst. Two new policy analysts, Natalie Lewis and Jill Boesel, complete an IGS research team that has made important contributions to the council's needs-assessment and other projects. Office and Business Administrator Daurice Gorham maintains records, arranges transportation and catering, and lends her practiced logistical skills to securing meeting space and planning council events. Last but far from least, James Salvador keeps the offices in fine working order.

Thanks for a great year, everybody.

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.

Annual Report 2006