

Planning Committee  
2007-2008 Year-End Report  
June 2008



Produced by Planning Council Support Services  
1010 Massachusetts Avenue  
Boston, MA 02118  
[www.bostonplanningcouncil.org](http://www.bostonplanningcouncil.org)

*The Planning Committee of the Boston EMA HIV Health Services Planning Council  
presents its 2007-2008 Year-End Report*

---

## **Committee Charge**

The Planning Committee is one of the Planning Council's standing committees. The Planning Council's bylaws state the charge to the committee in Section 6.4.2:

“The Planning Committee shall execute the development and implementation of a process to identify needs of individuals with HIV/AIDS and their caregivers, and keep assessment of said needs current. This process must be objective; ethnically, culturally, and linguistically sensitive; and should include quantitative analysis to the degree that appropriate data are available.”

---

## **Committee Membership**

### *Members*

Susan Tannehill (Chair)  
Freeda Rawson (Vice-Chair)  
Ethan Herschman  
George McGee  
Madeline Pagan  
Lester Payne  
Jirair Ratevosian  
Sheryl Watkins

### *Staff*

Michael Hager, PCS  
Steph Sharp, PCS  
Leela Strong, PCS  
Jessica Kraft, BPHC

---

## **Committee Meetings**

Monday, October 29, 2007	2pm-4pm	Boston Public Library
Monday, November 19, 2007	2pm-4pm	Boston Public Library
Monday, December 3, 2007	2pm-4pm	Boston Public Library
Monday, January 7, 2008	2pm-4pm	Boston Public Library
Monday, February 4, 2008	2pm-4pm	Boston Public Library
Monday, March 3, 2008	2pm-4pm	Boston Public Library
Monday, May 5, 2008	2pm-4pm	Boston Public Library

---

## **Work of the Committee**

During this past year, the Planning Committee devoted its efforts to the following tasks:

1. Guide the Planning Council through the process of removing a zero funded service category
2. Develop and present the 2008 Needs Assessment to the Planning Council
3. Revise/ present Priority Setting exercise to the Planning Council
4. Prepare/present Year-End Report

## ***1. Guide the Planning Council through the process of removing a zero funded service category***

During the 2006-2007 Council year the Planning Committee created criteria to remove zero funded service categories, which included:

- The category is zero funded for 3 consecutive years.
- A review and summary of the zero-funded service categories is performed prior to being removed.
- The Planning Council votes on the elimination of service categories prior to being removed.

The process was presented to the planning Council on January 11, 2007 and approved on February 8, 2007.

During the 2007-2008 Planning Council term the Planning Committee presented the impact of zero funding Adoption & Foster Care for three consecutive years (Please see Appendix A) to the Planning Council on January 10, 2008 and on February 14, 2008 the Planning Council voted to remove Adoption & Foster Care from the list of Part A service categories.

## ***2. Develop and present the 2008 Needs Assessment to the Planning Council***

The Committee worked with Planning Council Support staff to draft the 2008 Assessment of Need in the Boston EMA. The objective of the Needs Assessment is to provide information on the HIV service system so the Planning Council may make informed decisions related to the prioritization of Ryan White Part A service categories and the Ryan White Part A funding allocations process.

The 2008 Needs Assessment is intended to identify the potential service needs and services available to people living with HIV in the Boston EMA; to examine the capacity of the current service system and the resources available; to assess whether resources are being expanded to populations most in need and to emerging populations; and whether PLWH can effectively obtain and maintain HIV health and health related services.

This Needs Assessment was conducted in several steps. A picture of the epidemic was drawn using surveillance data from Massachusetts, New Hampshire, the Centers for Disease Control and Prevention as well as United States census data. Prevalence and incidence data was used to note trends in the local epidemic and identify emerging populations infected and affected by HIV/AIDS. Demographic factors such as race, gender, age, and mode of transmission were cross-referenced with payer-provided utilization data and examined to determine if all populations affected were accessing a full range of services. Provider capacity to serve all PLWH in the Boston EMA was estimated using both consumer- and provider-completed surveys. A literature review was conducted and included Part A funded Quality Management and Evaluation reports in addition to other documents published by the Massachusetts Department of Public Health (MDPH) and other payers in the Boston EMA. The literature review estimated barriers to accessing primary medical care services by examining consumer access to needed services, poverty and insurance, and housing and homelessness.

The Needs Assessments provide the basis for important decisions, taking into account payer, provider and consumer perspectives. Relying solely on data from some groups and not others introduces bias to this type of report. This Needs Assessment contains the most recent input available from each of these groups. Time and staffing constraints did not allow for consumer surveying to be completed in this project, which relies on information collected in FY 2002. Comparing demographic, funding, utilization, outcomes and survey information from different years decreases the validity of this Needs Assessment because there is variation in service definitions and PLWH demographics from year to year. To mitigate these limitations in the future, focus groups and additional consumer based input will be collected and effort will be made to encourage all payers and providers to create universal standards for data collection which would allow cross referencing of data.

**3. Revise/ present Priority Setting Exercise for the Planning Council.**

The Committee reviewed and approved the Priority Setting tool (Appendix B) at its February 4, 2008 meeting, presented it to the Executive Committee at its February 28, 2008 meeting, and finally presented it to the Planning Council at its March 13, 2008 meeting. The Priorities for FY 09 were approved at the April 24, 2008 Planning Council meeting.

Priorities for FY 2009	
<ul style="list-style-type: none"> <li>1. Primary Medical Care</li> <li>2. Drug Reimbursement</li> <li>3. Housing Services</li> <li>4. Case Management</li> <li>5. Substance Abuse</li> <li>6. Mental Health</li> <li>7. Food Services</li> <li>8. Dental</li> <li>9. Transportation</li> <li>10. Peer Support</li> </ul>	<ul style="list-style-type: none"> <li>11. Client Advocacy</li> <li>12. Complementary Therapies</li> <li>13. Respite Care</li> <li>14. Day Care</li> <li>15. Evaluation*</li> <li>16 Planning Council Support*</li> <li>17. Quality Management*</li> </ul>

\* Not "direct service" category. Not ranked by Council.

In addition the Planning Committee set learning objectives for the priority setting process, and presented a clear definition of priority setting, the Council's tasks related to priority setting, and where priority setting fits in the Planning Council cycle. Below is an outline of this work.

# Appendix A

## **Zero Funding Impact Statement: Adoption & Foster Care**

### **Adoption & Foster Care Definition**

The March 9, 2006 Planning Council service category definitions describes Adoption & Foster Care (AFC):

*Services funded under this category include, but are not limited to: temporary (foster) care; permanent (adoption) homes; early planning; permanency planning; and other legal services that assist children under the age of 20 whose parents or guardians are unable to care for them because of HIV related illness or death<sup>i</sup>.*

This definition for Part A, formerly Title I, AFC services has remained the same since 2002, the period of AFC services examined here<sup>ii</sup>. Historically, the agencies funded by this category focused on providing legal advocacy and permanency planning expertise.

### **Adoption & Foster Care Zero-funding Context**

Since March, 2003 AFC has consistently been ranked at the bottom of the Priority Setting Exercise<sup>iii iv v vi</sup>. Changes in HRSA mandates, reduced Part A resources, and a change in perception of the epidemic all played a role in that Priority Setting Exercise. With people living longer, fuller lives with HIV, the emphasis transitioned from preparing people for death to keeping people in a position to access the medical care services necessary for survival. AFC was identified for zero-funding by Resource & Allocations Committee for these reasons. Moreover, a review of FY 2003 funded AFC services revealed that many programs relied heavily on their Part A funded Case Management programs to enroll and follow-up on clients<sup>vii viii</sup>. Lastly, the Voices of Experience 2003 study exhibited a low level of interest in AFC services by Boston EMA consumers: 3% of those surveyed identified it as a needed service and 2% of those surveyed claimed to have ever used the service. 1% of those surveyed said that they had needed the service, but did not access it. When asked why they did not access the service, respondents explained that they have other more important priorities than seeking AFC services.<sup>ix</sup>

This was the first occasion that Resource & Allocations Committee recommended zero-funding a service category. The Planning Council accepted the zero-funding of AFC on June 26, 2003 when it voted to accept the 2002-2003 Resource & Allocations FY 2004 Funding Scenario Recommendations. Agencies in receipt of AFC funding at the end of FY 2003 were granted two months of transitional funding at the beginning of FY 2004 to allow for the administrative transition from Part A to the other available funding streams.

### **Adoption & Foster Care Funding Environment**

There have been changes to the funding environment since FY 2002.

#### **HRSA Mandates on Serving HIV Affected Individuals**

HRSA funding has become increasingly restricted to serving HIV-infected as opposed to HIV-affected individuals since the 2000 reauthorization of the Ryan White CARE Act. Changes made to HRSA policy governing this distinction allow for funding for permanency planning only.

#### **Funding Streams Analysis**

MassHealth/Medicaid is the largest source of public funding for Adoption & Foster Care services in the Boston EMA, but this funding focuses primarily on adult foster care and actual adoption services. Since FY 2004, the amount of available AFC funding increased from \$1,549,342 (FY 2004) to \$2,438,417 (FY 2007). Each of the four agencies in receipt of Part A AFC funding in FY 2003 were also in receipt of other funding for similar services in FY 2003. Some of the agencies were in receipt of Part B, formerly Title II, funding while others received funding from their parent agencies. For three of the four agencies, Part A funding constituted the minority of allocated funding. Three of the four Part A funded agencies are eligible for MassHealth funding.

#### **Adoption & Foster Care Service Elements**

According to the AFC service category definition, permanency planning, placements and ensuring care for the children of HIV patients are the main service elements previously funded by Part A. All AFC service elements, except placements and permanency planning, are within the scopes of the Part A Case Management and Client Advocacy definitions. Placements are still being made by a myriad of agencies around Massachusetts (see appendix). Permanency planning was deemed eligible for funding under Client Advocacy as a form of legal advocacy. One program that was de-funded through AFC was awarded a Client Advocacy contract through the FY 2004 RFP process. The Planning Council subsequently adopted a plan to eliminate permanency planning from the Client Advocacy service category when it voted to accept the 2004-2005 Resource & Allocations FY 2006 Funding Scenario Recommendations<sup>x</sup>. MDPH provided one year of transition funding for the one program affected by this change.

### Client Impact from Part A Adoption & Foster Care Zero-funding

Client impact is assessed in three ways, one by reviewing historic utilization of AFC services in FY 2003, two by analyzing the impact of zero-funding on health-related client outcomes, and third by confirming the existence and continuation of services and agencies formerly funded under this category.

✓ *Utilization Patterns*

Four agencies received \$217,899 to provide Part A AFC services in the Boston EMA in FY 2003. These agencies saw 173 clients and provided the following services: 37 intake appointments, 1,684 follow-up appointments and 2,580 follow-up phone calls. 5 temporary and 8 permanent placements were made. In all, AFC services cost Part A \$1,260 per client in FY 2003 on average. AFC services cost Part A \$17,761 per client placed in FY 2004. All placements occurred through one agency, which was converted to a Client Advocacy contract in FY 2004. All clients served by Part A AFC services were at or below 100% FPL in FY 2003.

✓ *Outcomes Patterns*

Outcomes measures are only collected for Part A funded agencies. To assess the effect of zero-funding AFC services on outcomes, the net change in outcomes for the Part A service system were reviewed. In the period since AFC services were zero-funded there has been no change in the rate at which Part A client outcomes have improved. Health and health-related outcomes continue to increase across measures and across the Part A service system.

---

<sup>1</sup> FY 2007 Client Services Provider Handbook. Boston Public Health Commission AIDS Program, Client Services, Unit. March 1, 2007.

<sup>1</sup> FY 2002 Client Services Provider Handbook. Boston Public Health Commission AIDS Program, Client Services Unit. March 1, 2002.

<sup>1</sup> 2003-2004 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.

<sup>1</sup> 2004-2005 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 23, 2005.

<sup>1</sup> 2005-2006 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 22, 2006.

<sup>1</sup> 2006-2007 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 28, 2007.

<sup>1</sup> 2002-2003 Resource & Allocations Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Resource & Allocations Committee. June 26, 2003.

<sup>1</sup> "March 24, 2004 Planning Committee Minutes". Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. March 24, 2004.

<sup>1</sup> Voices of Experience 2003. Suffolk University, Center for Public Management. February, 2004.

<sup>1</sup> 2004-2005 Resource & Allocations Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 23, 2005.

# Appendix B

**Priority Setting Exercise**  
**Ryan White HIV/AIDS Treatment Modernization Act**  
**Boston EMA**

- **The Priority Setting Process**

Priority setting is the process of ranking the Part A service categories to reflect the needs of people living with HIV/AIDS in the EMA. Each year, the Council sets service priorities for the upcoming year.

The **previous** year is **Fiscal Year (FY) 2007 which ended on Feb. 28, 2008**



The Council's **current** year is **Fiscal Year 2008 which began March 1, 2008.**



The Council will **set priorities for FY 2009, which starts March 1, 2009.**

- **What Information is used in the Priority Setting Decision Making Process?**

1. Epidemiological trends in the EMA; Suffolk and JSI outcomes surveys, the Assessment of Need and the Comprehensive Plan, as well as other studies, reports or presentations you have seen; and personal experiences as an informed consumer, provider, or advocate.

- **How Does the Priority Setting Process Relate to Other Council Work?**

*The Council sets priorities based on the current list of service categories.*

The 3 steps of the process are:

1. The Council defines the needs of the EMA by prioritizing service categories.
2. The Resources and Allocations (R&A) Committee then examines and assess the existing resources in the EMA and identifies where the funds will be most utilized as a “payer of last resort” and effective in meeting the overall needs of the EMA service system.
3. The R&A Committee presents the recommendations on allocation levels to the full Planning Council for review, discussion, and vote.

- **Why Does Priority Setting Occur Independently of Resource Allocation?**

There are many funding “streams” that support HIV/AIDS services in the Boston EMA. The R&A Committee might recommend that a high priority category should receive a relatively low Part A funding allocation if that category of service is provided through other federal monies or the State.

**Boston EMA Part A Service Categories**

Case Management	Housing	
Client Advocacy	Mental Health	
Complementary Therapies	Peer Support	
Day Care	Primary Care	
Dental	Respite Care	<i>Evaluation*</i>
Drug Reimbursement	Substance Abuse	<i>Planning Council Support*</i>
Food Services	Transportation	<i>Quality Management*</i>

\* = Not “direct service” category. Not to be ranked by Council.

**RETURN THIS PAGE TO PLANNING COUNCIL SUPPORT**

**Priority Setting Exercise 2009**

1. Remember this exercise is a forced choice exercise. This means all the categories are **important** but you are being asked to rank the importance of each service category from “**most important = (1)**” to “**least important = (14)**”. For most participants this will be a difficult task. Remember your input is an important part of the planning cycle process. Members’ answers will vary based on their individual knowledge and experience in the EMA.
2. Rank the categories based on **your understanding of which services are most needed by individuals with HIV/AIDS within the EMA.**
3. In the table below, rank the categories by priority level (1 is the highest priority, 14 is the lowest priority). **Be sure to rank all categories.**

Rank Order 1-14	FY 09 Categories (Alphabetical)
	Case Management
	Client Advocacy
	Complementary Therapies
	Day Care
	Dental
	Drug Reimbursement
	Food Services
	Housing
	Mental Health
	Peer Support
	Primary Care
	Respite Care
	Substance Abuse
	Transportation
15	<i>Evaluation**</i>
16	<i>Planning Council Support**</i>
17	<i>Quality Management**</i>

---

i

---