Boston Part A EMA HIV Health Services

Planning Committee
2008-2009 Year-End Report

June 2009

Planning Council Support
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The Planning Committee of the Boston EMA HIV Health Services Planning Council presents its 2008-2009 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
Darren Sack (Chair)
Brian Butler (Vice-Chair)
Charles Geary
Andre Jones
George McGee
Verny Samayoa
Annie Singh
Andrea Williams

Support Staff
Laura Kozek, PCS
Sharon Asonganyi, PCS
Apryl Pagliaro, PCS
Andrew Shawhan, PCS
Marcus Rennick, BPHC
Eric Thai, BPHC

Committee Meetings

- Thursday, October 30, 2008 2pm-4pm Boston Public Library
  Review 2007-2008 Year-End Report, Nominate Vice-Chair Candidates

- Monday, November 17, 2008 2pm-4pm Boston Public Library
  Elect Vice-Chair, Review Zero-Funding Impact Memos and Presentations

- Monday, January 6, 2009 2pm-4pm Boston Public Library
  Elect New Vice-Chair, Review Priority Setting Exercise, Review Draft Comprehensive Plan

- Monday, February 9, 2009 1pm-3pm Boston Public Library
  Finalize Priority Setting Exercise, Begin Drafting Year-End Report

- Monday, March 16, 2009 1pm-3pm Boston Public Library
  Develop recommendations to Resources and Allocations Committee on Service Needs

- Monday, April 13, 2009 1pm-3pm Boston Public Library
  Review Year-End Report

- Monday, May 11, 2009 1pm-3pm Boston Public Library
  Finalize Year-End Report

Work of the Committee

During this past year, the Planning Committee carried out the following tasks:

a. Guide the Planning Council through the process of removing a zero funded service category.
b. Develop the 2009-2012 Comprehensive Plan and present it to the Planning Council.
c. Develop the 2009 Needs Assessment and present it to the Planning Council.
d. Revise/ present Priority Setting Exercise for the Planning Council.
e. Report to Resources and Allocations Committee on service needs and gaps.

A. 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 from the list of service categories to be ranked by priority and funded. These criteria are:

- The category is zero-funded for three 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 by the Planning Council on February 8, 2007.

During the 2008-2009 Planning Council term, the Planning Committee developed memoranda on the impact of zero funding *Complementary Therapies*, *Day Care*, and *Respite Care* for three consecutive years (Please see Appendices A-C). This information was presented to the Planning Council by the Chair of the Evaluation Committee on December 11, 2008. On January 8, 2009 the Planning Council, voting on individual service categories, removed *Day Care* and *Respite Care* from the list of Part A service categories.

B. Develop the 2009-2012 Comprehensive Plan and Present it to the Planning Council

The Committee worked with Planning Council Support and Boston Public Health Commission staff to draft the *2009-2012 Comprehensive Plan* for the Boston EMA. The *Comprehensive Plan* discusses the state of the HIV/AIDS epidemic in the Boston EMA and lays out a vision for providing care and improving the quality of services over the next three years. The *2009-2012 Comprehensive Plan* was presented to the Planning Council on January 8, 2009, and submitted to the Health Resources and Services Administration (HRSA) on January 30, 2009.

C. Develop and Present the *2009 Needs Assessment* to the Planning Council

Although a Needs Assessment report was not required this term, the Executive Committee requested an update on the *2008 Needs Assessment*. The updated *Needs Assessment* drew on the *2009-2012 Comprehensive Plan* as well as *Inequitable Impact*, a Massachusetts Department of Public Health report (released December 2008) on HIV among MSM populations. The updated *2009 Needs Assessment* was largely prepared by Planning Council Support staff, with input from the Planning Committee. It was presented to the Planning Council on March 12, 2009 by the Planning Committee.

The *2009 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 to determine whether PLWH can effectively obtain and maintain HIV health and health related services.

D. Revise and Present Priority Setting Exercise for the Planning Council

Every year, the Planning Council, with the help of the Planning Committee, ranks service categories in priority order. This priority ranking is used to help the Resources and Allocations Committee make its decisions in setting levels of funding for each service category. The Planning Committee reviewed and approved the Priority Setting tool (Appendix D) at its February 9, 2009 meeting. At the suggestion of the Committee's members, a worksheet (Appendix E) was created to help Council members rank the service categories, along with a sheet with the definitions of the service categories (Appendix F).

The Priority Setting tool and the worksheet were presented to the Executive Committee at its February 26, 2009 meeting, and presented to the Planning Council at the March 12, 2009 meeting.

The Priority Setting Exercise results were voted on and approved at the Planning Council meeting of April 23, 2009.

Priorities for FY 2010	
1. Primary Medical Care	7. Dental
2. Drug Reimbursement	8. Food Services
3. Housing Services	9. Transportation
4. Case Management	10. Client Advocacy
5. Mental Health	11. Peer Support
6. Substance Abuse	12. Complementary Therapies

E. Report to Resources and Allocations Committee on Service Needs and Gaps

A report on service needs in the Boston EMA was prepared for the R&A Committee to use when developing funding scenarios (Appendix G). This report drew attention to the service needs of PLWH in the EMA, particularly in relation to the complex interaction among co-morbidities such as substance abuse, mental illness, and homelessness.
The brief report was submitted to the R&A Committee on May 18, 2009.

Recommendations for the 2009-2010 Planning Committee

1. Give an orientation to the Committee and its work at the Planning Committee's first meeting.
2. Monitor service needs and, if necessary, create new service categories.
3. Increase the Committee's involvement in important tasks and processes related to the Committee's charge.
4. Allow the Committee sufficient time to work on important documents such as the *Needs Assessment.*
5. Give a list of important tasks (and a timeline of when they should be started and finished) to Committee members at the beginning of the term.
6. Tell Committee members about the role of (and tasks carried out by) Planning Council Support and Boston Public Health Commission staff in relation to the Committee's work.
7. Create a 'syllabus' of the Committee's work in the form of a checklist, including the tasks that need to be completed at each meeting. Provide this syllabus at each meeting, on the reverse side of the agendas.
8. Invite Evaluation Committee members (or other Planning Council members) to discuss the Zero-Funding Impact/Service Category Elimination process and the history of service category removal.
9. Reschedule any meetings that are canceled due to inclement weather or other issues.
10. Recommend to the Executive Committee that the 2011 Priority-Setting Exercise be preceded by a well-structured discussion of the various service categories.

Recommendations for the 2009-2010 Planning Council/ Planning Council Support

1. If appropriate, provide assistance to people whose primary language is not English, including translations of important documents. (Such documents include but are not limited to the Priority-Setting Exercise, service category definitions, and a list of frequently-used acronyms and phrases.) Such assistance may also include providing a sheet summarizing the goals of the Planning Council meeting in Planning Council members' native language(s).

2. Add a question about language issues/potential language barriers to Planning Council evaluations.

3. Provide evaluations in multiple languages.

4. Planning Council Support should pay attention to language issues as they affect the mentor/mentee pairings, as well as at Orientation.

5. Planning Council Support should check-in with mentors and mentees after the October Planning Council meeting.

6. Planning Council Support should provide training on acronyms and important phrases. Members should also be provided with sheet listing commonly-used acronyms and phrases.

Appendix A:
Zero-Funding Impact Memo - Complementary Therapies

APPENDIX A

Boston Part A EMA HIV Health Services Planning Council Evaluation Committee & Planning Committee

Zero-Funding Impact / Service Category Elimination Memo

Complementary Therapies Definition

The March 2004 Planning Council service category definitions describe Complementary Therapies as:

> *Services funded under this category include, but are not limited to: acupuncture, chiropractic treatment, and, other holistic modalities. The purpose of this category is to provide services that enhance adherence to care, such as symptom management.*[1]

This definition for Part A (formerly Title I) Complementary Therapies services has remained constant since 2000, the beginning of the period of Complementary Therapies services examined here.[2] Historically, the agencies funded by this category focused on providing acupuncture and herbal therapies.

Complementary Therapies Zero-funding Context

The Boston Planning Council began funding Complementary Therapies in Fiscal Year (FY) 1991. The Voices of Experience 2003 study found there to be considerable interest in Complementary Therapies among Boston EMA consumers: 64% (287 out of 466) of those surveyed identified it as a needed service and 44% (199 out of 466) of those surveyed indicated having ever used this service. Twenty percent (88 out of 466) 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 there was a lack of services in their area and/or they did not know where to go for services. [3]

However, since April 2002, Complementary Therapies has consistently been ranked at the bottom of the Priority Setting Exercise.[4 5 6 7 8 9] Changes in HRSA mandates, reduced Part A resources, and a change in the epidemic all played a role in that year's Priority Setting Exercise and those in following years.

In January 2004, the 2003-2004 Planning Committee carried out a survey of Planning Council members to determine which service categories might be considered for zero-funding. Through this exercise, Complementary Therapies was one of the five service categories identified as a candidate for zero-funding.[10] This information was used to guide the Resource & Allocations Committee's development of funding scenario recommendations.[11]

The Planning Council accepted the zero-funding of Complementary Therapies on June 24, 2004 when it voted to accept the 2003-2004 Resource & Allocations FY 2005 Funding Scenario Recommendations. The only agency in receipt of Complementary Therapies funding at the end of FY 2004 was granted two months of transitional funding at the beginning of FY 2005 to allow for the administrative transition from Part A to the other available funding streams.

Complementary Therapies Funding Environment

Dialogue with other EMAs revealed that their levels of funding for Complementary Therapies have fallen steeply since 2000. No EMAs continue to provide this service.

HRSA Policy Guidance

Under HRSA policy, complementary therapies provided by state certified or licensed practitioners are allowable with appropriate referral, but HRSA gives higher priority to core medical services and other services which directly affect health and quality of life for PLWH.

Client Impact from Part A Complementary Therapies Zero-funding

Client impact is assessed by reviewing historic utilization of Complementary Therapies services in FY 2004 in addition to analyzing the net impact on health and health-related client outcomes.

- ✓ *Utilization Patterns*
  One agency in the City of Boston received $374,903 to provide Part A Complementary Therapies services in the Boston EMA in FY 2004. This amount comprised 2.5% of the total funding ($14,848,697) for all service categories in the Boston EMA in FY 2004. This agency saw 357 clients (out of a total of 7,228 clients served in the EMA) and provided the following services: 982 alternative therapy visits for herbal therapies and 6467 acupuncture visits.
- ✓ *Outcomes Patterns*
  Outcomes measures are only collected for Part A funded agencies. To assess the effect of zero-funding Complementary Therapies on outcomes, the net change in outcomes for the Part A service system were reviewed. In the period since Complementary Therapies were zero-funded, Part A client outcomes have continued to remain stable. Health and health-related outcomes remain high across measures and across the Part A service system.

Funding Streams Analysis

The Massachusetts Department of Public Health provides the majority of public funding for Complementary Therapies in the Boston EMA with Ryan White Part B and State AIDS Line Item dollars. These dollars are provided to the same provider in the City of Boston that had been funded by Ryan White Title I. In addition, two agencies in the City of Boston funded by Ryan White Part C allocate a small portion of their awards to Complementary Therapies, though the services are provided by the previously mentioned Complementary Therapies provider.[12]

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[1] FY 2004 Client Services Provider Handbook. Boston Public Health Commission AIDS Program, Client Services Unit. March 1, 2004.

[2] 1999-2000 Service Category Definitions. CARE Act Title I EMA HIV Health Services Planning Council Planning Committee. February 10, 2000.

[3] Voices of Experience 2003. Suffolk University, Center for Public Management. February, 2004.

[4] 2003-2004 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.

[5] 2004-2005 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 23, 2005.

[6] 2005-2006 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 22, 2006.

[7] 2006-2007 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 28, 2007.

[8] "April 11, 2002 Planning Committee Minutes." CARE Act Title I EMA HIV Health Services Planning Council Planning Committee, April 11, 2002.

[9] 2007-2008 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 2008.

[10] Planning Committee Year-End Report 2003-2004 Term. CARE Act Title I EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.

[11] Resources and Allocations Committee Report. CARE Act Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 24, 2004.

[12] 2008 Funding Streams Overview. Ryan White Part A EMA HIV Health Services Planning Council. May 8, 2008.

Appendix B:
Zero-Funding Impact Memo - Day Care

APPENDIX B

Boston Part A EMA HIV Health Services Planning Council Evaluation Committee & Planning Committee

Zero-Funding Impact / Service Category Elimination Memo

Day Care Definition

The March 2004 Planning Council service category definitions describe Day Care as:

> *Day Care services that are day care programs for children with HIV/AIDS, the siblings of children with HIV/AIDS, children of a parent or caregiver with HIV/AIDS and adults with HIV/AIDS.* [1]

This definition for Part A (formerly Title I) Day Care services has remained constant since 2000, the beginning of the period of Day Care services examined here.[2] Historically, the agencies funded by this category focused on providing educational and developmental services to children living with HIV/AIDS.

Day Care Zero-funding Context

The Boston Planning Council began funding Day Care in Fiscal Year (FY) 1992. Since April 2002, Day Care has consistently been ranked at the bottom of the Priority Setting Exercise.[3 4 5 6 7 8] Changes in HRSA mandates, reduced Part A resources, and a change in the epidemic all played a role in that Priority Setting Exercise and the ones that followed. Additionally, with people living longer, fuller lives with HIV, the emphasis transitioned from preparing people for death to assisting people in maintaining access to medical care services that are necessary for survival. While Day Care services provided support to parents and guardians living with advanced-stage HIV disease, advances in drug therapy and care have resulted in prolonged life and eventual reintegration into the community. Concurrent reductions in mother-to-child transmission of HIV also had a significant impact in the number of HIV-positive children born in the Boston EMA. The Voices of Experience 2003 study exhibited a low level of interest in Day Care services by Boston EMA consumers: 9% (39 out of 466) of those surveyed identified it as a needed service and 5% (24 out of 466) of those surveyed indicated having ever used this service. Four percent (15 out of 466) 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 did not know where to go for services.[9]

In January 2004, the 2003-2004 Planning Committee carried out a survey of Planning Council members to determine which service categories might be considered for zero-funding. Through this exercise, Day Care was one of the five service categories identified as a candidate for zero-funding.[10] This information was used to guide the Resource & Allocations Committee's development of funding scenario recommendations.[11]

The Planning Council accepted the zero-funding of Day Care on June 24, 2004 when it voted to accept the 2003-2004 Resource & Allocations FY 2005 Funding Scenario Recommendations. Agencies in receipt of Day Care funding at the end of FY 2004 were granted two months of transitional funding at the beginning of FY 2005 to allow for the administrative transition from Part A to the other available funding streams.

Day Care Funding Environment

Dialogue with other EMAs revealed that their levels of funding for Day Care have fallen steeply since 2000. Many EMAs no longer provide this service.

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. Current HRSA policy allows for services to affected individuals

in limited and specific circumstances when there is at minimum an “indirect benefit” to an HIV-infected individual. For example, if a service, such as child care, removes a barrier to receipt of medical or support services for an HIV-infected individual, then that service provides an indirect benefit to the individual.

Under a separate HRSA policy guidance, child care is specifically identified as an allowable service for HIV-infected children, but HRSA gives higher priority to core medical services and other services which directly affect health and quality of life for PLWH.

Client Impact from Part A Day Care Zero-funding

Client impact is assessed by reviewing historic utilization of Day Care services in FY 2004 in addition to analyzing the net impact on health and health-related client outcomes.

- ✓ *Utilization Patterns*
  Two agencies in the City of Boston received $277,712 to provide Part A Day Care services in the Boston EMA in FY 2004. This amount comprised 1.9% of the total funding ($14,848,697) for all service categories in the Boston EMA in FY 2004. These agencies saw 84 clients (out of a total of 7,228 clients in the EMA) and provided 12,744 units of center-based day care.
- ✓ *Outcomes Patterns*
  Outcomes measures are only collected for Part A funded agencies. To assess the effect of zero-funding Day Care services on outcomes, the net change in outcomes for the Part A service system were reviewed. In the period since Day Care services were zero-funded Part A client outcomes have continued to remain stable. Health and health-related outcomes remain high across measures and across the Part A service system.

Funding Streams Analysis

Limited public funding for Day Care services are provided by the US Department of Housing and Urban Development through a HOPWA grant in Southern New Hampshire and Ryan White Part D through University of Massachusetts Medical School.[12]

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1 FY 2007 Client Services Provider Handbook. Boston Public Health Commission AIDS Program, Client Services, Unit. March 1, 2007.
2 1999-200 Service Category Definitions. CARE ACT Title I EMA HIV Health Services Planning Council. February 10, 2000.
3 2003-2004 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.
4 2004-2005 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 23, 2005.
5 2005-2006 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 22, 2006.
6 2006-2007 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 28, 2007.
7 “April 11, 2002 Planning Committee Minutes”. CARE Act Title I EMA HIV Health Services Planning Council Planning Committee, April 11, 2002.
8 2007-2008 Planning Committee Year-End Report. Ryan White Part A EMA HIV Health Services Planning Council, Planning Committee. June 2008.
9 Voices of Experience 2003. Suffolk University, Center for Public Management. February, 2004.
10 Planning Committee Year-End Report 2003-2004 Term. CARE Act Title I EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.
11 Resources and Allocations Committee Report. CARE Act Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 24, 2004.
12 2008 Funding Streams Overview. Ryan White Part A EMA HIV Health Services Planning Council. May 8, 2008.

Appendix C:
Zero-Funding Impact Memo - Respite Care

APPENDIX C

Boston Part A EMA HIV Health Services Planning Council
Evaluation Committee & Planning Committee
Zero-Funding Impact / Service Category Elimination Memo

Respite Care Definition

The March 2004 Planning Council service category definitions describe Respite Care as:

> *Respite Care services that are residential and/or home-based non-medical assistance programs designed to relieve the primary caregiver(s) responsible for providing day-to-day care. This care encompasses that of adults and/or children as clients with HIV/AIDS or HIV negative parents or caregivers with HIV positive children.*[1]

This definition for Part A (formerly Title I) Respite Care services has remained constant since 2000, the beginning of the period of Respite Care services examined here.[2] Historically, the agencies funded under this category focused on providing respite care services to PLWH and their families, including child care, transportation, and general assistance in managing a household.

Respite Care Zero-funding Context

The Boston HIV Health Services Planning Council began funding Respite Care services in Fiscal Year (FY) 1991. Since April 1999, Respite Care has consistently been ranked near the bottom of the Priority Setting Exercise.[3 4 5 6 7] Changes in HRSA mandates, reduced Part A resources, and a change in the epidemic all played a role in that Priority Setting Exercise. Additionally, with people living longer, fuller lives with HIV, the emphasis transitioned from preparing people for death to assisting people in maintaining access to medical care services that are necessary for survival.

As examined in the 2001 Comprehensive Plan, decreasing demand is reflected in the overall funding environment for respite type services. In addition, the Voices of Experience 2003 study reported a low level of interest in Respite Care services by Boston EMA consumers: 14% of those surveyed (64 out of 466 respondents) identified it as a needed service and 12% (52 out of 466) of those surveyed indicated having ever used this service. Two percent (12 out of 466) 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 did not know where to go to receive services.[8]

In January 2004, the 2003-2004 Planning Committee carried out a survey of Planning Council members to determine which service categories might be considered for zero-funding. Through this exercise Respite Care was one of the five service categories identified as a candidate for zero-funding.[9] This information was used to guide the Resource & Allocations Committee's development of funding scenario recommendations.[10]

The Planning Council accepted the zero-funding of Respite Care on June 24, 2004 when it voted to accept the 2003-2004 Resource & Allocations FY 2005 Funding Scenario Recommendations. Agencies receiving Respite Care funding at the end of FY 2004 were granted two months of transitional funding at the beginning of FY 2005 to allow for the administrative transition from Part A to other available funding streams.

Respite Care Funding Environment

Dialogue with other EMAs revealed that their levels of funding for Respite Care have fallen steeply since 2000. Many EMAs no longer provide this service.

<u>HRSA Mandates on Serving HIV Affected Individuals</u>

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. Current HRSA policy allows for services to affected individuals

in limited and specific circumstances when there is at minimum an "indirect benefit" to an HIV-infected individual. For example, if a service, such as respite care, helps a non-infected individual to continue to provide care for someone with HIV, then it is considered to provide an indirect benefit to the person with HIV.

Under a separate HRSA policy, Respite Care is specifically identified as an allowable service, but HRSA gives higher priority to core medical services and other services which directly affect health and quality of life for PLWH.

Client Impact from Part A Respite Care Zero-funding

Client impact is assessed by reviewing historic utilization of Respite Care services in FY 2004 (the last year it was fully funded) in addition to analyzing the net impact on health and health-related client outcomes.

- ✓ *Utilization Patterns*
  Three agencies received $193,060 to provide Part A Respite Care services in the Boston EMA in FY 2004. This amount comprised 1.3% of the total funding ($14,848,697) for all service categories in the Boston EMA in FY 2004. These agencies saw 55 clients (out of a total of 7,228 clients in the EMA) and provided the following services: 6984.5 units of Hourly Respite Care (face-to-face interaction between a provider and a client) and 553.5 units of Daily Respite Care (face-to-face interaction between a provider and client lasting more than 8 hours but less than 24 hours).
- ✓ *Outcomes Patterns*
  Outcomes measures are only collected for Part A funded agencies. To assess the effect of zero-funding Respite Care services on outcomes, the net change in outcomes for the Part A service system were reviewed. In the period since Respite Care services were zero-funded, Part A client outcomes have continued to remain stable. Health and health-related outcomes remain high across measures and across the Part A service system.

Funding Streams Analysis

Very little funding exists specifically for Respite Care services in the Boston EMA. This funding is provided by Massachusetts Ryan White Part B and the Massachusetts AIDS Line Item.[11] The Massachusetts Commission on End of Life Care offers resources and assistance in accessing Respite Care to Massachusetts residents.[12] Respite care is available to New Hampshire residents through Easter Seals and the Visiting Nurses Association of America.

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1 FY 2007 Client Services Provider Handbook. Boston Public Health Commission AIDS Program, Client Services Unit. March 1, 2007.
2 1999-2000 Service Category Definitions. CARE ACT Title I EMA HIV Health Services Planning Council. February 10, 2000.
3 FY 2000 Priority Setting Exercise. CARE ACT Title I EMA HIV Health Services Planning Council. April 8, 1999.
4 1999-2000 Resources and Allocations Committee Year-End Report. CARE ACT Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 2000.
5 2000-2001 Resources and Allocations Committee Year-End Report. CARE ACT Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 2001.
6 2001-2002 Resources and Allocations Committee Year-End Report. CARE ACT Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 2002.
7 2002-2003 Resources and Allocations Committee Year-End Report. CARE Act Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 2003.
8 Voices of Experience 2003. Suffolk University, Center for Public Management. February, 2004.
9 Planning Committee Year-End Report 2003-2004 Term. CARE Act Title I EMA HIV Health Services Planning Council, Planning Committee. June 24, 2004.
10 Resources and Allocations Committee Report. CARE Act Title I EMA HIV Health Services Planning Council, Resources and Allocations Committee. June 24, 2004.
11 2008 Funding Streams Overview. Ryan White Pary A EMA HIV Health Services Planning Council. May 8, 2008.
12 Massachusetts End of Life Commission website. www.endoflifecommission.org.

Appendix D:
FY 2010 Priority Setting Exercise

APPENDIX D

Priority Setting Exercise
Ryan White HIV/AIDS Treatment Modernization Act
Boston EMA 2008-2009

- **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.

Priority Setting Cycle

The **previous** year is **Fiscal Year (FY) 2008 which ended on February 28, 2009.**

The Council's **current** year is **FY 2009 which began March 1, 2009**.

The Council will set priorities **for next year, FY 2010, which starts March 1, 2010.**

- **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, 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 the existing resources in the EMA; identifies where the funds will be most utilized as a "payer of last resort"; assesses the overall needs of the EMA service system; and determines how the funds can be most effectively allocated.
  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; for instance, Housing Options for People With AIDS (HOPWA) and the Bureau of Substance Abuse Services (BSAS) are two examples of other sources of funds outside of the Part A Ryan White HIV/AIDS Treatment Modernization Act funding stream. 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 through the state.

Boston EMA Part A Service Categories to be Ranked by the Council

Case Management	Drug Reimbursement	Peer Support
Client Advocacy	Food Services	Primary Care
Complementary Therapies	Housing	Substance Abuse
Dental	Mental Health	Transportation

RETURN THIS PAGE TO PLANNING COUNCIL SUPPORT.
THE RESULTS WILL BE GIVEN AT THE END OF THE COUNCIL MEETING.

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:

   1 = "most important"

   12 = "least important"

   For most participants this will be a difficult task. Remember your input is an important part of the Planning Council cycle. 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, 12 is the lowest priority). **Be sure to rank all the listed categories**.

Rank Order 1-12	FY 2010 Categories *(In alphabetical order)*
	Case Management
	Client Advocacy
	Complementary Therapies
	Dental
	Drug Reimbursement
	Food Services
	Housing
	Mental Health
	Peer Support
	Primary Care
	Substance Abuse
	Transportation

Appendix E:
FY 2010 Priority Setting Exercise Worksheet

APPENDIX E

Priority Setting Exercise Worksheet

1. Please use this optional worksheet to help you carry out the Priority-Setting Exercise, if it would be helpful.

2. To use the worksheet, take the Part A service categories from Table 1 and copy them into Table 2 in priority order (1 = highest priority, 12 = lowest priority).

3. Once you've completed the worksheet, copy the results over onto the Priority-Setting Exercise and turn that in to Planning Council Support. **Please do not turn in the worksheet.**

Table 1. Boston EMA Part A Service Categories
(In alphabetical order)

Case Management	Housing
Client Advocacy	Mental Health
Complementary Therapies	Peer Support
Dental	Primary Care
Drug Reimbursement	Substance Abuse
Food Services	Transportation

Table 2. Service Priority Order

Rank	FY 2010 Categories
1	
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Appendix F:
Service Category Definitions

Appendix F: Service Category Definitions

As approved by the Boston EMA Ryan White Part A HIV Health Services Planning Council, May 2008.

Service category *(In alphabetical order)*	**Definition**
Case Management	Services funded under this category are client centered services that link with primary medical care and health-related support services in a manner that ensures timely, coordinated access to appropriate levels of care. Client centered services support a clients ability in maximizing their self-sufficiency and independence. Key activities include: information and referral; assessment of the client's needs and personal support systems; development of a comprehensive individualized service care plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; periodic reevaluation and adoption of the plan.
Client Advocacy	Services funded under this category provide short-term "specialized" assistance to clients throughout the process of accessing and obtaining financial and legal services that include, but which are not limited to: healthcare benefits, immigration, social security and disability benefits.
Complementary Therapies	Services funded under this category include, but are not limited to: acupuncture; chiropractic treatment; and, other holistic modalities. The purpose of this category is to provide services that enhance adherence to care, such as symptom management.
Dental	Services funded under this category are recruitment of dentists and preventive diagnostic and therapeutic services rendered by dentists, dental hygienists and other dental practitioners
Drug Reimbursement	The service funded under this category is the provision of medically prescribed pharmaceuticals used in the prevention, management and treatment of HIV disease.
Food Services	The service funded under this category is the provision of calorically and nutritionally appropriate prepared food, which may include, but is not limited to: prepared meals; congregate meals; home-delivered food; food banks; nutritional supplements; and, the provision of nutritional counseling under the supervision of a registered dietician.
Housing	Services funded under this category include the provision of short-term and/or emergency rental assistance, the provision of housing support in a group home or scattered-site setting, and emergency housing-related expenses such as utilities. These services also include assessment, search, placement, and advocacy services provided by those who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.
Mental Health	Services funded under this category are psychological and psychiatric treatment, counseling and case consultation services provided by professional therapists (licensed or authorized within the state).
Peer Support	Services funded under this category provide assistance to clients where the person(s) providing the service is a person infected with HIV and of the client's self-identified community and provide services to a full spectrum of individuals infected by HIV. Such services include the provision of culturally competent psychosocial support; assistance in obtaining a range of services and entitlement that will meet the needs of the client and are provided by licensed or non-licensed, para-professional individuals.
Primary Care	Services funded under this category provide routine, non-emergency, non-inpatient medical care, case consultation, patient education, and OB/Gyn services.
Substance Abuse	Services funded under this category may include: pretreatment program of recovery readiness; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; drug-free treatment and counseling; neuro-psychiatric pharmaceuticals; relapse prevention in an outpatient or residential health service setting; and activities targeting persons with HIV disease so that they can be enrolled or retained in care/ treatment services.
Transportation	Services provide taxi vouchers, public transportation, coordination of volunteer transportation, and agency-sponsored vans to transport clients to vital medical and social service appointments.

Appendix G:
2009 Report on Service Needs

APPENDIX G

2009 Report on Service Needs

by the Boston EMA Planning Committee 2008-2009

Due to current trends in the HIV/AIDS epidemic and barriers to care in the Boston EMA, the Resources and Allocations Committee should consider the following factors when developing funding scenarios:

- A greater need for case management, mental health, and substance abuse services.
- A continued need for housing services.
- The effects of the economy on PLWH, especially as they affect needs for food services, housing, and transportation.
- An emphasis should be put on funding case management, client advocacy, and peer support, to deal with the effects of race, gender, stigma, and cultural competency.