USING RESULTS TO IMPROVE COMMUNITY HEALTH: PLANNING FOR RYAN WHITE FUNDED SERVICES

Background

The Greater Baltimore HIV Health Services Planning Council (the planning council) is a 40-member body congressionally mandated by the Ryan White Act to plan and allocate over $22 million annually for medical and support services for people living with HIV/AIDS (PLWH/As) in the Baltimore metropolitan area. Appointed by the Mayor of Baltimore City, the planning council identifies the service needs of PLWH/As residing in the Baltimore EMA and sets funding priorities for federal HIV/AIDS-related services under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), Part A, and Minority AIDS Initiative (MAI).

The mission of the planning council is to ensure comprehensive, high-quality services to PLWH/As in the greater Baltimore eligible metropolitan area (EMA), regardless of their ability to pay. The planning council plans for and ensures access to culturally sensitive, high-quality, cost-effective services in collaboration with local authorities, service providers and consumers of HIV prevention and care services. This system includes a plan to expand capacity, as well as monitor and evaluate services. InterGroup Services, Inc. (IGS) is the organization contracted by the Baltimore City Health Department (BCHD) to provide technical support to the planning council and its activities.

The Ryan White Act, first passed by Congress in 1990 and reauthorized most recently as the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), addresses the health needs of PLWH/As by funding core medical and support services that enhance access to, and retention in, care. The following four principles have been crafted by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, to guide local Ryan White program planners in implementing the act's provisions and meeting emerging challenges in HIV/AIDS care (HRSA 2002:1-4):

- Revise care systems to meet emerging needs.
- Ensure access to quality HIV/AIDS care.
- Coordinate Ryan White-program services with other health-care delivery systems.
- Evaluate the impact of Ryan White-program funds and make needed improvements.

Priority setting and resource allocation (PSRA) is actually a two-step process. The planning council (a) prioritizes services based on documented need and data and (b) allocates resources among prioritized services for the following fiscal year upon review of the expenditure and utilization data gathered from 39 providers and over 150 contracts. The planning council prioritizes service categories using the most up-to-date information available regarding epidemiological trends and data on unmet service needs of people with HIV. These priorities, and decisions about how best to meet them, must be based on: (a) documented need, (b) cost and outcome effectiveness, (c) priorities of the HIV-infected communities for whom the services are intended, and (d) the availability of other governmental and non-governmental resources.

Data Available For Planning

The following is a description of the types of data that are presented to the council prior to priority setting for use in planning for services and the allocation of funds.

1. Scorecards.

IGS's specially designed service-category "scorecards" are tables of summary information on each service category. The summaries include (a) projected and actual numbers of clients served, (b) estimated percentage of unmet need and the cost of meeting it, (c) total expenditure for the year, including any unspent funds, carry-over and reprogramming funds allocated to the category during the year, (d)

information about other funding streams, (e) a five-year funding comparison, and (f) service units distributed.

2. Expenditure and Service Delivery Report and Narrative.

The expenditure and service delivery report is provided at regular intervals by the grantee. This report provides a summary of expenditure and client utilization by service category and includes total allocation amount, expenditure, budgeted and actual numbers of clients, cost per client, and numbers of units expended and the cost per unit. The narrative that comes with the ESD report addresses any anomalies of five percent or greater in expenditure and program-performance measures.

3. Needs Assessment.

The council habitually undertakes two sorts of needs-assessment activity: (a) triennial, large-scale surveys and (b) special projects, such as focus groups, community forums, research reports, and/or small-scale surveys on topics of special interest. The most recent needs-assessment survey was administered in 2010; it captured the views of 791 respondents in the Baltimore EMA.

4. Unduplicated Client Data.

This information, compiled annually by the grantee, provides a profile of the clients served by Ryan White program's Part A-funded providers by service area, ZIP code, age distribution, gender, and race.

5. Clinical Quality Management.

The Baltimore City Health Department's Clinical Quality Management program determines whether, or how well, minimum standards of care have been met within the EMA by service providers. (See, for example, BCHD 2004; Brimlow *et al*. 2003a; Brimlow *et al*. 2003b; Brimlow *et al*. 2003c; Deigh *et al*. 2003; DeLorenzo *et al*. 2002; DeLorenzo *et al*. 2003a; DeLorenzo *et al*. 2003b; Drucker *et al*. 2002; Nesbitt *et al*. 2003; Thorner *et al*. 2002a; Thorner *et al*. 2002b; Thorner *et al*. 2002c.) Clinical quality management includes site visits to providers' establishments by BCHD and/or the review of client charts to determine compliance with current standards of care for the Baltimore EMA by BCHD staff and/or consultants.

6. Epidemiological Profile.

Every year, the Infectious Disease and Environmental Health Administration (IDEHA), a division of the state's Department of Health and Mental Hygiene, provides a document that summarizes rates of HIV infection and AIDS conditions in central Maryland. The information is obtained through laboratory and provider reporting and supplemental surveillance. The data show trends in the epidemic as well as prevalence by region, gender, race, and exposure. The data also include IDEHA's estimate of the number of HIV-positive people who are not in care.