COMPREHENSIVE HIV SERVICES PLANNING

SELF-ASSESSMENT MODULE

Ryan White CARE Act

Title I HIV Health Services Planning Councils
Title II HIV Care Consortia/Planning Bodies

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INTRODUCTION

The Self-Assessment Module Series, Second Edition

The Division of Service Systems (DSS) and the Office of Science and Epidemiology (OSE) of the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA) have developed a series of tools to help Titles I planning councils and Title II consortia and other planning bodies (collectively referred to as "planning bodies" throughout this report) assess their effectiveness in critical areas of responsibility defined by the Ryan White CARE Act. This second edition of the HRSA/HAB Self Assessment Module Series incorporates changes in the roles and responsibilities of CARE Act entities resulting from reauthorization of the CARE Act in 2000. The topics covered in the Self-Assessment series are:

- Comprehensive HIV Services Planning.
- Continuum of Care.
- Developing and Pursuing the Mission.
- Needs Assessment.
- Priority Setting and Resource Allocation.
- Representation and Diversity.

Each topic is addressed in a separate Self-Assessment Module (SAM). Information is complementary across the modules and cross-referenced when appropriate. The modules can be used independently of each other or as a full series.

The modules are designed to facilitate self-assessment by planning bodies. Use of any and all modules in the series is completely voluntary. Planning bodies are free to determine which area(s) they want to assess, when to conduct the self-assessment, how extensive the scope of the assessment will be, and with whom they will share results.

DSS staff and the Technical Assistance Contractor (TAC) are available to introduce the modules or to respond to any concerns raised through the self-assessment process. Please contact your DSS Project Officer if you have any questions about the Self-Assessment Modules or would like assistance.

Purpose of the Comprehensive HIV Services Planning SAM

Planning is central to the CARE Act's focus on local and State decision-making in developing HIV/AIDS care systems. Each grant year planning bodies establish service and resource allocation priorities and implementation plans. Comprehensive HIV services planning goes beyond this annual process and provides a road map for developing a system of care over time. It does so by reviewing needs assessment data, including HIV care needs of persons living with HIV disease (PLWH) in and out-of-care, existing resources to meet those needs, and barriers to care. Additional useful information to review includes evaluation data (including cost-effectiveness and outcome effectiveness of services data) and contract monitoring data from the Eligible Metropolitan Area (EMA) and State programs.

This self-assessment module is intended to help planning bodies assess their past planning activities in order to refine, improve, or expand future planning. The module also can increase understanding of the comprehensive HIV services plan components and how to conduct comprehensive planning.

What is Comprehensive HIV Services Planning?

The Ryan White CARE Act's goals are to develop, organize, coordinate, and implement high-quality and cost-efficient systems of services to individuals and families with HIV disease. Comprehensive planning is necessary to reach these goals.

The purpose of comprehensive HIV services planning is to help planning body members develop a detailed picture of the current and future local HIV/AIDS epidemic and to guide decisions about HIV-related services and resources in an EMA or region. Information from comprehensive planning is used to set long-term goals, objectives, and strategies for delivering services. The plan also reflects the community's vision and values about how best to deliver HIV/AIDS care, particularly in light of limited resources.

Comprehensive HIV services planning helps planning bodies make difficult decisions in an increasingly complex health care environment. This includes, for example, changes in treatment protocols and multiple care systems under Medicaid, Medicare, and other Federal, State, and local funding.

Comprehensive planning helps answer *four* basic questions:

1. ***Where are we now?***
   (What is our current system of care?)
2. ***Where do we need to go?***
   (What system of care do we want?)
3. ***How will we get there?***
   (What steps can we take to develop this ideal system? In particular, what strategies are needed to assure access to the system in order to eliminate disparities?)
4. ***How will we monitor our progress?***
   (How will we evaluate our progress in meeting our short-and long-term goals?)

In answering these questions, planning bodies engage in a planning process that results in a written plan.

Comprehensive HIV services planning helps planning body members clarify and articulate shared values. These values may be related to services that are provided as part of the continuum of care. Shared values influence who receives services, where and when services are provided, who provides services, and what benefits and outcomes are expected. Planning also helps to develop a shared vision of the system of care.

Once long-term and system-wide goals and objectives are established through comprehensive planning, planning bodies can set their sights on achieving them. Monitoring progress with a comprehensive plan can lead to modification of goals and objectives.

Questions To Ask In Comprehensive HIV Services Planning

Comprehensive HIV services planning helps planning body members answer many important questions. Many of these questions arise once a planning body is engaged in detailed exploration of the four basic questions involved in comprehensive planning.

1. Who has HIV disease and AIDS in our EMA or region now, and what have past trends been?
2. Who will have HIV disease and AIDS in the future based on projections for the next three to five years?
3. How can we describe people living with HIV disease and AIDS now and in the future?
4. What services and resources are available in our EMA or region for persons living with HIV disease and AIDS?
5. What is the existing continuum of care in our EMA or region?
6. How can we describe the continuum of care from different perspectives—for special needs populations, for people in different stages of health/illness, or for people living in different geographic areas in the EMA or region?
7. What are the utilization patterns of different services in the continuum?
8. What is the capacity and capability of our providers to deliver services?

Questions To Ask In Comprehensive HIV Services Planning (continued)

9. What are the costs of providing services?
10. What are the unmet service needs and delivery barriers in our continuum of care?
11. What are the major health service delivery issues affecting our ability to develop or maintain a comprehensive service delivery system?
12. What are our shared values about services for people living with HIV disease and AIDS in our EMA or region?
13. What is our shared vision of a continuum of care for people living with HIV disease and AIDS in our EMA or region?
14. How will we develop or maintain a continuum of care in our EMA or region for special needs populations in different stages of health/illness, or in different geographic areas over the long term (three- to five-year goals and objectives)?
15. How will we develop short-term (annual) service priorities, goals, and objectives?
16. How will we allocate resources this year based on our vision, values, goals, and all that we have learned in the planning process about service needs, barriers, and costs?
17. How will we monitor and evaluate our progress from year to year and over time in achieving our short- and long-term goals and objectives?

Components of a Comprehensive HIV Services Plan

This section presents the key components of the planning process and their presentation in the comprehensive HIV services plan. The comprehensive plan guides a planning body in the development of a coordinated system of care for PLWH. It should include clear goals, objectives and strategies for action as well as mechanisms for assessing progress.

Planning bodies differ in their approach to completing the components of a comprehensive HIV services plan. Some may decide to undertake a needs assessment first and then proceed with the other components. Others may begin with a more limited approach to quickly obtain information about service gaps and then build a comprehensive plan over time by conducting the components sequentially.

Early on, a planning body should prepare all the components of a comprehensive plan to provide a blueprint for decisions about service priorities and resource allocations. Once that blueprint is in place, specific components can be updated according to available resources and the need for new information for effective planning and priority setting. Approximately every three to five years, a comprehensive reassessment of all components should be considered. Each planning body must determine which components of the comprehensive plan should be repeated at which intervals.

The planning body may start by organizing the plan according to the four basic questions of comprehensive planning:

1. ***Where are we now?***

   This section can draw on the results of your planning body's needs assessment process and may include the following elements:

   - *An epidemiological profile* is a document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. It includes information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics. The epidemiologic profile serves as the scientific basis from which HIV prevention and care needs are identified and prioritized for any given jurisdiction.
   - *An assessment of service needs among the affected populations* explores the perspectives of PLWH, providers, and community representatives on service needs. It requires data analysis, including quantitative and qualitative information. The assessment may address some or all of the different types of need described in the Needs Assessment Self-Assessment Module. A careful assessment of barriers to PLWH receiving services is an important aspect of this component. A needs assessment should look at multiple perspectives with a focus on soliciting information from PLWH themselves, including those in care and those not in care.

- *A resource inventory* describes organizations and individuals providing the full spectrum of HIV services accessible to PLWH in the service area regardless of the funding source. The goal of the resource inventory is to develop a comprehensive picture of services supported by all funding sources.
- *A profile of provider capacity and capability* shows the extent to which services identified in the resource inventory are accessible, available, and appropriate for PLWH. Estimates of capacity describe how much of a service a provider can deliver. Assessments of capability describe the degree to which a provider is actually accessible and has the expertise needed to deliver services. Some needs assessments and comprehensive planning processes also explore acceptability of services; however, assessment of client satisfaction is an effort that should be undertaken in the planning body's quality improvement process.
- *An assessment of gaps in services* brings together the quantitative and qualitative data on service needs, resources, and barriers to help focus priorities for future allocation of resources.
- *A description of the existing continuum of care* identifies the services and linking mechanisms available to people living with HIV disease, in different stages of HIV-disease, and to PLWH living in different geographic areas within the service area.
- *A description of major service delivery issues in the service area* identifies geographic, infrastructure, legislative, financing, regulatory, treatment, and other health service delivery issues which impact on the system of care.
- *A description of the history of local, State, or regional response to the epidemic* outlines past and current planning efforts in the service area, including institutional, agency-based, community-, State-, and region-wide planning. In addition, it describes Ryan White CARE Act planning efforts to date.

2. ***Where do we need to go?***

   This section should outline goals for a comprehensive continuum of care:

   - *A shared vision* of how the planning council would like its system of care to function. This description may be an operational definition of "continuum of care," reflecting the context within which the planning council works (i.e., its specific circumstances and needs). This approach incorporates the "continuum of care" concept into the development of the plan at an early stage. It also provides an opportunity for addressing the Statewide Coordinated Statement of Need (SCSN), and the coordination of your services with other services available to PLWH, especially services provided through other funding streams. Addressing the SCSN and coordination of services are legislative requirements.
   - *Shared values or guiding principles* that shape the HIV-related system of care in the region. Values may include cost-effectiveness, high-quality services, the role of the grantee or planning council as the payer of last resort, etc.

3. ***How will we get there?***

   This section should outline goals and objectives and an action plan to help reach those goals.

   - *Goals and objectives.* These include long-term goals and objectives regarding systems planning, evaluation, and service-related goals and objectives that need to be considered and reviewed every three to five years. Short-term or annual goals and objectives for care and treatment should also be included. Objectives need to be stated in very specific and measurable terms.

4. ***How will we monitor our progress?***

   This section should outline the steps to be taken to monitor and evaluate the planning body's use of the plan.

   - *A monitoring and evaluation plan* should monitor progress in achieving short-term and long-term goals and objectives and update the comprehensive plan. It should monitor changes in the epidemic, service needs, provider capacity, and resources. A process also is needed as part of the monitoring and evaluation plan to keep track of legislative, regulatory, health service delivery, and treatment changes that will affect the system of care.

Phases of Comprehensive HIV Services Planning

The comprehensive planning process involves four phases, each of which includes several planning activities. These are:

1. ***Pre-planning.***

   A planning committee is formed and convenes to discuss the responsibilities and requirements for planning and to make recommendations for an overall approach to the planning process. In some instances, this initial activity is conducted by a "pre-planning" group. The planning committee develops its approach to creating (or updating) the comprehensive HIV services plan, including the final goals and objectives for the process, questions to be answered and tasks required to answer them; and a time line, a budget, and responsibilities broken down by task. A table of contents for the plan may be developed.

2. ***Data Gathering and Analysis.***

   During this phase, the planning committee develops a plan and priorities for collecting and analyzing data. The planning committee reviews the major planning questions that the planning process is intended to answer. It gathers and reviews existing data or "secondary data", such as epidemiologic data and other needs assessments for its usefulness for the plan.

   If more information is needed, instruments to collect data must be developed and pilot tested. "Primary data", or new data collected by the planning committee, are then collected through surveys, interviews, focus groups, and other methods.

Once collected, data are reviewed and discussed in terms of validity, strengths and limitations, and usefulness in answering planning body questions. Data are analyzed and formatted, so that planning committee and planning body members can use the data for decision making about service priorities and major HIV service delivery issues.

3. ***Plan Preparation, Approval, and Dissemination.***

Once the available data have been gathered and analyzed, the planning committee (or consultants/contractors) outlines and prepares a plan document. Key information is presented to the planning body, usually in an open meeting to which the public is invited. The draft plan is reviewed and revisions are made as needed. The comprehensive plan must be approved by the full planning body.

Once the planning body is presented with the plan, a dissemination plan is developed to ensure that key stakeholders receive copies or summaries of the plan and have an opportunity to provide feedback to the planning body. Public comments and feedback may be obtained formally at public hearings or through other venues such as community meetings, PLWH caucuses, and provider forums.

4. ***Implementation***

The last phase is to put the plan into action. In the implementation phase, the planning council uses the plan to make decisions about service priorities, resource allocation, and other critical service delivery issues. It also reviews the plan and updates it as needed.

It is important to understand that the comprehensive HIV services planning process occurs over an extended period of time. By investing in a thoughtful, step-by-step process, the planning committee attends to the critical roles of leadership, participation of stakeholders, participant skills, and technical and administrative support necessary for a successful planning process.

Conducting the Self-Assessment

This section discusses how to conduct the self-assessment. It provides tips to make the self-assessment process efficient, productive, and positive. These recommendations are based on experience and feedback from the pilot tests of the modules. Each planning body should adapt these processes to fit local constraints and issues.

A. Who Should Use This Module?

This SAM is designed to assist planning bodies in both the pre-assessment design and the post-assessment evaluation of the comprehensive planning process:

- For planning bodies that have not yet conducted a comprehensive planning process, this SAM can also be used as a development tool to design and plan future comprehensive plans. The questions in the module can serve as a checklist for items to include in the process.
- For planning bodies that have completed a comprehensive plan (or components of one), this SAM can be used to evaluate successes and identify areas for quality improvement in future comprehensive plans.

The decision to use the SAM is often made by a planning body's standing committee, e.g., evaluation, planning, or executive committee or an ad hoc group convened to make recommendations about whether to use the module. This same group should decide at the outset whether, how, and with whom the results of the self-assessment will be shared.

Use of this module is completely voluntary and should be decided upon solely by the planning body membership. Planning bodies are free to determine when to conduct the self-assessment and how comprehensive it will be.

B. Who Conducts the Self-Assessment?

A committee or workgroup should oversee the implementation of the self-assessment. This could be the same group that recommended the self-assessment or it could be a newly convened group. A group of five to ten is suggested and should include PLWH and HIV medical and support service providers, as well as people with expertise in needs assessment methodology, health services planning, and evaluation. Attention to racial, ethnic, gender diversity and geographic representation also is critical. Some members of the group should be drawn from existing planning body membership, but it may be useful to go outside the planning body for specific expertise. In general, it is desirable to include a grantee representative in order to promote a cooperative and collaborative relationship.

It is not advisable to have the person directly responsible for the comprehensive plan lead this self-assessment effort because it may be difficult for that individual to be objective. On the other hand, their participation in the self-assessment will provide an important perspective and may help ensure that improvements are implemented in future assessments.

This and all other SAMs have been designed to be completed by groups of volunteers—members of planning bodies and others. However, planning body staff may be involved, depending on local circumstances and availability. For instance, staff may be needed to help gather documents and ensure effective communication among members. Consultants should not be used to conduct the self-assessment. They may, however, be helpful in modifying this module for the local environment, facilitating the self-assessment process, or developing plans for revising the comprehensive plan following the self-assessment. DSS staff is also available to assist in the application of the module.

C. What Activities Should be Part of the Self-Assessment?

Six major activities must occur to complete the self-assessment.

1. Review and adapt the module to the local environment.
2. Collect information and documents needed to answer the questions in the module.
3. Conduct interviews.
4. Answer and score the questions in the module.
5. Develop an action plan to guide future activities.
6. Apply results of the self-assessment.

The five major activities of the self-assessment are described below.

1. ***Review and adapt the module.*** After the decision is made to proceed with the self-assessment, the first step is to review the module and adapt it as necessary to the local environment. Irrelevant questions should be eliminated and lists of stakeholders should be augmented or reduced as appropriate. Careful review of all the module's sections will facilitate its implementation and minimize frustration among workgroup members.

   The module should be distributed to all members of the self-assessment workgroup at least one week before the first workgroup meeting. The first meeting, to be held in person if possible, should be aimed at determining the scope, content and purpose of the self-assessment. The self-assessment workgroup should have and review the written charge from the planning body authorizing the self-assessment. Participants should define the process and time line by which the self-assessment will be conducted, assign roles and responsibilities of workgroup members, and clarify specific questions for all members. If a chairperson has not been appointed, one should be elected at this meeting.

2. ***Collect information and documents.*** Once the workgroup has agreed on the scope of the self-assessment, members should collect and review related documents, instruments, and reports. This task may require more than one person and should include at least one person with expertise in comprehensive planning. Documents that might be collected include:
   - The final comprehensive plan.
   - Tools used to conduct the comprehensive plan, e.g., survey instruments, interview protocols, and focus group guides.
   - Minutes and attendance logs from meetings of committees or advisory boards that participated in the comprehensive planning process.
   - Minutes from council and consortium meetings where the comprehensive plan was discussed.
   - Working papers and reports used in preparing the final comprehensive plan.
   - Request(s) for proposals and consultant reports (if any part of the comprehensive plan was produced by consultants).

3. ***Conduct Interviews.*** Interviews should be conducted with members of the planning body's comprehensive planning committee; members of any advisory group formed to oversee the process; planning body staff and consultants who worked on the comprehensive plan; people at the grantee, council, or consortium level who used the comprehensive plan; and people representing affected populations or services covered in the comprehensive plan. This task also will require the involvement of more than one person to be completed in a timely way.

   The goal of the interviews is to learn how well the comprehensive planning process was conducted and to identify areas for improvement in future plans. The purpose is not to repeat the comprehensive plan itself. Questions may be taken directly from the SAM for use in the interview. Identify in advance which questions you will discuss with each person being interviewed. For example, you may want to discuss methodology with a research consultant and the inclusiveness of the comprehensive planning process with affected populations.

4. ***Answer and score the questions.*** After collecting relevant information and conducting key interviews, the workgroup should convene to discuss the questions in the module. Depending on the number of questions being addressed, the discussion could take four to six hours. The discussion may occur in a single meeting, in a series of meetings, or by telephone conference calls. The questions have been subdivided into five sections to facilitate a segmented discussion. The sections correspond to the major components of the comprehensive planning process:

   A. Purpose And Structure Of Planning

   B. Planning Process

   C. Planning Tasks

   D. Outcomes: Putting The Plan Into Action

   There are two important things to consider in developing a response to each question.

   - Of primary importance, the qualitative discussion of each question will help identify what the planning body did well and what it could do better
   - The assignment of a score, where scoring is indicated, will help the planning body identify areas of strength and weakness. The scores can also provide a baseline for future self-assessments.

   Many questions will require significant discussion and coming to consensus. It is important to choose an individual to lead the process who can focus and facilitate the discussion.

   Further discussion of the questions is provided at the beginning of the Questions Section of this SAM.

5. **Develop action plans.** The self-assessment will be most successful if it improves future comprehensive planning efforts by keeping what works well, modifying what doesn't, and adding important aspects that are missing. Each section of the module concludes with the development of an action plan for tasks related to that section. The action plans are intended to direct future comprehensive planning efforts. Particular attention should be paid to questions that were scored 0 or 1, because these may represent problem areas. You also should note areas of strength to build into future planning activities.

   Each section's action plan is formatted to list objectives, time line, resources needed, and lead person responsible for completing the objective. This may be modified to meet the needs of a particular planning body. Once the section-specific action plans are done, an overall plan with priorities should be developed.

6. ***Apply results.*** The results of the self-assessment, including answers to questions, scores, and action plans, belong only to the planning body. However, a planning body may decide to share part or all of its results with the grantee, with DSS, or with the community.

The overarching purpose of conducting a self-assessment is to improve the comprehensive planning process so that the plan meets legislative requirements and DSS guidelines. There may be other reasons for conducting the self-assessment, such as responding to local questions or concerns, but the SAMs have been designed primarily as a tool to help planning bodies improve the quality of their operations. The action plan component of the module is intended to lead to such improvements.

At the conclusion of the self-assessment, the planning body may want to develop a brief report summarizing the process. The report could address the charge to the workgroup or committee, workgroup membership, processes used to complete the module, and major findings.

D. How Much Time and Money are Required?

The self-assessment process is designed to be very low cost. Time is the principal investment required of those who help complete the module.

Once a planning body decides to proceed with the self-assessment, the process should take between eight and fourteen weeks, beginning with the first planning meeting and ending with an action plan.

Sample Time Line For The Self-Assessment

Deciding to Conduct the Self-assessment

Week 1: Planning body decides to proceed with self-assessment, identifies ad hoc workgroup to conduct assessment, writes charge to the workgroup, distributes SAM to the workgroup, decides who will get results.

Preparatory Work

Weeks 2-3: Workgroup meets, elects chair, reviews and modifies questions, assigns responsibilities.

Weeks 4-7: Background documents obtained and reviewed, interviews conducted.

Answering Questions

Weeks 8-9: Workgroup meets to discuss and to score questions, develops action plans for completed sections.

Week 10: Workgroup meets to complete discussion of action plans.

Reporting and Implementing

Week 11: Present results to planning body, report on process and final decision.

Weeks 12-14: Decide on overall plan and implementation, request technical assistance, if needed.

Information Sources

To complete the Comprehensive HIV Services Planning self-assessment module, you will need:

- Planning body bylaws, mission statement, operating guidelines, annual plan.
- The comprehensive HIV services plan.
- The charge to the planning committee or committee responsible for overseeing planning, consultant contracts, or Request for Proposal (RFP) for consultant services.
- For Title I Planning Councils, the most recent grant application.
- For Title II consortia/planning bodies, the most recent local RFP/Request for Application, or proposal to grantee or administrative agency.
- Planning body meeting minutes.
- Public announcements about the comprehensive plan, the initial pre-planning document.
- Comprehensive Planning instruments used (e.g., surveys or interview protocols).

SELF-ASSESSMENT QUESTION FORMAT

Question Types

The module contains four types of questions:

a. Questions that rank responses from 0 to 3, with 0 being the lowest score and 3 being the highest. Each planning council and consortium completing the module determines where to rank itself along this continuum.

b. Questions with a yes or no response. When the desired direction of response is known, these questions are also scored with "no" scoring 0 and "yes" scoring 3. For some yes/no questions where either answer may be equally good, depending on circumstances, no score is given.

c. Multi-part questions in which the sub-parts are not scored, but a summary question asks for an overall assessment scored from 0 to 3.

d. Open-ended questions that are not scored. These questions enable planning bodies to highlight aspects of complex questions they feel are particular strengths or weaknesses.

Discussion of Questions

To the right of each question is a set of Discussion of Questions to assist you in developing thorough answers. These "tips" may include a brief discussion of the question topic, a set of benchmarks to consider in your response to the question, or guidance on how to interpret your score and answers.

Scoring

The points in each section are added up and divided by the number of scored questions in the section. By dividing the total points by the number of scored questions, you will have a single score of 0 to 3 for each section. That score can be compared to the score in other sections. Combined with a qualitative assessment of strengths and weaknesses in each section, the scores can be helpful in highlighting areas where a planning body has done very well (high scores, e.g., 2 to 3), as well as areas in which changes or enhancements should be considered (low scores, e.g., 0 to 1).

As you work to assign scores, please remember that scoring is not the ultimate goal of the self-assessment. It is much more important that the group engage in substantive discussion of the questions.

If you get stuck on scoring, move on. All scores are confidential and are not compared across Titles I and II planning bodies or shared with DSS.

COMPREHENSIVE HIV SERVICES PLANNING QUESTIONS

A. Purpose And Structure Of Planning

1. At the start of the planning process, did the planning body discuss the purpose of planning?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not discussed			*thoroughly discussed*

2. Did the planning body write a statement about the purpose of planning?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
no			*yes*

2a. If so, please include this statement.

____

____

2b. In which planning body document(s) was this statement included? (Check all that apply.)

- ❑ *Bylaws*
- ❑ *Mission statement*
- ❑ *Operating guidelines/procedures*
- ❑ *Comprehensive HIV services plan*
- ❑ *Other*

2c. Did your purpose statement include any of the following? (Check all that apply.)

- ❑ *An improvement in quality of life for PLWH*
- ❑ *An increase in information about the system of care*
- ❑ *An improvement in decision making about the service delivery system*
- ❑ *An increase in collaboration with other HIV programs or planning groups*
- ❑ *An increase in public awareness of HIV/AIDS issues*
- ❑ *Other (please specify)* ____________________

A **System Of Care** encompasses public and private, paid and voluntary service programs, information systems, and coordinating mechanisms to assist people living with HIV disease and AIDS. It usually develops with input from a needs assessment and includes a continuum of care to assure that the most comprehensive care is available.

A **Continuum Of Care** is a system of related services and linking mechanisms that responds to an individual or family's changing needs. These services and mechanisms include:

- *linkage(s) of Early-Intervention Services to primary medical care services; primary medical care for the treatment of HIV infection that is consistent with Public Health Service guidelines;*
- *access to drug therapies (including prophylaxis and treatment of opportunistic infections) and combination antiretroviral therapies;*
- *substance abuse treatment, mental health treatment, oral health and hospice services;*
- *integration of other public health programs; and*
- *support services that enhance access to and retention in a system of care as well as improved quality of life.*

The following questions ask about the composition of the committee responsible for planning activities during your last planning cycle. This is usually the past fiscal year or last full cycle of comprehensive planning.

3. Who was responsible for comprehensive HIV services planning? List all individuals, committees, or groups below.

____

____

____

4. Who had the lead responsibility for developing the comprehensive HIV services plan? (Check only one box.)

- ❑ *Entire planning body*
- ❑ *Standing planning committee*
- ❑ *Ad hoc planning committee*
- ❑ *Resource allocation committee*
- ❑ *Executive committee*
- ❑ *Other*

Throughout this module, the group responsible for the planning activities will be referred to as the planning committee.

5. To what extent did the following stakeholders (see Figure 1) participate on the planning committee?

5a. PLWH

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
no meaningful participation			*substantial participation*

5b. Racial/ethnic groups disproportionately affected by HIV/AIDS

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
no meaningful participation			*substantial participation*

5c. Other historically underserved groups (homeless, intravenous drug users, etc.)

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
no meaningful participation			*substantial participation*

5d. A range of service providers and organizations

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
no meaningful participation			*substantial participation*

5e. Other Stakeholders

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
no meaningful participation			*substantial participation by a range of stakeholders*

5f. Which stakeholders did not participate and do you have a strategy to improve participation?

____

____

Total Points for Question 5 ____________

Figure 1

The CARE Act Amendments of 2000 require that Title I and Title II Statewide comprehensive planning committees be representative of the following groups:
(A) health care providers, including federally qualified health centers;
(B) community-based organizations serving affected populations and AIDS service organizations;
(C) social service providers, including providers of housing and homeless services;
(D) mental health and substance abuse providers;
(E) local public health agencies;
(F) hospital planning agencies or health care planning agencies;
(G) affected communities, including people with HIV disease and historically underserved groups and subpopulations;
(H) non-elected community leaders;
(I) State government (including the State Medicaid agency and the agency administering the program under part B);
(J) grantees under subpart II of part C;
(K grantees under section 2671, or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area;
(L) grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services; and
(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV disease as of the date on which the individuals were so released.

6. Are planning committee activities overseen by the full planning body?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

If not, name the entity responsible for oversight.

____

7. What entity is responsible for final approval of the comprehensive HIV services plan?

❑ ***Full planning body***
❑ ***Executive or steering committee***
❑ ***Grantee***
❑ ***Other***

SUMMARY: Purpose and Structure of Planning

Scoring of Questions 1–7

To score, follow these steps:

STEP 1 Add up the points for questions 1 through 7 and enter that number in the **Total Points** box.

STEP 2 Add up the number of scored questions (and sub-questions) you answered and enter it in the **Total Number of Scored Questions Answered** box.

STEP 3 Calculate and record your final score: **Total Points** ***Divided by*** **Total Number of Scored Questions Answered**.

Total Points ________

(Divided by) Number of Scored Questions ________

(Equals) Score ________

Maximum possible score is 3

**If your score equals more than 3, double-check your addition of points (Step 1) and re-count the number of scored questions (Step 2).*

Strengths And Weaknesses for Questions 1–7

What parts of your comprehensive planning structure were effective?

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What needs to be improved?

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Action Steps for Questions 1–7

Based on your responses to questions 1 through 7, list the key areas where action should be taken to help planning bodies determine their purpose in and the structure for planning.

Objective:

Resources:

Time line:

Person Responsible:

Objective:

Resources:

Time line:

Person Responsible:

Objective:

Resources:

Time line:

Person Responsible:

Discussion of Questions 1–7

This section asks whether the purpose of comprehensive HIV services planning was discussed at the start of the planning process. It also assesses whether a purpose statement was developed to guide the process.

Question 1 awards maximum points if the purpose was fully discussed by the planning body.

Question 2 asks whether a statement of purpose was written and included in any planning body documents. It is best to write down your purpose of planning; therefore, maximum points are awarded for doing this.

Benchmark: In Title I areas, planning councils are responsible for developing a comprehensive plan for the organization and delivery of health services in the EMA.

Benchmark: Consortia/Title II planning bodies receive Title II funds from the State for assistance in planning, developing, and delivering services to individuals and families with HIV disease. Title II regional planning bodies are responsible for developing an assessment of service needs in the geographic area and a service plan to address needs. These regional service plans may be helpful in developing a Title II statewide comprehensive plan.

Benchmark: The CARE Act Amendments of 2000 added a new requirement that Title II States develop a comprehensive plan. This plan must describe "the organization and delivery of HIV health care and support services to be funded … [and] shall include a description of the purposes for which the State intends to use such assistance." See P. L. 106-345, CARE Act Amendments of 2000, Sec. 2617 (b)(4)]

Question 2b asks where the purpose statement was documented. Question 2c lists outcomes against which you can assess the success of your planning effort and asks you to identify any that were included in your purpose.

It is important that a structure be developed to support the comprehensive HIV services planning process, beginning with a clear understanding of responsibility for planning and the participation of key stakeholders in guiding the process. Question 3 asks if responsibility was assigned to an individual, committee, or group. Assigning responsibility to a committee is preferred to delegating responsibility to an individual. Diverse perspectives need to be involved in the planning process if it is to be successful. Question 4 asks who had lead responsibility for planning.

Benchmark: The purpose of planning for consortia/Title II planning bodies is to address the special care and service needs of populations and sub-populations with HIV disease (both those in care and those not in care) in the geographic area. Adequate planning must be carried out by Title II planning bodies to meet the special needs of families and youth with HIV disease.

Question 5 asks about the involvement of stakeholders on the planning committee. Your planning body must select stakeholders to be included in the planning process. Figure 1 provides an extensive list of people to include. The planning committee should be broadly representative while maintaining a reasonable size (ten to fifteen people).

It is critically important that the planning committee be representative of the community (e.g., race/ethnicity, gender, age, socioeconomic status). It is important that the planning committee be as diverse as the planning body and that it include PLWH, providers, and persons who have a special interest and experience in planning. This diversity will provide useful information and perspectives about services and plans. Score high points on questions 5a-5e if you have involved these groups and other stakeholders.

Question 6 asks if the full planning body oversees the activities of the planning committee. Regular reporting to the planning body during the planning process will generate feedback as decisions are made.

Question 7 asks you to name the entity responsible for final approval of your plan. Usually, the full planning body is responsible for planning and therefore retains final approval.

B. Planning Process

8. Did the planning committee have goals and/or objectives for the planning process?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

8a. If so, please write them below.

8b. In which document(s) were the goals and objectives included? (Check all that apply.)

❑ *Stand-alone document*
❑ *Comprehensive HIV services plan*
❑ *Planning committee charge (e.g., directive from planning body to planning committee)*
❑ *Planning body minutes*
❑ *Planning committee minutes*
❑ *Other planning documents*

9. Was a draft table of contents for the comprehensive HIV services plan completed, laying out major sections and chapters of the plan?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
not completed			*completed, with all major chapters identified*

10. Did the planning committee develop a draft list of questions to be answered by the plan?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
not developed			*developed*

11. Did the planning committee identify major tasks of each component of the plan?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
not identified			*identified all major tasks*

12. Was a time line established?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

13. Were you able to complete these tasks in the designated time frame?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

14. Was a budget established?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

15. Were you able to complete these tasks within the allocated budget?

❑	❑	❑	❑
0 pts	**1 pt**	**2 pts**	**3 pts**
no			*yes*

16. Did the planning body receive regular updates during the planning process?

❑ 0 pts *never* ❑ 1 pt ❑ 2 pts ❑ 3 pts *always*

17. How would you rate the planning process with respect to:

17a. Leadership

❑ 0 pts *poor* ❑ 1 pt ❑ 2 pts ❑ 3 pts *excellent*

17b. Participant skills

❑ 0 pts *poor* ❑ 1 pt ❑ 2 pts ❑ 3 pts *excellent*

17c. Technical support (preparation of epidemiologic data, etc.)

❑ 0 pts *poor* ❑ 1 pt ❑ 2 pts ❑ 3 pts *excellent*

17d. Administrative support (meeting minutes, scheduling, etc.)

❑ 0 pts *poor* ❑ 1 pt ❑ 2 pts ❑ 3 pts *excellent*

17e. Capacity building (orientation for participants, trainings on key issues, etc.)

❑ 0 pts *poor* ❑ 1 pt ❑ 2 pts ❑ 3 pts *excellent*

Question 18 — Phases of the Planning Process*

This chart is designed to help answer questions 18a-d on the following page. Identify whether each phase of the process was implemented and by whom.

Phase	Did implementation occur?		Check if group participated in implementation			
	No	Yes	PLWH	Providers	Community Leaders	Other
Pre-planning						
Data Gathering and Analysis						
Plan Preparation, Approval, and Dissemination						
Implementation						

*See Introduction, "Phases of HIV Services Planning".

18. To what extent were all phases of the planning process implemented?

❑ 0 pts *not implemented* ❑ 1 pt ❑ 2 pts ❑ 3 pts *implemented*

To what extent did the following stakeholders participate in the implementation of planning phases:

18a. PLWH?

❑ 0 pts *did not participate* ❑ 1 pt ❑ 2 pts ❑ 3 pts *substantial participation*

18b. Providers?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
did not participate			*substantial participation*

18c. Community leaders?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
did not participate			*substantial participation*

18d. Other stakeholders?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
did not participate			*substantial participation*

19. To what extent did the planning committee discuss the plans or activities of other HIV programs or planning groups?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
few groups or not discussed			*many groups' efforts discussed thoroughly*

Question 19 — Consideration of Other HIV Programs or Planning Groups

Comprehensive planning should involve other HIV programs or planning groups in the planning body's geographic area. A good plan incorporates the plans and activities of related service providers and planners. This chart is designed to help answer question 19

Coordinated Group	Not Applicable (program or group doesn't exist)	Program or Group's Activities Discussed in Planning Process
Statewide Coordinated Statement of Need (SCSN) working group		
AIDS Drug Assistance Program (ADAP)		
Title III grantees		
Title IV grantees		
Planning bodies with overlapping service areas		
AIDS Education and Training Center (AETC) programs		
Special Projects of National Significance (SPNS)		
Centers for Disease Control and Prevention (CDC) HIV Prevention Community Planning Groups		
Substance Abuse and Mental Health Services Administration (SAMHSA) programs		
Housing Opportunity for People with AIDS (HOPWA) programs		
Federally-funded Migrant, Homeless, and Community Health Centers		
Maternal and Child Health programs		
TB programs		
STD programs		
State Medicaid program		
Corrections programs		
Other		

SUMMARY: Planning Process

Scoring of Questions 8–19

To score, follow these steps:

STEP 1 Add up the points for questions 8 through 19 and enter that number in the **Total Points** box.

STEP 2 Add up the number of scored questions (and sub-questions) you answered and enter it in the **Total Number of Scored Questions Answered** box.

STEP 3 Calculate and record your final score: **Total Points** ***Divided by*** **Total Number of Scored Questions Answered**.

Total Points ________

(Divided by) Number of Scored Questions ________

(Equals) Score ________

Maximum possible score is 3

**If your score equals more than 3, double-check your addition of points (Step 1) and re-count the number of scored questions (Step 2).*

Strengths And Weaknesses for Questions 8–19

What parts of your comprehensive planning process were effective?

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What needs to be improved?

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Action Steps for Questions 8–19

Based on your responses to questions 8 through 19, list the key areas where action should be taken to help planning bodies determine their purpose in and the structure for planning.

Objective:	Resources:
Time line:	Person Responsible:
Objective:	Resources:
Time line:	Person Responsible:
Objective:	Resources:
Time line:	Person Responsible:

Discussion of Questions 8–19

This section assesses the planning process that has been established to develop the comprehensive HIV services plan. The section asks about the overall approach to the planning process, including development of goals and objectives, planning questions, time line and budget, implementation of all planning phases and stakeholder involvement.

Question 8 asks whether goals and objectives for the planning process were developed as part of the comprehensive plan. Give yourself maximum points if you developed them. Clearly stating goals and objectives at the beginning of the process helps to keep you “on target” throughout the process. Goals and objectives also familiarize new participants with the process. Planning bodies are facing complex issues and a rapidly changing environment in terms of organization, delivery, treatment protocols, and financing of health care for PLWH. Goals and objectives for the planning process should reflect these realities and help to address the context in which decisions about Title I and Title II services and resources are being made. Written goals and objectives can be referred to when undertaking the tasks of comprehensive planning. Question 8b lists documents where your goals and objectives may be stated in order to track your process of comprehensive planning.

In addition to goals and objectives, questions 9-11 ask about other parts of the pre-planning phase. Question 9 recognizes the value of outlining a draft table of contents in order to structure the components of the comprehensive HIV services plan , while questions 10 and 11 focus on whether you identified the questions to be answered by your plan and the tasks of each component.

The planning process occurs over an extended period of time with some activities happening concurrently but many unfolding sequentially. Careful planning at the beginning is key to developing a reasonable time line and budget for the overall planning process (questions 12-15). Give yourself maximum points if you established a reasonable time line and budget.

Question 16 asks if the planning body received regular updates about the planning process. One of the most important challenges of the planning process is to keep all planning body members, not only the planning committee, engaged and up-to-date.

Question 17 asks you to rate your planning process in terms of leadership (question 17a), participant skills (question 17b), technical support (question 17c), administrative support (question 17d), and capacity building (question 17e). Each factor contributes to the success of the planning process.

Question 18 asks you to identify which stakeholders participated in each phase of the planning process. In some planning bodies, members may have a more “hands-on” role in collecting and reviewing data, so that PLWH, providers, community leaders, and others participate significantly. In

other planning groups, a consultant, grantee, or planning body staff may have the lead in data collection and analysis, with PLWH, providers, and community leaders actively involved in review and comment on the draft or final plan. Although there is no "right" level of participation for individual stakeholders in specific phases, the planning process should be designed to maximize meaningful participation of stakeholders.

Question 19 asks if the activities and plans of other HIV-related programs and planning groups were part of your planning process. At a minimum, discussion between your planning committee and other HIV program or planning groups should take place. Other activities to consider include: inviting members of other planning group to your planning committee meetings; using other groups' data; reporting between groups intermittently; and holding joint planning sessions.

Benchmark: Comprehensive planning should be coordinated with other related planning efforts (e.g., CDC HIV Prevention Community Planning Groups, other Ryan White CARE Act Titles, AETCs, and other Federal, State, and local planning efforts.)

Benchmark: Titles I and II planning bodies are expected to participate in the development of the Statewide Coordinated Statement of Need process led by the State.

Benchmark: The comprehensive plan must be compatible with all State and local planning tools related to the provision of services to individuals living with HIV disease. It is particularly important to ensure compatibility with the Statewide Coordinated Statement of Need

C. Planning Tasks

20. Did the planning committee use the epidemiologic profile?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

If no, skip to Question 23

21. Did the planning committee use secondary data?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

22. Did the planning committee use the epidemiologic profile to analyze AIDS incidence, prevalence, and trends?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

If no, skip to Question 24.

23. From which source did the needs planning committee obtain HIV prevalence data? profile?

❑ **0 pts** *no HIV prevalence data used*	❑ **1 pt** *CDC HIV prevalence*	❑ **2 pts** *CDC HIV prevalence case surveillance*	❑ **3 pts** *Actual State reported prevalence case surveillance*

24. Describe any difficulties encountered when using an epidemiologic profile or describing future trends of the epidemic.

____

____

25. Describe any benefits of using an epidemiologic profile or future HIV/AIDS trend data.

____

____

26. Did the planning committee use or develop needs assessment information that:

26a. Is based upon a combination of qualitative and quantitative methods?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

26b. Describes the needs of PLWH?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

26c. Describes the need of individuals who know their HIV status but are not in care?

❑ **0 pts** *no*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *yes*

26d. Includes a resource inventory?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

26e. Describes provider capacity and capability?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

26f. Describes capacity development needs resulting from disparities in the availability of HIV related services?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

26g. Describes gaps in services based upon an analysis of information from the epidemiologic profile, the needs assessment, resource inventory, and provider capacity and capability?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

26h. Describes unmet need?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

Total Points for Question 26 __________

Please refer to the Needs Assessment module for self-assessment on this topic.

27 Did the planning committee describe the continuum of care available within the EMA or region?

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

Please refer to the Continuum of Care module for self-assessment on this topic.

28 Did the planning committee consider major issues with an impact on delivery of services to PLWH? (See chart below for a list of major issues.)

❑ 0 pts *no*	❑ 1 pt	❑ 2 pts	❑ 3 pts *yes*

If no, skip to Question 32.

Questions 28 & 29	Major Issues that have an Impact on the System of Care	
This chart is designed to help answer questions 28 & 29.		
Major Issues	**Impact Discussed?**	
	No	**Yes**
Evolving research (e.g., new treatment protocols)		
Geography (e.g., divided or distant jurisdictions)		
Health care financing and regulation (e.g., Medicaid, ADAP)		
Managed care		
Public health infrastructure constraints		
Welfare reform		
Other		

29. To what extent did the planning committee discuss a range of issues that have an impact on the system of care?

❑ 0 pts *not discussed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *discussed thoroughly*

30. Describe difficulties encountered when considering major issues with an impact on delivery of services to PLWH?

____

____

31. Describe any benefits of considering major issues with an impact on delivery of services to PLWH?

____

____

32. Did the planning committee develop a description of the local response to the HIV/AIDS epidemic, including a description of past and current planning efforts?

❑ 0 pts *no* ❑ 1 pt ❑ 2 pts ❑ 3 pts *yes*

33. Did the planning committee develop shared values (sometimes referred to as guiding principles) about a system of care for PLWH?

❑ 0 pts *no* ❑ 1 pt ❑ 2 pts ❑ 3 pts *yes*

If no, skip to Question 35.

Question 34 — Shared values for a system of care

Shared values and shared vision are usually considered separately. Values refer to the guiding principles or ideas used to organize a system of care, such as client-centered and high-quality. Vision refers to the specific qualities of this system, such as the continuum of care and availability of services. This chart is designed to help answer questions 34a and 34b.

	Did discussion occur?		Was consensus reached?	
	No	**Yes**	**No**	**Yes**
Client-centered				
Compassionate, respectful				
Culturally competent				
Efficiency of services				
Empowerment of consumers				
Equitable				
Essential health services				
Essential support services				
Improved health status/quality of life				
Other				

34a. To what extent did the planning committee discuss a range of principles or ideas when developing shared values for its system of care?

❑ 0 pts *not discussed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *discussed thoroughly*

34b. To what extent was consensus reached on shared values?

❑ 0 pts *no consensus* ❑ 1 pt ❑ 2 pts ❑ 3 pts *consensus*

35. Did the planning committee develop a shared vision of a system of care for PLWH?

❑ 0 pts *no* ❑ 1 pt ❑ 2 pts ❑ 3 pts *yes*

If no, skip to Question 37.

Question 36	**Shared values for a system of care**			
This chart is designed to help answer question 36.				
	Did discussion occur?		**Was consensus reached?**	
	No	**Yes**	**No**	**Yes**
Accessibility of services				
Availability of services				
Cost/outcome effective services				
Mechanism for feedback from clients				
Quality of services				
Other				

36a. To what extent did the planning committee discuss a range of qualities or elements when developing a shared vision of its system of care?

❑ 0 pts *not discussed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *discussed thoroughly*

36b. To what extent was consensus reached on a shared vision?

❑ 0 pts *no consensus* ❑ 1 pt ❑ 2 pts ❑ 3 pts *consensus*

37. Describe any difficulties encountered when developing shared values or a shared vision of a system of care.

____

____

38. Describe any benefits of developing shared values or a shared vision for a system of care.

____

____

39. Did the planning committee develop long-term (three- to five-year) goals and objectives for services in the EMA or region?

❑ 0 pts *no* ❑ 1 pt ❑ 2 pts ❑ 3 pts *yes*

If no, skip to Question 41.

40. To what extent were the following steps taken to develop long-term goals and objectives?

____

____

40a. Reviewed met and unmet service needs (i.e., gaps analysis using needs assessment data)

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

40b. Reviewed unmet needs of individuals who know their status but are not in care?

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

40c. Reviewed governmental and non-governmental resources available to fund services.

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

40d. Reviewed providers' capacity* for services.

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

40e. Reviewed providers' capability* for services.

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

40f. Reviewed capacity development needs

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

** See Introduction, "Components of a Comprehensive Plan" for definitions*

40g. Developed service delivery goals and objectives.

❑ 0 pts *not developed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *developed*

40h. Developed service coordination goals and objectives.

❑ 0 pts *not developed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *developed*

40i. Developed information management goals and objectives.

❑ 0 pts *not developed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *developed*

40j. Developed qualit2y assurance goals and objectives.

❑ 0 pts *not developed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *developed*

Total Points for Question 40 __________

41. Did the planning committee develop short-term (one-year) goals and objectives for services in the EMA or region?

❑ 0 pts *no* ❑ 1 pt ❑ 2 pts ❑ 3 pts *yes*

If no, skip to Question 43.

42. To what extent were the steps listed below taken to develop short-term goals and objectives?

____

____

42a. Reviewed long-term goals and objectives as they relate to short-term goals and objectives.

❑ 0 pts *not reviewed* ❑ 1 pt ❑ 2 pts ❑ 3 pts *reviewed thoroughly*

42b. Reviewed the most recent list of service priorities and resource allocations.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not reviewed			*reviewed thoroughly*

42c. Reviewed the most recent service delivery goals and objectives.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not reviewed			*reviewed thoroughly*

42d. Revised service delivery goals and objectives if necessary.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not revised			*revised*

42e. Developed service coordination goals and objectives.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not developed			*developed*

42f. Developed information management goals and objectives.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not developed			*developed*

42g. Developed quality assurance goals and objectives.

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not developed			*developed*

Total Points for Question 42__________

43. Did the planning committee develop an implementation strategy for its comprehensive HIV services plan?

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not developed			*developed*

44. Did the implementation plan include strategies for:

44a. Identifying individuals who know their HIV status but are not in care?

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not included			*included*

44b. Informing these individuals of and enabling them to utilize HIV services?

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not included			*included*

44c. Eliminating disparities in access and services among historically underserved populations?

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not included			*included*

44d. Coordinating provision of services with programs for HIV prevention?

❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
not included			*included*

44e. Coordinating provision of services with programs for substance abuse prevention and treatment?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not included			*included*

Total Points for Question 44 ___________

45 Did the strategy identify specific activities?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not identified			*identified*

46 Was a time line established for accomplishing these activities?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not established			*established*

47 Was a person or group assigned responsibility for each activity?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
no activities assigned			*all activities assigned*

48 Describe difficulties encountered when developing long- and short-term goals and objectives and the implementation strategy.

____

____

49. Describe any benefits of developing long- and short-term goals and objectives and the implementation strategy.

____

____

50. Did the planning committee have mechanisms to monitor the comprehensive HIV services plan?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
no			*yes*

51. Were specific outcomes identified to monitor progress?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not identified			*identified*

52. Did the planning committee use monitoring information to revise its comprehensive HIV services plan?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not used			*used*

53. Was a time line established to revise components (e.g., epidemiologic profile, needs assessment, long- and short-term goals and objectives) of the comprehensive plan?

❑	❑	❑	❑
0 pts	1 pt	2 pts	3 pts
not established			*established*

54. Describe any difficulties encountered when monitoring and revising the comprehensive HIV services plan.

____

____

55. Describe any benefits of monitoring and revising the plan.

____

____

SUMMARY: Planning Tasks

Scoring of Questions 20–55

To score, follow these steps:

STEP 1 Add up the points for questions 20 through 55 and enter that number in the **Total Points** box.

STEP 2 Add up the number of scored questions (and sub-questions) you answered and enter it in the **Total Number of Scored Questions Answered** box.

STEP 3 Calculate and record your final score: **Total Points *Divided by* Total Number of Scored Questions Answered**.

Total Points ________

(Divided by) Number of Scored Questions ________

(Equals) Score ________

Maximum possible score is 3

**If your score equals more than 3, double-check your addition of points (Step 1) and re-count the number of scored questions (Step 2).*

Strengths And Weaknesses for Questions 20–55

What parts of your planning tasks were effective?

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What needs to be improved?

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Action Steps for Questions 20–55

Based on your responses to questions 20 through 55, list the key areas where action should be taken to help planning bodies determine their purpose in and the structure for planning.

Objective:	Resources:
Time line:	Person Responsible:
Objective:	Resources:
Time line:	Person Responsible:
Objective:	Resources:
Time line:	Person Responsible:

Discussion of Questions 20–55

Following is a discussion of questions 20-55. The discussion is intended to help interpret the questions and assign scores.

This section assesses whether and how you conducted the various planning tasks to develop a comprehensive HIV services plan. The planning tasks include developing:

1. *An epidemiologic profile describing the current epidemic and future trends.*
2. *Up-to-date needs assessment information, including a resource inventory, provider capacity and capability, and a gaps analysis.*
3. *A description of the existing continuum of care.*
4. *Major service delivery issues with an impact on the system of care.*
5. *Summary of past and current planning efforts.*
6. *Shared values and shared vision about the system of care.*
7. *Long- and short-term goals and objectives.*
8. *An implementation strategy for the plan.*
9. *Mechanisms to monitor and revise the plan.*

This section asks about whether you completed the task, steps you followed, and specific outcomes related to it.

Not all planning bodies complete every task or step each year. Some tasks are carried out as part of one year's planning process; others may be carried out in subsequent years.

Comprehensive HIV services planning is a cyclical process that continues from year to year to develop information the planning body needs to make decisions about service and resource allocation priorities and the HIV service delivery system.

Questions 20-25 ask about epidemiologic information developed as part of the plan. Question 20 asks whether the planning body used the epidemiologic profile and question 21 asks whether secondary data was used.

An epidemiologic profile is a document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. Its main components are:

AIDS data, presenting data on people who are living with AIDS and those who have died from AIDS-related illnesses.

HIV data, presenting data (reported or estimated) on HIV-infected persons who have not developed AIDS.

Trends, analyzing changes in the epidemic over time.

Because all HIV/AIDS data are not "created equal," a profile also should discuss the strengths and limitations of different types and sources of information.

Question 22 asks whether the profile was used to analyze AIDS incidence, prevalence, and trends. Question 23 asks whether you used CDC HIV prevalence estimates or used actual State reported HIV cases. HIV prevalence data can either be based on CDC estimates (for those States not yet collecting HIV case data), HIV prevalence reported to CDC by the State (that may lag behind actual cases reported at the local level), or the actual cases of HIV reported by the State. For question 23, give yourself 0 points if no prevalence data was used, 1 point for using prevalence estimates, 2 points for using CDC HIV prevalence case surveillance, and 3 points if you used actual State reported HIV prevalence case surveillance.

Benchmark: Epidemiologic data should be part of needs assessment and comprehensive planning. AIDS surveillance data and estimates of HIV disease incidence and prevalence should be used to describe trends in the epidemic since the outset and in the last two years. These trends should be forecast three to five years, as appropriate.

Question 24 asks you to describe the difficulties encountered when developing an epidemiologic profile or describing future trends of the epidemic. Question 25 asks you to describe what went well or any benefits of that activity.

Question 26 asks whether the planning committee used or developed needs assessment information. Questions 26a-e ask about different types of information used in your needs assessment. For further questions about needs assessment, please refer to the Needs Assessment module of this series.

Benchmark: Consortia must demonstrate that they have carried out an assessment of need in the geographic area to be served and have developed a plan to ensure delivery of services to meet identified needs. Planning councils are required to undertake a needs assessment process that documents unmet need for specific services.

Question 27 asks whether the existing continuum of care in the area was described. Refer to the Attachment, HIV Continuum of Care, at the end of this module for a full discussion of the HIV continuum of care and a definition of primary care. Detailed questions about the continuum of care were not included in this module. Please refer to the Continuum of Care module of this self-assessment series.

Questions 28 and 29 ask whether and to what extent major issues that impact delivery of services for PLWH were considered. These issues include evolving research, geography, health care financing and regulation, managed care, public health infrastructure, and welfare reform constraints.

Questions 30 and 31 elicit comments on the difficulties and benefits of considering major service delivery issues.

Question 32 asks whether you described the local response to the epidemic as well as past and current planning efforts. Understanding this history helps with planning for the future.

Question 33 asks if the planning committee developed shared values about a system of care. Question 34a asks whether committee members discussed a range of principles when developing shared values for its system of care. Committee members may wish to have other stakeholders participate in this discussion. Question 34b asks whether consensus was reached on shared values. Most importantly, shared values must be agreed upon by the planning committee to help guide decisions about services and resources.

Question 35 asks if a shared vision of a system of care for PLWH was developed. Question 36 lists issues that the planning committee and key stakeholders might have discussed.

Questions 37 and 38 provide you with the opportunity to describe what was difficult and what went well when developing shared values or a shared vision for a system of care.

Questions 39 and 40 ask whether the planning committee developed long-term (three- to five-year) goals and objectives for services in your area. Steps needed to develop long-term goals and objectives are presented in question 40. Long-term goals and objectives often shape a short-term plan which can take many forms. For example, planning councils develop annual service objectives as part of the annual grant application.

Question 41 asks whether short-term (one-year) goals and objectives were developed. Question 42 asks whether steps were implemented to carry out the task of developing these short-term goals and objectives. If it was not necessary to revise your current service delivery goals and objectives, do not score question 42d. In comprehensive planning, participants will look to long-term goals and objectives when developing short-term plans.

Questions 43 and 44 ask if an implementation strategy was developed and which strategies were used. An implementation strategy should focus on achieving long- and short-term goals and objectives. Question 45 asks if the strategy identified specific activities to be carried out. Question 46 asks if a time line was established, and Question 47 asks if an individual or group was assigned responsibility for each activity. High points on these questions show that thought was given to moving your plan from a well-developed concept into action.

Question 48 asks you to describe the difficulties of developing the strategy, goals, and objectives, and Question 49 asks you to describe the benefits.

Benchmark: Service priorities and resource allocation should be based on the documented needs and priorities of the infected population.

Question 50 asks if the planning committee developed mechanisms to monitor its development of the comprehensive HIV services plan. Award yourself maximum points if you developed mechanisms such as regular meetings, periodic review of goals and objectives, conference call updates, etc. Question 51 asks if specific outcomes were identified to monitor progress.

Question 52 asks if the planning committee used the information gained from monitoring to revise its comprehensive HIV services plan. Question 53 asks whether a time line was established to revise the plan's components. They may include but need not be limited to an epidemiologic profile, description of future trends, a needs assessment, and long- and short-term goals and objectives. If your plan is a new one, establish a schedule for review and revision. This strategy should focus on achieving long- and short-term goals and objectives. Monitoring progress is crucial to the success of any plan and allows for adjustments to be made. This section ends with questions 54 and 55 which request that you describe the difficulties and benefits of monitoring and revising the plan.

D. Outcomes: Putting The Plan Into Action

56. Was information in the comprehensive HIV services plan shared with:

56a. Full planning body

❑ **0 pts** *not shared* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *shared*

56b. Other stakeholders

❑ **0 pts** *not shared* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *shared*

56c. Other community members

❑ **0 pts** *not shared* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *shared*

57. To what extent were there opportunities for stakeholders and community members to provide feedback on the plan?

❑ **0 pts** *no opportunity* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *great deal of opportunity*

58. Were suggested changes to the plan considered and incorporated as appropriate?

❑ **0 pts** *not incorporated* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *frequently incorporated*

59. Rate the comprehensive HIV services plan with respect to:

59a. Comprehensiveness

❑ **0 pts** *not comprehensive* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *comprehensive*

59b. Clarity

❑ **0 pts** *unclear* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *clear*

59c. Community acceptance

❑ **0 pts** *not accepted* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *accepted*

60. To what extent did the comprehensive HIV services plan provide the planning body with more knowledge and understanding of the local HIV epidemic and the system of care?

❑ **0 pts** *no new knowledge or understanding provided* ❑ **1 pt** ❑ **2 pts** ❑ **3 pts** *a substantial increase in knowledge and understanding*

Question 60 — System of Care Information

This chart is designed to help answer question 60.

System of Care Component	Did the Plan Increase Your Knowledge or Understanding of the Indicated System of Care Component?	
	No	Yes
Epidemiology:		
• Current/past trends		
• Past two years		
• Future (three to five years)		
Services:		
• Needs		
• Barriers		
• Demand (current)		
• Demand (future)		
• Availability		
• Access		
• Acceptability		
• Utilization		
• Costs		
Outcome/Impact:		
• Benefits		
• Gaps		
Resources:		
• Public Funding		
• Federal Ryan White Titles I-IV		
• Other Federal (HOPWA, SAMHSA,CDC,etc.)		
• State (Medicaid, Maternal and Child Health)		
• State (other HIV/AIDS)		
• Local		
• Health Insurance Plans:		
- *Fee-for service plans*		
- *Managed care plans*		
• Donations, Fundraising		
• Other		

Question 61 — Services Information

This chart is designed to help answer question 61.

Service	Did the Plan Increase Your Knowledge or Understanding of the Services Indicated?	
	No	Yes
Ambulatory/Outpatient Medical Care		
Inpatient Hospital care		
Case Management		
Dental Care		
Drug Reimbursement Program		
Health Insurance		
Home Health Care:		
• Para-Professional		
• Professional		
• Specialized		
• Durable medical equipment		
Hospice Services:		
• Home-based		
• Residential		
Mental Health Therapy/Counseling		
Nutritional Services		
Early Intervention Services		
Rehabilitation Care		
Substance Abuse Treatment/Counseling		
Support Services:		
• Adoption/Foster Care Assistance		
• Buddy/Companion Services		
• Child Care		
• Client Advocacy		
• Counseling (other)		
• Day or Respite Care		
• Direct Emergency Financial Assistance		
• Food Bank/Home Delivery		
• Health Education/Risk Education		
• Housing Assistance/Housing-related Services		
• Outreach		
• Referral		
• Transportation		
• Other Support Services		

61. To what extent did the comprehensive HIV services plan provide the planning body with knowledge and understanding of specific services?

❑ 0 pts — *no new knowledge or understanding provided*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *a substantial increase in knowledge and understanding*

62. How useful were the following planning tasks in the development of the comprehensive HIV services plan?

62a. Epidemiologic profile

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62b. Needs assessment (including resource inventory, provider capacity and capability, and gaps analysis)

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62c. Continuum of care

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62d. Discussion of major issues that have an impact on the health system

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62e. Description of past and current planning efforts

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62f. Shared values

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62g. Shared vision

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62h. Long-term goals and objectives

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62i. Short-term goals and objectives

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

62j. Implementation strategy

❑ 0 pts — *not useful*
❑ 1 pt
❑ 2 pts
❑ 3 pts — *very useful*

Total Points for Question 62 ___________

63. Did the comprehensive HIV services plan address the system of care with respect to:

63a. An improvement in the quality of life for PLWH?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

63b. An increase in stakeholder understanding of how the system of care works?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

63c. An improvement in decision making about expanding, reducing, adding, eliminating, or refining services?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

63d. An improvement in coordination with other HIV programs or planning groups (see list on page 31)?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

63e. An increase in public understanding about the HIV/AIDS epidemic and Ryan White CARE Act activities?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

63f. Changes in the epidemic and the delivery system (e.g., managed care and new treatment advances)?

❑ **0 pts** *did not address this area*	❑ **1 pt**	❑ **2 pts**	❑ **3 pts** *addressed this area*

Total Points for Question 63 __________

SUMMARY: Outcomes: Putting the Plan into Action

Scoring of Questions 56–63

To score, follow these steps:

STEP 1 Add up the points for questions 56 through 63 and enter that number in the **Total Points** box.

STEP 2 Add up the number of scored questions (and sub-questions) you answered and enter it in the **Total Number of Scored Questions Answered** box.

STEP 3 Calculate and record your final score: **Total Points *Divided by* Total Number of Scored Questions Answered**.

Total Points ________

(Divided by) Number of Scored Questions ________

(Equals) Score ________

Maximum possible score is 3

**If your score equals more than 3, double-check your addition of points (Step 1) and re-count the number of scored questions (Step 2).*

Strengths And Weaknesses for Questions 56–63

What success did you have in putting the plan into action?

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What needs to be improved?

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Action Steps for Questions 56–63

Based on your responses to questions 56 through 63, list the key areas to help planning bodies put their plan into action.

Objective: Resources:

Time line: Person Responsible:

Objective: Resources:

Time line: Person Responsible:

Objective: Resources:

Time line: Person Responsible:

Discussion of Questions 56–63

Questions 56-63 help you assess the results of your comprehensive plan. Comprehensive HIV services planning is not an end in itself. It is worth the time, effort, and expense only if it helps assure that a system of care is in place for PLWH. This system must be maintained or reconfigured over time to meet essential PLWH health and support needs in a changing environment.

Questions 56a-c ask if the planning committee shared information in the comprehensive HIV services plan with the full planning body, other stakeholders, or other community members. Information can be shared through public presentations, or by mailing an executive summary or the entire plan.

Question 57 asks about the extent to which other stakeholders and community members had an opportunity to provide feedback on the plan. Feedback can be provided as the plan is developed or when a final draft is issued.

Question 58 asks about the extent to which suggested changes were considered and incorporated, as appropriate. This question gets to the heart of any thorough planning process--one that is flexible and inclusive.

Questions 59a-c ask you to rate your plan in terms of its comprehensiveness, clarity, and community acceptance. If you have scored high on these questions, your plan is likely to be well received and implemented.

Question 60 lists many components of the system of care and asks if your plan increased the planning body's knowledge or understanding of those care system components.

Similarly, question 61 includes a chart listing specific services and asks if the plan provided the planning body with more knowledge or understanding of those specific services. The comprehensive HIV services planning process should lead to increased knowledge and understanding of these services.

Questions 62 and 63 ask you to summarize what you've gained from planning. Question 62 asks how useful each of the planning tasks was to developing the comprehensive plan. Question 63 asks if your plan addressed the system of care with respect to six factors. Question 63a underscores why planning is so crucial: to improve the quality of life for people living with HIV disease and AIDS. Questions 63b-e emphasize the importance of developing a plan that results in a better understanding of how the system of care works, improvement in making decisions about service delivery, improving coordination with other HIV programs, and increasing public understanding about the HIV/AIDS epidemic and Ryan White CARE Act activities. Question 63f asks if your plan supports a community response to the changing epidemic. While each of these factors is important, you may have considered other equally important factors in your plan.

ATTACHMENT A: HIV CONTINUUM OF CARE

Continuum of care is a term encompassing the comprehensive range of services required by individuals or families with HIV infection in order to meet their health care and psychosocial service needs throughout the course of their illness. The concept of a continuum suggests that services must be organized to respond to the individual or family's changing needs in a holistic, coordinated, timely, and uninterrupted manner, reducing fragmentation of care. The continuum must also include strategies for linking services, so that from the perspective of people living with HIV disease, there exists a "seamless" service delivery system.

The continuum of care must be defined by and for each community. The defined continuum of care should be the ideal set of services and set of mechanisms for linking services that would be available to PLWH if the community had unlimited resources to allocate to HIV care. From this "wish list," the community should define its "core" continuum of care. The core continuum of care is the set of services and mechanisms to link services that a planning body has decided should be available to PLWH in their community. Neither the ideal continuum of care nor the core continuum of care is defined only by the resources directly available to the planning body. The planning body's funded continuum of care should represent a subset of the core continuum of care.

The following categories of services should be considered for inclusion in the continuum of care:

1. *Ambulatory/outpatient medical care* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
2. *Mental health services* are psychological and psychiatric treatment and counseling services, to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
3. *Oral health care* includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

4. *Substance abuse services-outpatient* is the provision of medical treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician.

5. *Substance abuse services-residential* is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).

6. *Rehabilitation services* include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

7. *Home health: para-professional care* is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

8. *Home health: professional care* is the provision of services in the home by licensed health care workers such as nurses.

9. *Home health: specialized care* is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

10. *Case management services* is a range of client-centered services that links clients with health care, psychosocial and other services. Ensures timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

11. *Buddy/companion service* is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

12. *Child care services* is the provision of care for the children of clients who are HIV positive while the clients are attending medical or other appointments or attending Title-related meetings, groups, or training. NOTE: This does not include daycare while client is at work.

13. *Child welfare services* is the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services are designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or

actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of HIV-positive children about risks and complications, care giving needs, and developmental and emotional needs of children.

14. *Client advocacy is* the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

15. *Day or respite care for adults* is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client.

16. D*evelopmental assessment/early intervention services* is the provision of professional early intervention by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational setting for HIV-affected clients, and education/assistance to schools.

17. *Early intervention services for Titles I and II* are a combination of services that include outreach, HIV counseling and testing, referral, and the provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.

18. *Emergency financial assistance* is the provision of short-term payment for essential utilities and for medication assistance when other resources are not available.

19. *Food Bank/home-delivered meals* is the provision of actual food, meals, or nutritional supplements. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

20. *Health education/risk reduction* is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

21. *Housing services* is the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Related housing services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for clients who are HIV affected. Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement and the fees associated with them. NOTE: If housing services include other service categories (e.g., meals, case management, etc.) these services should also be reported in the appropriate service categories.

22. *Legal services* is the provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible

for funding under CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

23. *Nutritional counseling* is provided by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

24. *Outreach services* include programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

25. Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

26. *Psychosocial support services* is the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

27. *Referral for health care/supportive services* is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

28. *Residential or in-home hospice care* means room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

29. *Transportation services* include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

30. *Treatment adherence services* is the provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

31. *Other services* are other services not listed above.

ATTACHMENT B: RESOURCES

Below is a list of legislative, HRSA documents, articles, and books related to needs assessment.

Legislation

- Ryan White CARE Act of 1990 as amended by the Ryan White CARE Act Amendments of 1996 and amended by the Ryan White CARE Act Amendments of 2000.

HRSA Documents

- Title I and II Manuals, chapters on Comprehensive Planning (updated 2002)
- Needs Assessment Guide (updated 2002)
- FY 2002 Title I Grant Application Guidance.
- FY 2002 Title II Application Guidance.
- Letter to Title I Colleagues (March 6, 1996) with enclosure entitled "Summary of Methodology for Estimating HIV Prevalence in Metropolitan Areas."
- Comprehensive HIV Services Planning: Technical Assistance Conference Call, Report by MOSAICA, The Center for Nonprofit Development and Pluralism, Washington, D.C., February 1996.
- Activities of Ryan White CARE Consortia, FY 1993, Conviser, R. October, 1994.
- First Year Experience of Title I Eligible Metropolitan Areas with Standard Protocol for Baseline Data Collection, Division of Service Systems.

Abstracts, Articles and Reports

- "State Efforts to Assess Met and Unmet Needs for HIV/AIDS Care Programs A Review of FY 1999 Ryan White CARE Act Title II Applications." National Alliance of State and Territorial AIDS Directors, September 2000.
- The Academy for Educational Development. Centers for Disease Control and Prevention. Handbook for HIV Prevention Community Planning. April 1994.
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