

**Summary of Planning Body and Joint Decision Making
to Address Unmet Need:
Ideas from the FY 2006 Ryan White Title I and Title II Applications**

Type of Activity	Description
Planning	
Goal for reducing unmet need	EMA includes in its comprehensive plan a goal of reducing unmet need by 5% per year.
Task force on unmet need	The planning body establishes a task force to coordinate its efforts to assess and address unmet need. It includes representatives from multiple committees and helps ensure that unmet need is considered in all aspects of planning body activity and decision making.
Training and Data Presentations	
Training on unmet need	Prior to priority setting, the planning body receives training on unmet need, including its responsibilities for assessing and addressing unmet need.
Presentation by surveillance staff	Each year, a surveillance staff member makes a presentation on unmet need to the State HIV Treatment and Care Consortium, which incorporates the information into data review, bid proposals, contracts and interagency agreements, and quality management plans with contractor sites.
Data presentations	In preparation for priority setting, the planning body participates in a data presentation that includes detailed discussion of unmet need estimates, and on needs assessment findings that describe the out-of-care population, their service needs and gaps, and their barriers to care.
Priority Setting	
Changes in priorities	Planning body gives higher priority to services that can help address barriers to care and reduce the level of unmet need – including substance abuse treatment, transportation, and peer case management.
Elimination of some service categories	Planning body eliminates several lower-priority supportive service categories in order to focus on core services most likely to be needed by individuals entering care.
MAI priorities	Planning body gives higher priority to targeted outreach to specific subpopulations identified as having unusually high levels of unmet need
Resource Allocations	
Funding for primary care and medications	The planning body carefully considers unmet need data when making resource allocations. Primary care and medications receive additional funding to ensure the availability of services for individuals entering care.
Funding to overcome specific barriers to care	The EMA increases funds for specific core services such as substance abuse, in order to ensure the availability of services to address identified service barriers.

Early intervention services	The planning body increases funding for early intervention services in response to unmet need data indicating delays in entry to care after testing.
Core services estimates and allocations	The EMA has a goal of reducing unmet need by getting 250 PLWH/A into care over the next year. Planning body and grantee work together to explore the mix of services typically needed by clients. They project how many of those 250 people will need primary care paid for by Title I, and how many will need each of the other core services and transportation. Using cost per client data provided by the grantee, the planning body adjusts funding allocations for these services to ensure sufficient resources to serve the 250 projected new clients. Funds for lower-priority services are reduced in the EMA's "flat funding" scenario.
Funding to address specific service gaps	Planning Council has made it a priority to provide adequate funding to address unmet need through strategies such as integrated case management, client advocacy, ensuring systems of care for the elderly, and rapid HIV testing linked with "supported entry" into care. Allocations reflect these commitments.
Use of MAI funds	The unmet need estimate and assessment lead to increased use of Minority AIDS Initiative (MAI) funds for two service categories: case management, because of its perceived key impact retention in care, and outreach, to target minority groups most likely to be out of care.
Funding for community education	The EMA increases funding for community education to make people more informed and confident in accessing care. This allocation is directly related to data indicating that lack of information about available services, limited information about medications, fear, and stigma represent important barriers to care in this EMA.
Funding for defined outreach	The Planning Council increases funding for outreach, calling for a late night outreach program that targets specific populations.
Reallocation of funds to promote access to and retention in care	Planning Council reallocates funds from lower-priority services to services that promote access to and retention in care, including outreach, early intervention services, access-to-care initiatives that include new maintenance-in-care strategies, and co-located services.
Directives	
Using unmet need data in developing geographic directives	Planning body uses unmet need data, including estimates, demographic data, and identified barriers to write directives to address geographic barriers to care. Grantee is directed to ensure that each county in the EMA has a funded primary care site and that other core services are available in each county.
Specialized case management	Planning body directs the grantee to support case managers trained specifically to work with dually diagnosed PLWH/A.
New Initiatives	
Creating new service models	The Planning Council calls for support of new service models to address factors that contribute to unmet need, such as mental illness, substance abuse, and unstable housing.
Primary care associated with housing and shelters	The planning body allocates funds for primary care at homeless shelters and outstationing of medical teams in AIDS housing and single-room occupancy (SRO) hotels. This is a response to unmet need data indicating that PLWH/A in these housing situations find it especially

	difficult to access care and adhere to medications.
Links to testing	Grantee identifies initiatives designed to get people into care, focusing heavily on outreach and related efforts to increase testing (including rapid testing) of high-risk populations, communities of color, youth, and the general population, and then get those who test positive into care.
Bringing people back into care	Grantee adopts plans and strategies such as records review and follow up with clients who have fallen out of care – which have proven successful in bringing individuals back into medical/primary care.
System of Care	
Work group review	The EMA establishes a work group that reviews the current system of care and agrees on an updated graphic describing it. The work group identifies factors limiting access to care and recommends changes to make it easier to enter care and to obtain the needed mix of services.
Assessment of the system of care from the perspective of specific populations	Grantee, providers, and consumers together prepare a graphic describing the system of care, then review the system of care, with a focus on identifying service gaps and barriers affecting specific populations. Small groups take the perspective of types of PLWH/A who are especially likely to be out of care (e.g., an African American woman with two small children who lives on one of the outlying counties, a young Latino MSM whose family does not know his sexual orientation or HIV status), and identify service gaps and barriers within the system of care from this perspective. The discussion leads to identification of needed refinements in the system of care.