PRIORITY SETTING AND RESOURCE ALLOCATION: TRAINING MANUAL

FY 2019

GREATER BALTIMORE HIV HEALTH SERVICES PLANNING COUNCIL

BALTIMORE CITY HEALTH DEPARTMENT

Produced by BCHD's Office of Policy and Community Engagement, PC Office
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1. INTRODUCTION.

The Greater Baltimore HIV Health Services Planning Council (planning council) is a 40-member body federally mandated by the Ryan White Act to plan for HIV-related service needs of people living with HIV/AIDS (PLWH/As) in the Baltimore eligible metropolitan area (EMA). The mayor of Baltimore City appoints each member. In accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), Part A, and Minority AIDS Initiative (MAI), the planning council identifies the service needs of PLWH/As residing in the Baltimore EMA and sets funding priorities federal HIV/AIDS-related services in Baltimore City and surrounding counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's.

The mission of the planning council is to ensure comprehensive, high-quality services to PLWH/As in the greater Baltimore EMA, regardless of their ability to pay. The EMA consists of Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's.

The planning council plans for and ensures access to culturally sensitive, high-quality, cost-effective services in collaboration with local authorities, service providers and consumers of HIV prevention and care services. This system includes a plan to expand capacity, as well as monitor and evaluate services. The planning council and its advisors strive to act in a timely and unbiased manner when setting priorities for the allocation of resources.

As of June 1, 2017, the Office of Policy and Community Engagement (OPCE) within the Baltimore City Health Department (BCHD) is pleased to provide technical and administrative support to the planning council and its activities. This manual has been created as a supplement to the in-person orientation training provided by OPCE for members of the planning council. **The training and the manual are specifically developed to familiarize members with setting service priorities and allocating funds to services in the Baltimore EMA.**

All decisions made by the council must be based on the documented needs of the community infected and affected with HIV/AIDS. Note that many abbreviations and complex terms appear in this manual. A full explanation of each may be found in the glossary. The Comprehensive Planning Committee of the Planning Council took the recommendations of council members and developed a training curriculum to help fellow members plan for priority setting. Each year, the committee reviews recommendations from members as part of its improvement process. This manual reflects the efforts of the Comprehensive Planning Committee and the input of members of the full council.

We hope you find it useful.

— OPCE-PC Support Team
June 2018

2. THE RYAN WHITE PROGRAM.

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

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

3. SETTING PRIORITIES AND ALLOCATING FUNDS.

Priority setting and resource allocation (PSRA) is actually a two-step process. The planning council (a) prioritizes services based on documented need and data and (b) holds the resource-allocation conference at which the planning council votes to allocate resources among prioritized services for the following fiscal year. In other words, in spring/summer 2018 we are planning for fiscal year (FY) 2019 (covering March 2019 up to February 2020).

The planning council prioritizes service categories using the most up-to-date information available regarding epidemiological trends, the EMA's unmet need, service utilization and more. This process is completed using an on-line voting system prior to the allocation of resources to service categories.

This June, the council will be using two contingency plans for allocating funds. These two contingencies are (a) level-funding or up to a 2% decrease in funding without a 75/25 waiver and (b) level-funding or up to a 2% decrease in funding of 2% with a 75/25 waiver. The dollar figures are hypothetical, but the dollar allocations applied to the percentages from the actual grant are binding, regardless of the eventual actual size of the increase or decrease.

4. GUIDELINES FOR MAKING DECISIONS.

4.1. HRSA Guidelines.

HRSA makes various suggestions for guiding planners through the process of making decisions about Part A and MAI funds. HRSA's "Possible Principles to Guide Decision Making" (HRSA 2013:203) are these:

- Decisions must be based on documented needs.
- Services must be responsive to the epidemiology of HIV in the service area.

- Priorities should contribute to strengthening the agreed-upon continuum of care.
- Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
- Services must be culturally appropriate.
- Services should focus on the needs of low-income, underserved and disproportionately impacted populations.
- Equitable access to services should be provided across geographic areas and subpopulations.
- Services should meet HHS Treatment Guidelines and other standards of care and be of demonstrated quality and effectiveness.

4.2. Data Presentations.

The council's Comprehensive Planning Committee (CPC) is charged with recommending to the planning council the most critical data sources needed to prepare for PSRA. This committee takes the lead on inviting stakeholders to present data and information to the planning council in advance of the PSRA conference. These presenters provide data on a wide range of subjects including, but not limited to: epidemiology of the Baltimore EMA; trends in the epidemic; HIV prevention; various service categories; and other funding streams such as Ryan White parts B, C and D, and Medicaid. Data also will be provided during the PSRA training to help members in the decision-making process.

Each planning council member who plans to take part in PSRA must attend or view the data presentations. These presentations will outline the most recent data collected within the Baltimore EMA. Each member is also required to attend the training or read this training manual in advance.

5. GROUND RULES AND WHAT TO EXPECT.

It is important that all priority-setting participants abide by the same rules, understand those rules, and observe standards of professional behavior. This will make the priority-setting event more manageable and productive.

5.1. Ground Rules.

In accordance with the planning council's "code of conduct" for regular meetings (GBHHSPC 2015), each participant in the conference is asked to adhere to the following ground rules throughout the priority-setting and allocation proceedings.

- Every member will treat every other member with the courtesy and respect resulting from his or her legitimate right to be part of discussions and decision making. This means that all members/participants in meetings will have the opportunity to speak and be listened to without interruptions.
- There will be no personal attacks on anyone; disagreements will focus on issues, not upon individuals.

- Once decisions are made by majority vote, every member of the group will support the decision, regardless of his or her personal position.
- Information presented in confidence will be held in confidence and not discussed outside the meeting.
- Members will behave in a professional manner that reflects recognition of their responsibility to present and consider the concerns of specific communities, or population groups, while considering the overall needs of people living with HIV disease, and act on their behalf, not to benefit themselves. Members will refrain from behavior that is disruptive, distracting or threatening with regard to any planning council related business, whether such behavior is directed toward, among others: the planning council, its committees or its members (including committee members); any Ryan White service providers; or the planning council support office or its employees or contractors. With regards to complaints and grievances, members are prohibited from filing same complaint or grievance more than once.
- All members will speak positively about the planning body in public; problems will be addressed within the group, not with outsiders.
- Any member who feels he or she cannot support the mission, goals, strategies, programs, and/or leadership of the planning council as agreed upon by the members should resign from the planning body.
- Every member will take responsibility not only for abiding by these rules of conduct personally, but also for speaking out to assure that all members abide by them.
- No member may speak on behalf of or represent a position of the council without the express permission of the chair or the full council.
- At all times, members shall be aware of and adhere to all local, state and federal laws and regulations. Acts which may cause embarrassment to the council or create the appearance of impropriety, including but not limited to, being noticeably under the influence of intoxicants at planning council-related meetings or events, failure to disclose all conflicts of interest, allegations of violation of said laws and regulations, dishonesty, conduct involving moral turpitude, conviction of a felony, infamous crime, or any federal crime which is punishable in a federal penitentiary, whether or not ultimately proven to be true, all shall be causes for immediate discipline, up to and including dismissal from the council, at the recommendation of the chairperson with the approval of the Executive Committee.
- Every member shall abide by this code of conduct and the conflict-of-interest provisions set forth in the bylaws.

If all participants abide by these simple rules of common courtesy, the meeting will proceed more quickly and more smoothly.

5.2. What to Expect.

The PSRA proceedings are coordinated by a professional facilitator. The facilitator has been oriented on the priority-setting ground rules of the Baltimore planning council and is familiar with the parliamentary and customary procedures the council uses. The planning council support

staff will provide you with the essential materials needed for all activities. All members will be given a PSRA resource book of information and recommendations provided by the Ryan White Part A Office to help you make decisions about the distribution of Ryan White Part A funds.

It is important to note that a great deal of information will be distributed and presented within a short period of time. Since a tremendous amount of information needs to be considered in order for members to prioritize services and allocate funds, it is the obligation of each member to familiarize himself or herself with how to read the data being presented and to use the information to make informed decisions.

The first component of PSRA involves prioritizing the services that are eligible for funding and are needed by HIV-positive individuals in the Baltimore EMA.

The second and most time-intensive component of PSRA involves the allocation of funds to the services identified and prioritized by the PC. In other words, once participants have decided the hierarchy of importance among services, they must allocate funds to these services accordingly.

5.3 Conflict-of-interest Policy.

All planning council members must complete a disclosure and conflict-of-interest form prior to the priority setting and resource allocation event. On this form, you are asked to identify your employment status with current Ryan White providers, as well as any financial interests that you, or an immediate family member, may have. These financial interests include any stipends, honoraria, gifts, wages, salaries, or other payments. The planning council identifies conflict when a member has financial interests in excess of $1,000 with any given provider; if you have a conflict, thus defined, you will not be able to vote on categories pertinent to that provider. Even if your financial interests do not reach the $1,000.01 threshold, you must still disclose amounts lower than this; amounts up to $1,000 will not bar you from voting.

Please be aware of all contractual obligations your organization may have related to Ryan White funding and report them on the disclosure and conflict-of-interest form. Some organizations may receive Ryan White funding through a subcontract that may not be reported to the planning council. Failure to report all conflicts and potential conflicts puts the planning council at risk for grievance, and you will be recommended to the Executive Committee for removal.

If you are conflicted under the conflict-of-interest policy, or believe you may be conflicted, you must abstain from all voting on service categories in which your organization receives funding. During discussion of a service that you are conflicted for, you must announce that you are conflicted prior to making your statement. All conflicts regarding a service category will be read prior to each vote.

6. SETTING PRIORITIES.

The Ryan White program's legislation requires the council to establish the best process for setting priorities and to decide on other factors that the grantee should consider in disbursing funds. (The Baltimore City Health Department serves as the grantee for the Baltimore EMA.) These priorities, and decisions about how best to meet them, must be based on: (a) documented need, (b) cost and outcome effectiveness, (c) priorities of the HIV-infected communities for whom the services are intended, and (d) the availability of other governmental and non-governmental resources.

The purpose of the exercise is to require participants to consider which services are more important than others. While each service is important to someone, council members must think in terms of which serve the greatest good for the greatest number of people. There is only a finite amount of Part A and MAI money to go around, so it is important to make sure that the most important services get an adequate share.

The following is the process by which the council sets priorities and votes, based on the documented needs of people living with HIV and AIDS.

6.1. Voting on Service Categories.

The first step is to determine which services are most important. This is done by assigning numerical values, or scores, to each service category. There are about two-dozen possible service categories allowed by HRSA. These services are divided into two types of services: (a) core medical services and (b) support services. Within each of these two categories, the service category with the highest aggregate score is the service category with the highest priority; it will be discussed first during the resource-allocation exercises. The service category with the next-to-highest score is deemed the second most important service priority; it will therefore be discussed second, and so forth.

6.1.1. Service Categories Defined: A list with the HRSA service definitions of each service category is provided in each member's PSRA book. Planning council staff and/or the facilitator will address questions regarding descriptions.

6.1.2. Voting Process: Services are ranked using an on-line survey following the members' review of data presentations. For those without access to the on-line survey, a hard-copy format of the on-line survey can be provided.

After a planning council member receives supporting data, he or she is eligible to rank, based on that data, the top five core-medical and top five support services he or she feels are needed to meet the needs of the PLWH/As in the Baltimore EMA.

The survey is divided into two sections: (a) Ryan White-eligible core medical services and (b) Ryan White-eligible support services. Each service category you vote for is assigned a score from one through five. The first service category you vote for will be given a score of five, followed by a score of four for the second service category you rank, three for the next and so

on. This pattern will continue until you have completed the ranking of five core medical services and five support services.

A member may not vote for the same category more than once. For example, once you have voted for outpatient ambulatory health care/primary medical care, you may not vote for it again. Any additional votes for it will be disregarded. You may, however, change your vote before completing the ranking process.

On the bottom of each page, the planning council member must cite a data source or rationale for making his or her selection. You may choose as many data sources that apply and may repeat this rationale for as many selections as necessary. You must select at least one data source to support your vote.

In making his or her decision, a member should rely on the data presented to the planning council in preparation for priority setting — epidemiological profiles, medical updates, consumer-survey information, focus-group or forum results (if available), and any other information distributed by planning council support office staff. So, if the data show that primary medical care is the most important core medical service, in your view, and your opinion is based on the epidemiological profile presentation, check the "primary medical care" box on the first page of the form (five points), and on the bottom of the page, check "epidemiological profile" as your data source.

6.2. Establishing Rankings.

6.2.1. Vote Scoring: A majority of eligible voters — those council members who have viewed the data presentations and participated in priority-setting training — must vote within the scheduled timeframe allotted for the ranking process. Once this process has concluded, the planning council staff will aggregate scores.

6.2.2. Ranking: Any category that receives at least one vote is ranked and placed on the list of categories to be considered for funding. Generally, service categories not voted for in the survey will receive no points and cannot be considered for funding. The category with the highest total number of points is ranked number one; the category with the second-highest score is ranked two; and so forth.

Below is an example of page one of the electronic voting cards used in the ranking exercise. It is for your review only. In the case of this sample vote, the council member has voted for substance-abuse treatment/outpatient as his or her first priority, thereby giving it five (5) points. The member's justification for this vote is: committee recommendations, epidemiological profile, CQM reports,[1] and funding-stream information.

[1] I.e., the Baltimore City Health Department Clinical Quality Management program, formerly called the Quality Improvement Program.

FY 2009 MAI Priority Setting Polling (EMA)

(Front of Card)

Core Medical Voting Card #1 (5 points)

Please select the core medical service that you believe should have the highest priority in the Baltimore EMA based upon available data.

(Only one selection can be made.)

- ○ AIDS Drug Assistance Program (ADAP)
- ○ AIDS Pharmaceutical Assistance
- ○ Early Intervention Services (EIS)
- ○ Health Insurance Premiums & Cost-sharing Assistance
- ○ Home and Community-based Health Services
- ○ Home Health Care
- ○ Hospice Services
- ○ Medical Case Management
- ○ Medical Nutritional Therapy
- ○ Mental Health Services
- ○ Oral Health Care
- ○ Outpatient/Ambulatory Health Services (OAHS)
- ◉ Substance Abuse Services — Outpatient

Comments:

(Back of Card)

From which data source/s are you basing your ranking for core medical voting card #1 (5 points)? Please select all of the following that apply. If you select "other", please specify the data source in the box provided.

- ☐ Adherence Strategies
- ☐ Client Services Continuum
- ☑ Committee Recommendations
- ☐ Early Intervention Strategies
- ☐ Other (please specify)
- ☑ Epidemiological Profile
- ☐ Medical Trends & Outcomes
- ☐ Needs Assessment Information
- ☑ QIP Report
- ☑ Ryan White/Other Funding Streams
- ☐ Unduplicated Client Data

Electronic Voting Cards

Please make your selection for core medical voting card #2. After you make your selection, click "next" to go to the next voting card until you are finished.

Only one selection can be made for each voting card. Answers can be changed by clicking on the check mark indicating your selection. Space for additional comments is provided if needed.

If you have any questions or concerns regarding the electronic voting process, please feel free to contact the planning council support office at (410) 662-7253 x121.

7. ALLOCATING FUNDS.

The prioritizing described in section 6 is not an abstract exercise: real money rests on your decisions. This section describes the next step in the PSRA process: allocating dollars to the prioritized service categories. As stated in section 3, the planning council will consider two contingencies. If the figures have been received from HRSA with preparation time to spare, the current fiscal year's revised initial funding levels are used as the starting point for the allocation exercises for both the decrease and 75/25 waiver contingencies; if these figures have not been received from HRSA, the previous year's figures are used. The planning council will be under the guidance of a facilitator who will use Robert's Rules of Order as a guide to conduct the meeting (Zimmerman 2005). This year, the current year's award is known and so these FY 2017 figures will be used as the allocation starting point.

7.1. Process for Allocation Based on Level or Decreased Funds of up to 2% without a waiver.

The process for considering a funding decrease involves two components: (a) the ranking activity described in section 6 and (b) an actual funding allocation exercise.

7.1.1. Allocations Activity: Each service category will be discussed in order of priority. Recommendations for decreases and increases by category will take the form of a dollar amount (not a percentage). The council will recommend based on a level-funding scenario. Under normal circumstances, at least 75 percent of the dollars must be allocated to medical, not support, services. The council is reminded that this allocation will be used even if there is a decrease in funding of up to 2%.

7.1.2. Guidelines: Be sure to follow these simple guidelines when planning for a funding decrease:

- Before making a reduction in funding, consider: (a) relevant needs assessments; (b) epidemiological profiles; (c) past expenditure and utilization data as made available by the planning council support office; (d) the current expenditure and service delivery (ESD) report and the recommendations in the ESD narrative; and (e) other available funding streams.
- All funding reductions must be supported by a justification derived from the available data. No category should be arbitrarily reduced in funding for no apparent reason or merely because the goal of the activity is to reduce overall expenditures by 5 percent.
- You must keep in mind that the planning council has determined that an overall reduction should not be made simply by applying a percentage reduction spread evenly across all categories. The council believes that responsible planning mandates that each category must be reviewed individually.

7.2. Process for Allocation Based on Decreased Funds of up to 2% with a waiver from the core medical services requirement.

The following process will be used for a more drastic decrease in funding scenario.

7.2.1. Allocations Activity: Each service category will be discussed in order of priority. Recommendations for decreases will take the form of a dollar amount (not a percentage). The council will continue to recommend decreases until an overall 2% percent reduction is reached regardless of whether or not 75% of the funds are allocated to core medical services.

7.2.2. Guidelines: Be sure to follow these simple guidelines when planning for a funding decrease:

- Before making a reduction in funding, consider: (a) relevant needs assessments; (b) epidemiological profiles; (c) past expenditure and utilization data as made available by the planning council support office; (d) the current expenditure and service delivery (ESD) report and the recommendations in the ESD narrative; and (e) other available funding streams.
- All funding reductions must be supported by a justification derived from the available data. No category should be arbitrarily reduced in funding for no apparent reason or merely because the goal of the activity is to reduce overall expenditures by 5 percent.
- You must keep in mind that the planning council has determined that an overall reduction should not be made simply by applying a percentage reduction spread evenly across all categories. The council believes that responsible planning mandates that each category must be reviewed individually.

7.3. Core Medical Services Provision.

According to legislation, all planning councils receiving Ryan White Part A funding must abide by the 75-percent core medical rule. In brief, 75 percent of direct service funding must be allocated to core medical services (as defined by HRSA) at the PSRA event and spent by the providers receiving funding for those core medical services. A waiver of the 75 percent requirement may be available only if Maryland's AIDS Drug Assistance Program (MADAP) has no waiting list and core medical services are available to all individuals with HIV/AIDS identified and eligible under the Part A program.

In addition to Part A funding, the Baltimore EMA also receives MAI funding which must be prioritized and allocated in the same way as the Part A grant. The Ryan White legislation of 2009 aligned the MAI fiscal cycle with the Part A fiscal cycle (March through February). All allocations to and expenditures by MAI are aggregated with all Part A funding allocations and expenditures to determine a total allocation and expenditure for the Baltimore EMA. No less than 75 percent of the direct services of this total should be allocated to core medical services. In other words, Part A by itself must adhere to the 75 percent rule. Part A and MAI combined must also adhere to it. However, MAI by itself need not. This means that MAI can be a little under 75 percent if, in compensation, Part A is a little over. This year, the Baltimore EMA will plan for scenarios without a core medical services waiver and with a core medical services waiver.

7.4. Allocations as Percentages.

The planning council will make recommendations based on actual dollar amounts. However, when all funding decisions are finalized, these dollar figures will be converted into percentages of the total award. For example, if in the PSRA exercises a service category is allocated $10 of a total award of $100, the service category will, in fact, be receiving 10 percent of the award. Since we do not actually know whether the final award total will actually be $100 at the time of the priority-setting event, we use percentages. When the final award amount is released, each percentage is converted into an actual dollar amount and disseminated appropriately by the grantee. So if, in fact, six months later the award turned out to be $110 (not the predicted $100), the service category in question would receive 10 percent of that $110, or $11 (not the $10 allocated by the council).

7.5. Tracking Funding Decisions.

In an effort to assist the planning council during its resource allocation process, the support office develops a spreadsheet to track funding recommendations voted on by the council. This spreadsheet is projected onto a screen during the PSRA event and captures the funding decisions as they are made to ensure compliance with federal mandates and allocation of all funds to prioritized service categories.

7.6. Making a Motion for an Increase or Decrease.

The process for increasing or decreasing a service category is as follows:

- Announcement of service category.
- Recommendations for funding allocations are made (by adding to or subtracting from the current fiscal year's allocation).
- Clarification of recommendation or request for additional data is provided as requested (about five minutes).
- A motion is made.
- Discussion on the motion occurs (generally, three pros for the motion and three cons against the motion are allowed).
- Vote is taken on the motion.

First, the facilitator will announce a category (in the order in which the service categories have been ranked and prioritized). Second, a recommendation for funding is made, followed by requests for clarification or additional data. Five minutes are allotted for questions and clarifications on each recommendation.

Once the questions have been addressed, the facilitator will entertain a motion in order to proceed.

The facilitator will wait for someone to second the motion. If the motion receives a second, the facilitator will allow the person who made the motion to speak on behalf of the motion. If the motion does not receive a second, the facilitator will open the floor to entertain another motion from the body.

Once the motion receives a second, the person who made the motion will speak on behalf of the motion. Usually, the facilitator will then allow three people (in addition to the person who made the motion) to speak in favor of the motion (pro) and three people to speak against the motion (con). Once recognized by the facilitator, a planning council member should state whether he or she (a) is in conflict with the service category being discussed and (b) is speaking for (pro) or against (con) the motion. If your comment has already been made by another person, please allow someone else to speak in your place. You should be as succinct as possible as time is limited.

The planning council has traditionally allowed a "friendly amendment" to be made to an original motion to change, enhance, or strengthen the motion, but not to change its basic original intent. To do this, a voting member may ask the person who originally made the motion to consider an amendment. The person may accept or decline the amendment.

Regular or "unfriendly" amendments, per Roberts' Rules of Order, may be proposed before passage of the original motion, but such amendments must be (a) word-specific, (b) moved and seconded, and (c) receive a majority vote. Once the amendment has been accepted by the majority, the earlier — but now amended — motion must still be voted on. (This regular amending process is obviously more time consuming than the customary friendly-amendment process, which is why the latter has traditionally been considered permissible by the council.)

Once discussion has been completed, the facilitator will move to vote on the motion. This will be accomplished by means of a roll-call vote.

For roll call voting, each person will be assigned a voting number at the beginning of the PSRA event. During the roll-call vote, say your assigned place number loudly and clearly and say "yes," "no," or "abstain" to the motion on the floor.

For some pro forma matters, the council may permit a voice vote. During a voice vote, all the "no" voters shout in unison and then all the "yes" voters. The moderator decides which group was louder and that group wins the vote.

Please be aware that many people will be in conflict for certain service categories. These service categories will be listed on the nameplate in front of your seat. If you are in conflict, you must abstain from all voting for that service category. The planning council support office will record all motions, discussion points, votes and final funding decisions throughout the PSRA process.

8. DATA AVAILABLE FOR PLANNING.

The following is a description of the types of data that are presented to the council.

8.1. Services Allocation Recommendations Book.

The Ryan White Part A office compiles a book of allocation recommendations to guide the priority setting conference. The document includes (a) a summary the recently ended fiscal year's allocations and expenditures, (b) recommendations for initial allocations of the planning

council ranked categories and rationale, (c) a brief summary of the service category's expenditure rate and clients served. The fiscal recommendations book will be presented at the priority setting conference.

8.2. Expenditure and Service Delivery Report and Narrative.

The expenditure and service delivery report is provided at regular intervals by the grantee. This report provides a summary of expenditure and client utilization by service category and includes total allocation amount, expenditure, budgeted and actual numbers of clients, and numbers of units expended. The narrative that comes with the ESD report may address any anomalies of 5 percent or greater in expenditure and program-performance measures.

8.3. Needs Assessment.

The council periodically undertakes two sorts of needs-assessment activity: (a) periodic, large-scale surveys and (b) special projects, such as focus groups, community forums, research reports, and/or small-scale surveys on topics of special interest. The most recently completed needs-assessment survey was administered in 2013; it captured the views of 374 respondents in the Baltimore EMA. Community forums have also recently been held in 2016 to collect information on enhancing the continuum of care in the EMA. The comprehensive planning committee and the planning council are currently working on this year's needs assessment. The results of this year's needs assessments will be presented at the June 2018 planning council meeting.

8.4. Unduplicated Client Data.

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

8.5. Clinical Quality Management.

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

8.6. Epidemiological Profile.

Every year, the Prevention and Health Promotion Administration (PHPA), a division of the state's Department of Health and Mental Hygiene, provides a document that summarizes rates of

9. GLOSSARY.

This manual contains numerous abbreviations, acronyms and medical terms. These are explained in this glossary. Not all of the terms appearing in the glossary appear in the manual, but you can expect to encounter many of these terms during the priority-setting conference. TWG has therefore included them in this list for your convenience. If you see "q.v." after a term (*quod vide*, Latin for "which see"), this means that the term is explained elsewhere in the glossary.

AA: See "administrative agent or agency."

ABC: See "Associated Black Charities."

Abstention or Abstaining: Processes during voting where a person does not vote for or against an issue, usually because of a conflict of interest (q.v.).

Acquired Immune Deficiency Syndrome: AIDS is the severe, late stage of human immunodeficiency virus (q.v.) infection. Without treatment, individuals with AIDS die but, with treatment, the degree of infection (the viral load) can be reduced and the immune system may improve and, with it, the patient's general health.

ACTG: See "AIDS clinical trials group."

Administrative Agent or Agency: Before March 2008, the grantee (q.v.) for the Baltimore EMA (q.v.) contracted with a private party to disburse Part A grant funds to community-based organizations (q.v.), hospitals, health departments, AIDS service organizations (q.v.) and other organizations or agencies. The AA identified agencies and organizations to receive grant funds through a process called a "request for proposals" (q.v.), after which contracts for service provision were awarded to successful proposal submitters. The AA was responsible for monitoring each contract it awarded and for making reports through BCHD (q.v.) to HRSA (q.v.) and to the planning council (q.v.). All functions except for fiscal responsibility have now been restored to the grantee.

AETC: See "AIDS education and training center."

AIDS: See "acquired immune deficiency syndrome."

AIDS Clinical Trials Group: Clinical trials are part of the process for testing new drugs before they are given approval for use by the public. The U.S. Food and Drug Administration (q.v.) reviews all the research studies and clinical trials information before approving a new drug for general use. Both the University of Maryland Medical System and the Johns Hopkins Medical Institutions carry out clinical trials for new drugs.

AIDS Drug Assistance Program: This program was created as part of the Ryan White program (q.v.) and is administered under Part B (q.v.). ADAP provides medications to low-income people living with HIV/AIDS that are uninsured or underinsured and lack coverage for medications. In the Baltimore area, these funds are administered by PHPA (q.v.).

AIDS Education and Training Center: The AETC program was created as part of the Ryan White program (q.v.) and is administered under Part F (q.v.) of the act. The AETC program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health-care providers.

AIDS Service Organization: An AIDS service organization is a provider of direct services to people living with HIV or AIDS.

Allocation: The allocation is that portion — expressed either as an amount (dollars) or a proportion (percentage) — of the overall EMA (q.v.) funding award going to a particular service category (q.v.). The term "allocation" can also refer to a process by which a planning council divides up a grant award among service categories, also known as "resource allocation" (q.v.).

Antiretroviral: This is an adjective describing certain substances used to kill or inhibit the multiplication of retroviruses, such as HIV. There are a number of antiretroviral drug groups: (a) highly active antiretroviral therapy (q.v.), (b) nucleoside analog (q.v.), (c) non-nucleoside reverse transcriptase inhibitors (q.v.), and (d) protease inhibitors (q.v.).

Application: This is the written document developed each year and sent by the EMA to HRSA (q.v.) for the purpose of requesting funds under Part A of the Ryan White program (q.v.). The fiscal agent (q.v.), the grantee (q.v.) and the planning council (q.v.) and its support office (q.v.) all write portions of the application.

ASO: See "AIDS service organization."

Associated Black Charities: ABC is the entity currently contracted by the grantee (q.v.) to serve as the fiscal agent (q.v.). Before March 2008, ABC served as the administrative agent for the Baltimore EMA (q.v.).

Asymptomatic: This term means "without symptoms." A person who tests positive for HIV but who does not show or experience the signs of the disease is called asymptomatic (cf. "symptomatic").

Baltimore City Health Department: This is the entity that, acting on behalf of the CEO (q.v.), oversees the Ryan White HIV/AIDS Treatment Extension Act of 2009 (q.v.) for the Part A and MAI grant funds for the Baltimore EMA (q.v.). Part A (q.v.) and MAI (q.v.) direct-service grants are contracted through a fiscal agent (q.v.).

BCHD: See "Baltimore City Health Department."

CAB: See "consumer advisory board."

Carry-over: The term "carry-over" refers to funds unspent at the end of one fiscal year that, with permission of the federal oversight agency, HRSA (q.v.), can be "carried over" for use in

the next fiscal year. The current amount of funding allowed to be "carried-over" stands at 5 percent.

Caveat: Something that is said as a qualification, warning or clarification.

CBO: See "community-based organization."

CDC: See "Centers for Disease Control and Prevention."

Centers for Disease Control and Prevention: The Centers for Disease Control and Prevention collectively is an agency of the U.S. Department of Health and Human Services. The CDC's mission is to promote health and quality of life by preventing and controlling disease, injury and disability. The CDC is the federal agency responsible for tracking diseases that endanger public health, such as HIV (q.v.).

CEO: See "Chief Elected Official."

Chief Elected Official: In any EMA (q.v.), HRSA (q.v.) designates as the "chief elected official" the popularly elected executive of the component part of the EMA with the highest proportional HIV/AIDS rate. As a practical matter, this generally means that the CEO is the mayor of the city at the center of the EMA in question. To the CEO falls the responsibility of appointing members of the planning council (q.v.) and selecting an agency to serve as grantee (q.v.), usually that city's health department.

Clinical Quality Management: This program, coordinated by the Baltimore City Health Department, involves activities aimed at determining whether, or how well, service providers have met minimum standards. Program staff visit provider locations and review samples of client charts to determine compliance with standards of care. (Formerly known as the Quality Improvement Program [q.v.].)

Cocktail: See "highly active antiretroviral therapy."

COI: See "conflict of interest."

Community-based Organization: There is no precise definition for a CBO, but this sort of entity is usually considered to be a locally based, non-profit organization, generally serving clientele drawn from a finite and relatively small geographical area.

Community Forum: A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group (q.v.), it usually includes a larger number of people; participants are often self-selected (i.e., not randomly selected).

Co-morbidity: A co-morbidity is a medical condition suffered simultaneously with having a primary medical condition. For example, a person is co-morbid when he or she has HIV and

mental illness or HIV and a substance addiction. Homelessness is also considered a co-morbid condition when the homeless person is HIV positive.

Conflict of Interest: In this context, a COI is a circumstance where a council member or committee member is an employee, a relative of an employee, a board member (excluding consumer advisory boards), or a consultant to, or a person otherwise receiving renumeration from, a Ryan White Part A provider. When a person is in conflict (q.v.), he or she should state the conflict before engaging in any discussion and he or she must abstain (q.v.) from voting on any matter concerning allocations of funds to the provider or the service category in question.

Consumer Advisory Board: A CAB is an advisory group of consumers associated with a service provider from whom they, the consumers, receive services. The group offers advice to the provider about the services delivered and the ways that the delivery impacts consumers. Providers are not required to implement a CAB's suggestions.

Continuum of Care: A set of services and linking mechanisms that responds to an individual's or family's changing needs for HIV prevention and care. A continuum of care is the complete system of providers and available resources (Ryan White-funded and others) for people at risk for or living with HIV and their families within a particular geographic service area, from primary care to supportive services.

CQM: See "Clinical Quality Management program."

Cross Resistance: See "resistance."

Directive: A statement of general instruction, order or direction. Issued by a planning council, a directive is a statement that, when carried out, is intended to improve the way services are delivered or a statement that identifies a special population or area to be served.

Directly Observed Therapy: This is a way of giving medications with a view to increasing adherence. DOT has long been used to control and reduce the spread of tuberculosis, but has only recently been adopted for HIV treatment.

DOT: See "directly observed therapy."

Efficacy: Term used to describe how well a treatment or process or program produces the desired result. When the desired result is produced, the treatment is said to be efficacious.

Eligible Metropolitan Area: A designation used by the Ryan White program (q.v.) to identify an area eligible for funds under Part A (q.v.) of the act, which provides monies for aid to metropolitan areas hardest hit by HIV (q.v.). EMAs are metropolitan areas with at least 2,000 new cases of AIDS reported in the past five years and at least 3,000 cumulative living cases of AIDS as of the most recent calendar year. There are 22 EMAs. The Baltimore EMA consists of the following jurisdictions: Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties.

ELISA: See “enzyme-linked immunosorbent assay.”

EMA: See “eligible metropolitan area.”

Enzyme-linked Immunosorbent Assay: This is the most common test used to detect the presence of HIV antibodies in the blood. A positive ELISA test may be confirmed by another test called a Western Blot (q.v.).

Epidemic: The spread of an infectious disease through a population or geographic area.

Epidemiological Data: Epidemiological data comprise statistical information that describes an epidemic (q.v.); information that is gathered regularly and in a planned way. The U.S. Centers for Disease Control and Prevention (q.v.) collect data on all infectious and contagious diseases in the United States.

Epidemiological Profile: A description of the current status, distribution and impact of an infectious disease or other health-related condition in a specific geographic area.

Epidemiologist: A professional who studies the factors associated with health and disease and their distribution in the population.

Epidemiology: The study of factors associated with health and disease and their distribution in the population.

FDA: See “Food and Drug Administration.”

Fiscal Agent: The agency subcontracted by the grantee to be responsible for executing Part A (q.v.) and MAI (q.v.) direct-service contracts and for managing the fiscal responsibilities as assigned by the grantee for vendors to provide HIV/AIDS-related health services and support services to PLWH/As. Associated Black Charities (q.v.), formerly the AA (q.v.), is now the fiscal agent.

Focus Group: A method of information collection involving a carefully planned discussion among a small group led by a trained moderator. A focus group is usually smaller and more structured than a community forum (q.v.).

Food and Drug Administration: The U.S. Food and Drug Administration is a federal agency that, among other things, approves the sale or distribution of new drugs for use by the public.

GART: See “genotypic antiretroviral resistance assay.”

Genotypic Antiretroviral Resistance Assay: See “genotypic assay.”

Genotypic Assay: This is a test that determines if HIV has become resistant to the antiretroviral drug(s) the patient is currently taking. The test analyzes a sample of the virus associated with resistance to specific drugs. Also known as genotypic antiretroviral resistance assay.

Grant: A grant is an amount of money given to a city, state, agency or organization to perform certain services. The Ryan White program, Part A grant is an award made to the Baltimore eligible metropolitan area (q.v.) to provide HIV services for eligible HIV-affected individuals.

Grantee: The recipient of federal funds. In the context of the Ryan White program, the term generally refers to the initial recipients of funds under Parts A and B. In the Baltimore EMA, the Part A grantee is the Baltimore City Health Department, acting for the CEO (q.v.); in Maryland, the Part B grantee is the Prevention and Health Promotion Administration (q.v.).

HAART: See "highly active antiretroviral therapy."

Health Resources and Services Administration: The Health Resources and Services Administration is a division of the U.S. Department of Health and Human Services. Known as HRSA, it directs national health programs that improve the nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through state programs, and train a healthy work force that is both diverse and motivated to work in underserved communities. HRSA administers the Ryan White program.

Highly Active Antiretroviral Therapy: This is a combination of drugs used to control the HIV virus.

HIV: See "human immunodeficiency virus."

HRSA: See "Health Resources and Services Administration."

Human Immunodeficiency Virus: This is an infection that attacks the immune, or disease-fighting, system in the human body. Without treatment, the amount of virus in the body (viral load) increases to the point where the individual no longer has any immune system to fight off diseases. Then what are known as opportunistic infections develop. When the level of healthy immune cells falls below 200 cells per cubic millimeter of blood, the HIV infection is said to have progressed to AIDS. HIV virus can be controlled but not cured and, once infected, the individual remains infected and is able to spread the infection to others for life.

Incidence: The number of new occurrences (e.g., of diagnosed HIV cases) over a given period of time. Incidence is often expressed as an annual measure (the number of new cases occurring during a year). Incidence should not be confused with prevalence (q.v.), a measure of all existing living occurrences (e.g., of diagnosed HIV cases) at a given point in time.

Independent Review Board: An IRB is an objective group of individuals assembled to read and rate proposals and make general recommendations for funding. Members usually have expertise in the service category that they are reviewing.

IRB: See "independent review board."

MADAP: See "Maryland AIDS Drugs Assistance Program."

MAI: See "Minority AIDS Initiative."

Maryland AIDS Drugs Assistance Program: MADAP is a statewide program that offers prescription coverage for HIV drugs to eligible HIV-positive individuals.

Memorandum of Agreement or Memorandum of Understanding: Much the same thing, these are written documents that set out agreements between two entities, organizations or agencies.

Minority AIDS Initiative: In 1998, the Clinton administration and the Congressional Black Caucus announced the creation of the MAI program to target HIV funds at minority populations. MAI funds are disbursed through a competitive application process separate from the Part A application. MAI funds must be allocated and used in accordance with the requirements of the Ryan White program.

MOA or MOU: See "memorandum of agreement or memorandum of understanding."

Motion: A motion is a statement of an issue seeking to commit a planning council or a committee to take a particular action, for or against the issue in question. Motions generally must be proposed and seconded before they can be discussed or voted upon.

National Institutes of Health: The National Institutes of Health collectively is an agency of the U.S. Department of Health and Human Services. NIH carries out and funds health research throughout the United States.

Needs Assessment: A process of collecting information about the needs of people at risk for, or living with, HIV and their families (both those receiving care and those not in care), identifying current resources (Ryan White program and others) available to meet those needs, and determining what gaps in care exist.

NIH: See "National Institutes of Health."

NNRTIS: See "non-nucleoside reverse transcriptase inhibitor."

Nucleoside Analog: This is a type of antiviral drug to treat HIV infection.

Nucs: See "nucleoside analog."

Non-nucleoside Reverse Transcriptase Inhibitor: This is a type of antiviral drug to treat HIV infection.

Non-Nucs: See "non-nucleoside reverse transcriptase inhibitor."

Part A: Ryan White-program funding is given to the nation's eligible metropolitan areas (q.v.) and transitional grant areas (q.v.) hardest hit by the HIV/AIDS epidemic. In the Baltimore area, Part A funding is (a) granted to the mayor of the City of Baltimore, (b) overseen and disbursed by the Baltimore City Health Department as grantee (q.v.), and (c) guided by the Greater Baltimore HIV Health Services Planning Council.

Part B: Ryan White-program funding that is given by formula to states and territories to improve the quality, availability and organization of health care and support services for people living with HIV/AIDS. In Maryland, Part B funding is (a) granted to and administered by the Maryland Department of Health and Mental Hygiene's Prevention and Health Promotion Administration as grantee (q.v.) and (b) guided by the state's five regional planning consortia, which have a role in relation to the Part B award similar to the planning council's role in relation to the Part A award (though the consortia's recommendations are not mandatory, as the council's allocations are).

Part C: Ryan White-program funding that is granted directly to community-based organizations (q.v.) for outpatient early intervention services.

Part D: Ryan White-program funding that is given to public and non-profit entities to coordinate services to, and improve access to research for, children, youth, women and families. Prior to July 1, 2015, the Part D grant was administered by the Prevention and Health Promotion Administration (q.v.). The grant is now administered by the Johns Hopkins University Pediatrics and Adolescent HIV/AIDS Program.

Part F: Part F of the Ryan White program (q.v.) administers several programs: (a) special projects of national significance (SPNS) (q.v.), which support the development of innovative models of HIV care and are designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations; (b) the AETC program (q.v.), a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health-care providers; and (c) the HIV/AIDS dental reimbursement program, which assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral-health treatment to patients with HIV.

Phenotypic Assay: This is a procedure whereby sample DNA (deoxyribonucleic acid) of a patient's HIV is tested against various antiretroviral drugs to see if the virus is susceptible or resistant to these drugs.

PHPA: See "Prevention and Health Promotion Administration."

PI: See "protease inhibitor."

Planning Council: Planning councils are volunteer planning groups composed of community members and service providers who prioritize services and allocate funds under Part A (q.v.) of the Ryan White program (q.v.). In the Baltimore area, the planning council is known as the Greater Baltimore HIV Health Services Planning Council.

Planning Council Support Office: An entity providing technical, administrative and managerial services to a planning council, the latter not being an incorporated entity in its own right. The planning council support office may be a public or a private sector entity. In the Baltimore EMA (q.v.), the Baltimore City Health Department (q.v.), in its capacity as the grantee (q.v.), has appointed BCHD's Office of Policy and Community Engagement (q.v.), to provide this service.

PLWH/A: People (or person) living with HIV/AIDS; PLWH and PLWA also are used.

Prevalence: The number of occurrences of a given disease or other condition existing in a given population at a designated time. In the case of HIV and AIDS, prevalence measures all existing living cases at any given time. Prevalence should not be confused with incidence (q.v.), which measures only the new cases occurring over a given period of time.

Prevention and Health Promotion Administration: PHPA, formerly the Infectious Disease and Environmental Health Administration, is a division of the Maryland Department of Health and Mental Hygiene. PHPA serves as the Part B grantee.

Priority Setting and Resource Allocation: This is the process used by a planning council for identifying service priorities for the use of Ryan White funds that are consistent with locally identified needs. Priority setting also requires addressing how best to meet each priority and involves the resource allocation (q.v.) of funds to the prioritized service categories (q.v.).

PSRA: See "Priority Setting and Resource Allocation."

Procurement: This is the process of selecting and contracting with service providers, often through a competitive RFP process (q.v.).

Project Officer: The function of the HRSA (q.v.) project officer for the Baltimore EMA is to provide technical support to, and compliance monitoring of, the Part A grantee (q.v.) and the planning council support office (q.v.).

Protease Inhibitor: This is a type of antiviral drug to treat HIV infection.

Public Health Surveillance: This is an ongoing, systematic process of collecting, analyzing and using data on specific health conditions and disease, in order to monitor these health problems. An example is the Centers for Disease Control and Prevention (q.v.) surveillance system for AIDS cases.

QIP: See "quality improvement program."

Quality Assurance: The term "quality assurance" covers a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards when delivering services.

Quality Improvement: The term "quality improvement" covers a broad range of activities aimed at improving service quality, regardless of whether or how well minimum standards have been met.

Quality Improvement Program: This is the former name for what is now known as the Clinical Quality Management program (q.v.), coordinated by the Baltimore City Health Department, a program that involves activities aimed at determining whether, or how well, service providers have met minimum standards. Program staff visit provider locations and review samples of client charts to determine compliance with standards of care.

Reprogramming: This is a process by which money that is not being spent in one service category or program is reallocated and given to another service category or program. Grant funds in excess of the funds planned by a planning council at priority setting (q.v.) go through a similar process referred to as programming out.

Resistance: In the HIV context, resistance is a condition whereby the HIV virus no longer responds to a drug because the body has developed a "protection" against the drug. Cross resistance is when the virus not only does not respond to a drug that it has been receiving, but also becomes unresponsive to other drugs that it has never before encountered. This most often happens when the amount of medication in the system falls below the level needed to control the virus fully. Missed doses, stopping one drug in a mix of drugs (cocktail), or becoming infected with a different strain of HIV virus that is resistant — these are all ways that resistance develops.

Resource Allocation: Resource allocation is the process by which dollars or percentages of funding are allocated to specific priority service categories. This is a legislatively mandated responsibility of Part A (q.v.) planning councils, which must consider factors such as documented need and availability of other resources. Part B (q.v.) consortia often carry out a similar process, but it is not legislatively mandated.

Request for Proposals: As its name suggests, a request for proposals is a request for project proposals (bids) distributed or made available to prospective bidders in an open and competitive process for the selection of providers of services.

RFP: See "request for proposals."

Ryan White Program: On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act; the law was most recently reauthorized as the Ryan White HIV/AIDS Treatment Extension Act of 2009, and activities undertaken under the terms of this legislation are referred to collectively as the Ryan White program. The Ryan White program is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS. The Ryan White program includes the following major programs: Part A, Part B, Part C, Part D and Part F. The Ryan White program is now the largest single source of HIV funding in the nation.

Seroprevalence: This is the number of persons in a population who test positive for HIV based on serology (blood serum) specimens.

Seroprevalence Reports: These are reports that provide information about the percentage of, or rate within, a specific testing group of persons that have tested positive for HIV.

Service Category: Service categories are broad groupings of services qualifying for funding under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (q.v.). Examples include primary medical care, substance-abuse treatment, case management, housing assistance and others.

Special Projects of National Significance: This program is administered by Part F of the Ryan White program (q.v.). It supports the development of innovative models of HIV care and is designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations.

SPNS: See "special projects of national significance."

Supplemental Grant Application: A large component of the annual application (q.v.) is formula driven; that is, the funding is based solely on the severity of the HIV/AIDS epidemic within the EMA in question. However, a certain portion of each award — the supplemental award — is made on a competitive basis, based on demonstrated need and ability to use and manage money. Supplemental award funds are disbursed as part of the annual Part A grant (q.v.).

Surveillance Reports: Reports providing information on the number of reported cases of a disease, such as AIDS, nationally and for specific locations and subpopulations. The Centers for Disease Control and Prevention (q.v.) issue such reports, providing both cumulative cases and new cases reported during a specific reporting period.

Symptomatic: This term means "with symptoms." When there is a sign that can be seen or identified, this indicates that a disease or phase of a disease is present, and the sufferer is described as being symptomatic (cf. "asymptomatic").

TA: See "technical assistance."

Technical Assistance: This is training offered or given for the purpose of building skills for individuals or to provide information that can be used to improve programs.

TGA: See "transitional grant area."

Title I: Now known as "Part A" (q.v.).

Title II: Now known as "Part B" (q.v.).

Title III: Now known as "Part C" (q.v.).

Title IV: Now known as "Part D" (q.v.).

Transitional Grant Area: A designation used by the Ryan White program (q.v.) to identify an area eligible for funds if the area has at least 1,000, but not more than 1,999 cumulative AIDS cases during the most recent five years, and at least 1,500 cumulative living cases of AIDS as of the most recent calendar year. There are 34 TGAs.

Vaccine: A vaccine is a type of medical treatment, usually an injection or series of doses, that renders its recipients immune to certain viruses. There is currently no vaccine against HIV.

Western Blot: This is a test for detecting the specific antibodies to HIV in a person's blood. It commonly is used to double-check HIV-positive ELISA tests (q.v.). The Western Blot test is more reliable than the ELISA, but it is more complex and more expensive.

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