Ryan White Part A Office

Questions

1. On slide 9, the data indicates that 80% of RW clients in Baltimore City live below the Federal Poverty Level. It is not logical or believable, given that dire level of poverty and how widespread it is, that 95% of the RW population lives in "stable housing." Please give us HRSA's definition of "*stable*housing" (not the general definition of "housing" that Anene passed around at the meeting). The implication of this slide is that housing is no longer an issue for RW clients - and/or that the current system and current allocation level of funding for housing is ample. The Council should discuss this topic.

Answer: Stable housing is trending upward by a few percentages since 2010 but I may have overestimated the 2015 housing data. I will provide a revised housing information for 2015. The NHAS aims to reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent by 2020. The percentage of people in our EMA who are currently in unstable housing conditions is about 5 percent; in other words, nearly 95% of our consumers are living either in stable or temporary housing conditions. The ACA was a recent landmark event and I have tried to make some data comparisons before and after ACA without specifically attributing any changes to it. However, many Ryan White medical care consumers have transitioned to other medical coverages through the ACA and that may have resulted in some unobligated money that may have been reprogrammed into wrap around support services such as housing.

Below is HRSA/HAB's definition of Housing Services (also available at the PC's site under 'Standards of Care'):

> *"Housing Services are short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care."*

HRSA/HAB does not fund Stable/Permanent housing and so there is no such a thing as 'definition of stable housing' in their lexicon.

2. You also attributed the recent increase in stable housing to the ACA? Why? Perhaps any increase is due instead to a change in definition of "stable housing?" I am concerned that the data (95%) is inaccurate and that there might not have been such a large increase (15%).

Answer: See response for question #1

3. The data given on slide 12 suggest that the volume of cases, ages 25-34 years, means we need to increase services going forward - given that they will need services for more years than older clients. Correct?

Answer: This information is based on newly diagnosed clients in 2015 reported via the Part A client-level data. Total rate of prevalence in this age group is only about 15 percent currently and in recent prior years. The recent EMA wide State data (which is more comprehensive than Part A data since data is not fragmented by funding sources) shows new diagnoses in the 20 – 29 age group trending upward the most since 2000 and was about 30% by the end of 2014. Cases in the 30 – 39 age groups were also slightly upward since 2012 and were about 25 percent by the end of 2014 (Flynn, 2016). In terms of redirecting resources to respond to perceived 'emerging issues', one has to look at data contextually and consider additional factors surrounding the issue. Triangulating data from different sources will also help to make a more informed decision.

4. The age data on slide 12 do not square with the data on slide 14. Please comment.

Answer: Slide 12 is based on new diagnoses while slide 14 is for total prevalence cases. Age data can be analyzed using different age intervals.

5. Slide 16 - same basic question as with slide 9 (re housing).

Answer: See response for question # 1.

6. Does Slide 18 data indicate a decrease in utilization of Outpatient Ambulatory Health Services of over 34% (difference between 68.5% in 2010 and 33.9% in 2015). Am I interpreting your chart correctly?

Answer: Yes this is correct for Part A funded services.

7. If correct, how does this square with the 60% retained in care in the Cascade?

Answer: The cascade is based on patient clinical data we received from our providers regardless of funding streams. HRSA/HAB changed the reporting requirement in 2015 to eligible scope that includes funded clients so that we can continue to create the continuum of care and continue measuring client health outcomes and progress towards achieving the National HIV/AIDS Strategy. Please refer to slide #4. This would not have been possible if we collected clinical data only for funded services.

8. Slide 19 shows that the % of infected individuals who have not yet been diagnosed is likely to be 18.7%. I am aware that the %s are not the same across states. The CDC assigns a % to each state, based on what formula or theory?

Answer: We will research this question more, perhaps reach out to CDC, and share information we obtain back to you.

9. Slide 25 shows a sharp dip in Viral Load Suppression in 2013. What factors explain that dip? (Despite the increase in 2015, we should know what led to the dip in order to prevent it happening again.)

Answer: Most likely it was the result of underreporting but we can reach out to our providers to dig deeper and verify the issue.

10. I am concerned that some of these discrepancies are due to poor tracking and reporting on the part of Providers. You can only work with the data you receive from them. What is being done to support them around tracking and reporting? I have worked directly with both FQHC and hospital-based providers, and know the MANY challenges that they encounter internally in terms of data management and reporting. If I am wrong about this, then you will tell me. If I am right, I suggest that we talk about this topic (with your assistance) at the next Council meeting.

Answer: Providers have myriads of data collection and reporting challenges. This challenge will continue to be there and may never be totally eliminated. But we can take small but continuous steps to minimize the challenges by working closely with our funded agencies. We have recently undertaken a difficult but bold initiative to implement State wide centralized data collection system to streamline and unify data reporting processes for Maryland. We hope that this new system will result in a more quality real time data and significantly reduce data reporting burden for both the recipients and sub-recipients in the EMA. Members of the Planning Counsel are welcome to participate and contribute to the central CAREWare implementation process that is expected to continue to the end of this calendar year.