CHAPTER 1: BALTIMORE EMA IN CONTEXT.

1.1. Introduction.

In 1984, a young boy received blood transfusions for hemophilia. At that time, transfusions were the best treatment for him. He contracted HIV from his treatment. At that time, people around the boy did not know the facts about HIV transmission. At that time, people were terrified of the deadly virus. At that time, people did not know how to care for and about those who have HIV. The boy was named Ryan White.

This is not that time. Today, we know better. Today, we do better. Today, we have legislation to ensure everyone can access treatment. Today, we have well-educated providers. Today, we have the capacity to track the changing epidemic. White's nationally publicized struggle led citizens and Congress to learn more and act compassionately.

Congress enacted laws to help care for those who contract HIV and offer guidance to professionals who provide services. The first iteration of the law was the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. It has been amended and reauthorized four times, most recently with the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87). The Ryan White legislation provides grants to the areas that have been the most impacted by HIV and AIDS. Under Part A of Ryan White, funds are provided to the Baltimore eligible metropolitan area (EMA), granted to the mayor of Baltimore City, and administered by the Baltimore City Health Department (BCHD).

An EMA is defined as a large urban area with a population of at least 50,000 and a minimum of 2,000 AIDS cases reported in the most recent 5 years. The Greater Baltimore HIV Health Services Planning Council consists of 40 mayorally appointed volunteers. Every year, the planning council completes a priority setting and resource allocation exercise (PSRA). During the exercise, Ryan White-fundable medical and support services are prioritized and allocation levels are determined.

This comprehensive plan utilizes the most up-to-date data, research and prior utilization patterns to provide guidance for the allocation of service dollars to people living with HIV/AIDS in the Baltimore EMA. This chapter describes the Baltimore EMA within the context of the national epidemic and the rest of Maryland. We now know that in order to treat people we must address the whole person. Among the topics that will be addressed are the geographic, demographic and socio-economic characteristics — including poverty, Medicaid enrollment, homelessness, and access to health care — of the EMA. Specific information about the HIV/AIDS epidemic facing EMA residents and their characteristics, trends, and implication can be found in chapter 2.

To show how the EMA has changed over time, this chapter will use many of the same indicators employed in the previous comprehensive plan. Data regarding each of the EMA's jurisdictions (i.e., Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's) will be included in the sections that follow. Using the above socio-economic indicators as proxies, it is evident that the residents of the Baltimore EMA, as a whole, are faring better than those from many other jurisdictions in Maryland and the country. The overall health of the EMA, however, masks deep disparities among the jurisdictions. Economic expansion in the nation's capital is benefiting Anne Arundel, Carroll, and Howard counties. Military base realignment and closure activities have promoted population and

This chapter describes the Baltimore EMA within the context of the national epidemic and the rest of Maryland.

job growth in Harford County. These counties are among the most affluent jurisdictions in the country, and the counties of Queen Anne's and Baltimore are not far behind. Conversely, Baltimore City continues to struggle as one of the most disadvantaged jurisdictions in the country. In short, the chapter presents a picture of the EMA that has made positive steps forward yet still has challenges to overcome.

Table 1.1.

Demography of the Baltimore EMA by Jurisdiction

Jurisdiction	Population (2010)	Land Area (miles^2)	Population Density (population per mile^2)
Maryland	*5,773,552*	*9,773.82*	*590.7*
Anne Arundel County	537,656	415.94	1,293
Baltimore City	620,961	80.80	7,685
Baltimore County	805,029	598.59	1,345
Carroll County	167,134	449.13	372
Harford County	244,826	440.35	556
Howard County	287,085	252.04	1,139
Queen Anne's County	47,798	372.21	128
Baltimore EMA	**2,710,489**	**2,609.06**	**1,039**

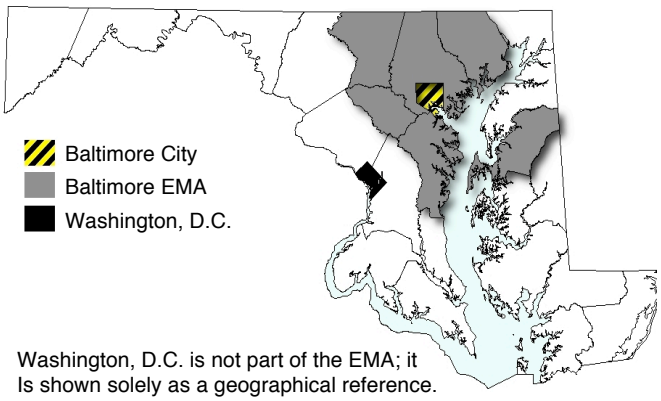
Source: BC 2010b.

1.2. Geography.

Centrally located in Maryland, the Baltimore EMA is composed of Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's counties. Together, these jurisdictions also are classified as the Baltimore/Towson metropolitan statistical area (MSA) by the U.S. Census Bureau and the U.S. Centers for Disease Control and Prevention (CDC), and as the "central region of Maryland" (except Queen Anne's County) by several state agencies (including the Department of Health and Mental Hygiene [DHMH]). Shaded in gray in Figure 1.1, the EMA is located between the northwestern shore of the Chesapeake Bay and the Pennsylvania state line, and just north of Washington, D.C.'s inner suburbs. Baltimore City, built on the banks of the Patapsco River and a wholly independent municipality of the state, anchors the EMA. It is almost completely surrounded by Baltimore County (of which it is not a part). Baltimore County is in turn is bordered clockwise from the south by Anne Arundel, Howard, Carroll and Harford counties (the latter east of Baltimore County). Queen Anne's County is located at the eastern end of the Chesapeake Bay Bridge, across from the state capital of Annapolis in Anne Arundel County. Queen Anne's County, composed mostly of rural communities, is the only jurisdiction of the Baltimore EMA not contiguous with the other counties; it is located on the Eastern Shore of Maryland.

Figure 1.1.

Baltimore Eligible Metropolitan Area (EMA)



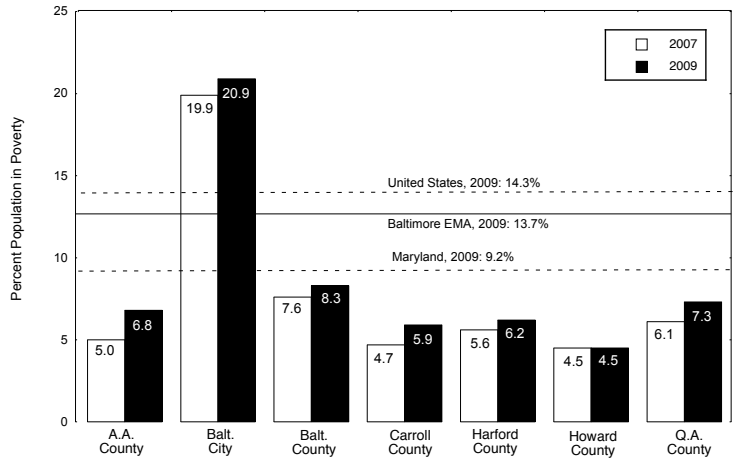
Washington, D.C. is not part of the EMA; it
Is shown solely as a geographical reference.

Anne Arundel (1,293 people/miles^2) and Howard counties (1,139 people/miles^2) are markedly suburban. Baltimore County (1,345 people/miles^2) exemplifies the diversity found within the EMA (BC 2010b). In some areas it is indistinguishable from the more urban areas in Baltimore City. Baltimore County transitions to more suburban areas outside the Baltimore beltway, the I-695 interstate highway that surrounds the city. Moving north, Baltimore County becomes one of the most rural areas in Maryland.

The diversity of the Baltimore EMA has been evident not only in the contrasting population densities of the jurisdictions, but also through the ethnic diversity and range of socio-economic indicators presented in this chapter.

Figure 1.2.

Poverty in the EMA by Jurisdiction, 2007 and 2009



Source: BC 2008, 2010a.

1.3. Ethnicity.

In 2010, the ethnic composition of the Baltimore EMA was similar to that of Maryland overall (BC 2010b). One major distinction was the percentage of Hispanic residents.[1] The Baltimore EMA (4.6 percent) had about half the proportion of Hispanics as the rest of Maryland (8.2 percent). Maryland had roughly half that of the nation as a whole (16.3 percent) (BC 2010b). These census figures suggest that the need to increase Latino-specific programming in the Baltimore EMA is not as pressing as it is elsewhere in the country.

The EMA (28.7 percent) and Maryland as a whole (29.4 percent) had proportionally more African-American residents than the country (12.6 percent). Baltimore City, with 63.7 percent of its residents black, accounted for the high proportion within the EMA. Other jurisdictions such as Baltimore County (26.1 percent), Howard County (17.5 percent), Anne Arundel County (15.5 percent), and Harford County (12.7 percent) had a higher percentage of African-American residents than the rest of the country, but a lower percentage than Maryland as a whole (BC 2010b).

The EMA (4.5 percent) had proportionally fewer Asian-American residents than Maryland (5.5 percent) and slightly fewer than the country (4.8 percent). The percentage of Asian-Americans in Howard County (14.4 percent) was much higher than the rate for Maryland and triple that of the nation in 2010 (BC 2010b).

The percentage of residents who were white in Carroll (92.9 percent), Queen Anne's (88.7 percent) and Harford (81.2 percent) counties was in 2010 well above the national average (72.4 percent). As with the rest of the country, multi-racial Americans, Native Americans, and Pacific Islanders were not found in large numbers in the Baltimore EMA or Maryland (BC 2010b).

1.4. Poverty.

As of 2009, the EMA and Maryland had lower levels of poverty than the nation (BC 2010a). The Baltimore EMA, with 13.7 percent of residents in poverty, was between Maryland, at 9.2 percent, and rest of the country at 14.3 percent.

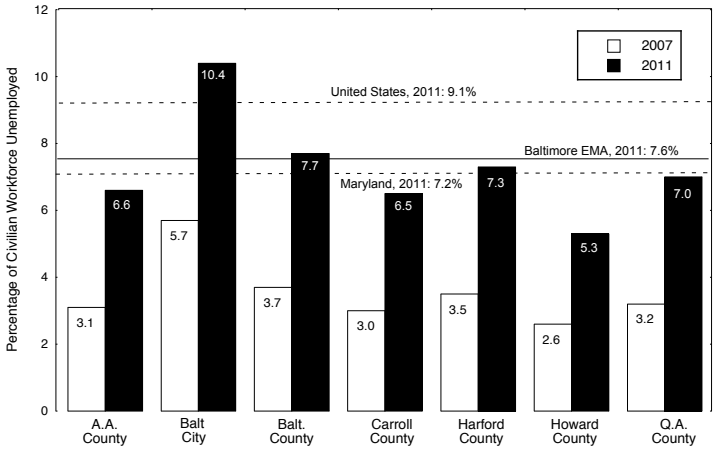
The relative affluence of the area should not obscure the need of the thousands of residents below the poverty threshold. More than 120,000 Baltimore City residents live in poverty. In 2009, the federal poverty level was $10,830 for an individual and $22,050 for a family of four (BC 2010a). Baltimore City's estimated poverty rate of 20.9 percent in 2009 was more than twice the state average and the single greatest contributor to the poverty rate of the EMA and Maryland. Figure 1.2 illustrates that all the other jurisdictions of the EMA were below the state average.

Howard (4.5 percent), Carroll (5.9 percent), Harford (6.2 percent), and Anne Arundel (6.8

[1] This document uses "black" interchangeably with "African-American," "white" interchangeably with "Caucasian," and "Latino" interchangeably with "Hispanic."

Figure 1.3.

Unemployment in the EMA by Jurisdiction, 2007 and 2011



Source: LLR 2011.

percent) counties residents were the least likely of all Marylanders to be in poverty. The poverty rates in Queen Anne's (7.3 percent) and Baltimore (8.3 percent) counties were higher and closer to the state average.

Poverty rates increased in the EMA between 2002 (9.2 percent), 2007 (10.0 percent), and 2009 (13.7 percent) (BC 2008, 2010a). Estimated poverty rates increased in each of the various jurisdictions of the EMA, in Maryland as a whole, and the entire United States.

1.5. Unemployment.

Estimated unemployment in the Baltimore EMA rose from 3.8 percent in 2007 to 7.6 in 2011 (LLR 2011). Since the last comprehensive plan, unemployment has increased in every jurisdiction of the EMA. Increases occurred in Anne Arundel County (3.1 to 6.6 percent), Baltimore City (5.7 to 10.4 percent), Baltimore County (3.7 to 7.7 percent), Carroll County (3.0 to 6.5 percent), Harford County (3.5 to 7.3 percent), Howard County (2.6 to 5.3 percent), and Queen Anne's County (3.2 to 7.0 percent).[2] Unemployment in Maryland increased from 3.6 percent in 2007 to 7.2 percent in 2011 (see figure 1.3).

Baltimore City was in 2011 the only jurisdiction in the EMA where the unemployment rate was higher than the national rate (9.1 percent). Baltimore City and Baltimore County were the only jurisdictions in the EMA with estimated unemployment rates higher than the average rate found in the EMA.

The recession has increased poverty and unemployment levels since 2007. This *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2012-2015* takes into account the recession that has threatened the economy the past several years.

1.6. Homelessness.

Homelessness is another powerful indicator of the social and economic health of a region. The stability obtained with housing provides a basis for all other care. In a June 2010 report on homelessness to Congress, the U.S. Department of Housing and Urban Development (HUD) identified sub-populations of homeless. Nationwide, a third of homeless individuals had substance-abuse problems, a quarter suffered

Table 1.2.

Sheltered and Unsheltered Homeless in Baltimore City, 2009

Category	Sheltered	Unsheltered
Black	85%	75%
White	13%	15%
Other	2%	10%
Male	59%	70%
Female	41%	30%

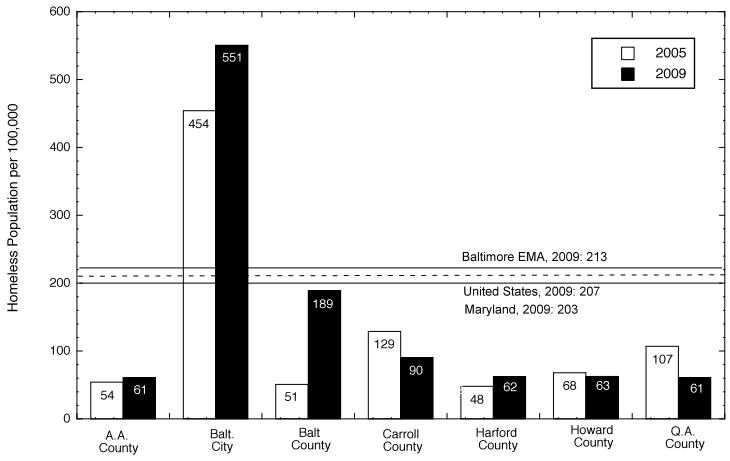
Source: MSU 2009.

[2] The 2011 figures use the average of January 2011 through August 2011. The 2007 figures use the average of January 2007 through December 2007. These data are not seasonally adjusted. They are estimates relating to the week of the 12th of the month. The count is of persons by place of residence (LLR 2011).

mental illness, 13 percent were veterans, 12 percent were victims of domestic abuse, 4 percent had HIV/AIDS, and 1 percent were unaccompanied youth (individuals under the age of 18) (HUD 2010).

Figure 1.4.

Homelessness in the EMA by Jurisdiction, 2005 and 2009



Source: NAEH 2007, HUD 2010.

Obtaining an accurate estimate of the homeless population can be difficult. Homeless individuals tend to be transient and their usage of shelters and related facilities varies with the seasons and weather. Recent efforts have been undertaken to standardize the methodology for counting homeless individuals across the country. Further, various funding implications provide incentive to inflate or minimize the total estimate and increase potential to politicize the counting process. As a result, the following data should only be used for relative comparisons between jurisdictions and not as an absolute measure of homelessness, as estimates differ between organizations (NAEH 2007). The 2009 rate of homelessness in the Baltimore EMA (213 per 100,000) was slightly higher than the Maryland rate (203 per 100,000) and the national rate (207 per 100,000) (HUD 2010).

Baltimore City (551 per 100,000) had more than twice the national rate of homelessness. Of the surrounding counties, Baltimore County (189 per 100,000) had the next highest rate, less than a third of the city rate. Carroll (90 per 100,000), Howard (63 per 100,000), Harford (62 per 100,00), Anne Arundel (61 per 100,000), and Queen Anne's (61 per 100,000) counties all had homelessness rates below the EMA as a whole, the state and the nation, as seen in figure 1.4 (HUD 2010).

In the 2009 Baltimore Homeless Census, the demographics of the homeless population were surveyed. A distinction was made between sheltered and unsheltered homeless people. The sheltered homeless had a primary night-time residence of a publicly or privately operated shelter or institution designed for temporary living accommodations. The unsheltered homeless had a primary night-time residence of a public or private place not designed or ordinarily used for regular sleeping accommodations by human beings (MSU 2009). Table 1.2 compares demographics between the sheltered and unsheltered homeless. Both sheltered and unsheltered homeless individuals tend to be African-American and male. Among the unsheltered homeless, fully three-quarters are African-American, while among the sheltered homeless, 85 percent are. Well over half the homeless are men: 59 percent of the sheltered homeless and 70 percent of the unsheltered. One explanation for the disproportionate number of male homeless individuals is that females may be more likely to obtain shelter in exchange for sexual favors. (This possibility of high-risk behavior may further fuel the AIDS epidemic.)

The stability obtained with housing provides a basis for all other care.

1.7. Medicaid.

The 2009 Patient Protection and Affordable Care Act (P.L. 111-148, also known as ACA), transformed health care coverage and created health reform that will expand Medicaid coverage. Signed into law on March 23, 2010, implementation will be rolled out in phases until 2020. On January 1, 2014, Medicaid will be expanded to all non-Medicare-eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes of up to 133 percent of the poverty level (Kaiser 2010). The ACA has expanded health care access to PLWH/As that was previously unavailable (Kaiser 2011a). Additionally, Medicaid coverage has increased over the past decade across the country to include millions of new children through the State Children's Health Insurance Plan (Kaiser 2010), as well as new enrollees that were negatively impacted by the poor economy.

Residents of the Baltimore EMA (17.1 percent) are more likely than Maryland residents overall (15.3 percent) and Americans in general (15.4. percent) to be Medicaid recipients in 2011, but this was almost entirely attributable to Baltimore City (35.4 percent) (DHMH 2011). While more than a third of Baltimore City residents receive some form of medical assistance from Medicaid, none of the other jurisdictions has an enrollment rate higher than the rest of the state (see figure 1.5).

Table 1.3.

Medically Underserved Areas and Populations in the EMA in 2011

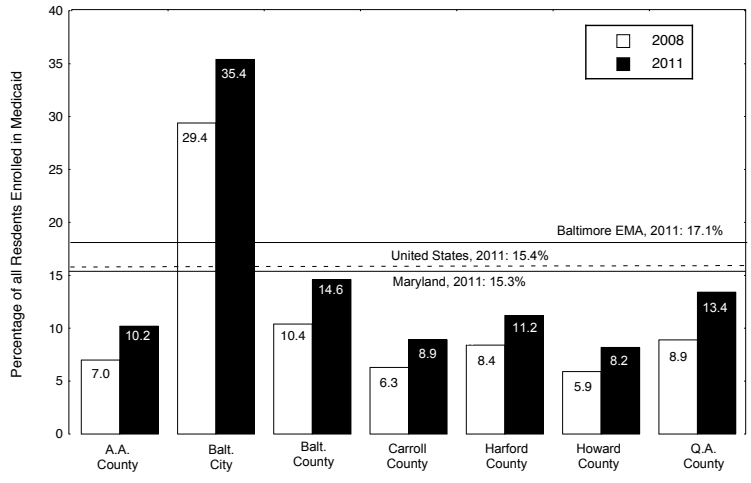
Jurisdiction	Number of MUAs	Number of MUPs
Maryland	*42*	*13*
Anne Arundel County	3	1
Baltimore City	13	0
Baltimore County	2	1
Carroll County	0	0
Harford County	0	1
Howard County	0	0
Queen Anne's County	2	0
Baltimore EMA	**20**	**3**

Source: HRSA 2011.

Due to changing eligibility requirements and to current economic fluctuations, it is difficult to make inferences about the changing level of Medicaid need over time. What can be said with certainty, though, is that Medicaid enrollment increased in every jurisdiction from 2008 to 2011, as illustrated in figure 1.5 (DHMH 2008b, DHMH 2011).[3]

Figure 1.5.

Medicaid Enrollment by Jurisdiction, 2008 and 2011



Source: DHMH 2008b, 2011; Kaiser 2011b.

1.8. Health Access.

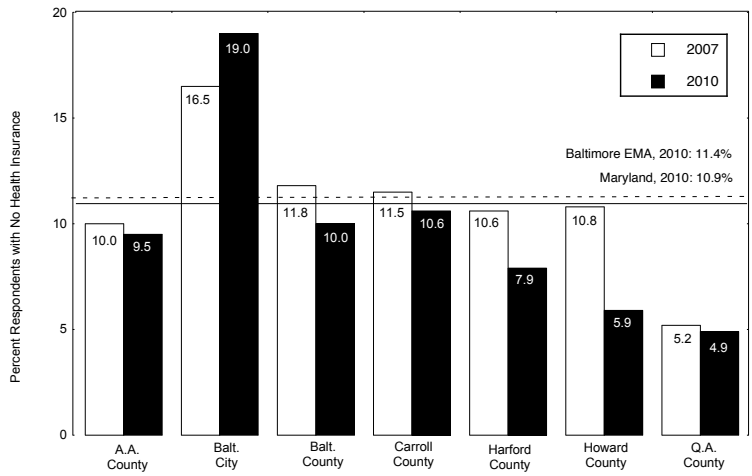
As discussed in the previous section, 17.1 percent of the EMA's low-income residents rely upon Medicaid for their health-care needs. Due to eligibility requirements, however, Medicaid does not provide insurance to everyone in need. Many in the EMA do not have any health insurance. According to data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS), 11.4 percent of

[3] The numbers are from the Medicaid eligibility in January 2008 and January 2011.

respondents from the Baltimore EMA reported not having any health insurance in 2010, as shown in figure 1.6 (DHMH 2010).[4]

Figure 1.6.

Rate of Uninsured in the EMA, 2007 and 2010



Source: DHMH 2008a, 2010.

Baltimore City had the highest rate of uninsured in the EMA (19.0 percent) and the highest percentage of residents enrolled in Medicaid (35.4 percent) in 2010 (DHMH 2011). This implies that only half of city residents relied on private insurance that year, 2010. Baltimore City was the only jurisdiction where the percentage of respondents with no health insurance increased from 2007 to 2010. Carroll (10.6), Baltimore (10.0 percent), Anne Arundel (9.5 percent), Harford (7.9 percent), Howard (5.9 percent), and Queen Anne's counties (4.9 percent) all had decreases in their percentages of uninsured residents (DHMH 2010).

Even with insurance, many of the EMA's residents have not been guaranteed access to quality health care. The U.S. Department of Health Human Services' Health Resources and Services Administration (HRSA) defines a medically underserved area (MUA) as a whole county, a group of counties or civil divisions, or a group of urban census tracts, in which residents have a shortage of personal health services (HRSA 2011). Medically underserved populations (MUPs) are designated as groups of persons who face economic, cultural, or linguistic barriers to health care (HRSA 2011). Table 1.3 compares MUAs and MUPs in the EMA. Baltimore City has the highest number of MUAs with 13. Howard, Harford, and Carroll counties have no MUAs.

1.9. Conclusion.

While medical care remains the primary focus of Ryan White programs, it is difficult to imagine an effective continuum of care that does not address both health- and non-health-related barriers to care — the ideal continuum of care addresses the whole person.

Often the challenges surrounding access to medical care are compounded by the life circumstances and societal problems faced by the person. Some of these factors, such as poverty, a poor labor market and a large numbers of visible and invisible homeless people, were discussed in this chapter. Other broad social ills such as crime and violence, excessive high-school drop-out rates, high rates of incarceration, and high numbers of substance abusers and chronically mentally ill persons are present in the Baltimore EMA, but are beyond the scope of this four-year plan for the provision of emergency HIV services.

The EMA's varied socio-economic status, demographics and the large geographic area complicate planning HIV health services in the Baltimore EMA. Solutions and services have to be tailored to the highly concentrated need found in Baltimore City and the dispersed need found in the counties. Despite their relative prosperity, county residents have to travel outside their jurisdiction to receive many of the medical and support services required by people living with HIV and AIDS.

Planners also will have to contend with several factors that are not captured by statistical data. The

[4] The Maryland Behavioral Risk Factor Surveillance System uses 95 percent confidence intervals. The median number is presented within the text here.

economic recession — and the resulting loss in tax revenues — is making it even more difficult for government agencies to keep pace with rising needs. Planners will have to provide more services due to the growing need, while also coping with level or decreased funding scenarios and rising costs. The next four years may see substantial funding cuts at a time when potential Ryan White clients may need the greatest assistance. Evolving legislation and policy changes challenge planners and providers to provide quality care to more people with less funding.

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