PREAMBLE.

Purpose.

This comprehensive plan outlines and explains the goals and objectives for HIV service delivery in the Baltimore eligible metropolitan area (EMA). The plan, created by the Greater Baltimore HIV Health Services Planning Council (planning council), is a guide for administering services funded through Part A and the Minority AIDS Initiative (MAI) of the Ryan White HIV/AIDS Treatment Extension Act of 2009 and for all partners collaborating in the care of persons living with HIV/AIDS (PLWH/As) in the Baltimore EMA.

Ryan White Part A provides emergency relief to adversely affected metropolitan areas within the U.S. (areas defined by having at least 2,000 cumulative AIDS cases over the last five-year period for which data are available and a population of at least 50,000). The Baltimore EMA encompasses Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties and Baltimore City.

Planning Council.

The planning council is a 40-member, all-volunteer body, appointed by the mayor of Baltimore City. The council is responsible for: developing a comprehensive plan for delivering HIV services to PLWH/As; conducting consumer needs assessments; setting priorities for the allocation of Ryan White Part A and MAI funds; evaluating the administrative mechanism that distributes Ryan White program funds and follows planning council priorities; and other related tasks.

Mission.

The mission of the planning council is to provide comprehensive, high quality services to PLWH/As in the greater Baltimore EMA regardless of their ability to pay. The planning council will plan for and ensure access to culturally sensitive, high quality, cost-effective services in collaboration with local authorities, providers and consumers of HIV-prevention and care services. The planning council and its advisors will act in a timely and unbiased manner when setting priorities to allocate resources.

Vision.

The planning council's vision is to promote a responsive system of excellent holistic care and prevention services by encouraging balanced participation of professional consumer partners enlightened by trends in the HIV epidemic and to ensure that needed services are developed and sustained to keep pace with the HIV epidemic.

EXECUTIVE SUMMARY.

Introduction.

The 2012-2015 comprehensive plan for HIV health service delivery sets forth the development and implementation strategies to put into action an ideal continuum of care in the Baltimore EMA.

The document has been designed to answer the following questions:

- Where are we now?
- Where do we need to go?
- How will we get there?
- How will we monitor progress?

To answer these questions, the planning council has gathered evidence-based planning and research to provide medical and support services to people living with HIV/AIDS in the Baltimore EMA. Chapters 1 through 3 will paint the picture of the demographics, epidemiology, and need related to the HIV/AIDS epidemic in the EMA. Chapters 4 though 6 will present the current continuum, barriers to care, and the ideal continuum. Chapter 7 will present the strategic plan to achieve the ideal continuum. Chapter 8 will describe partnering coordinating efforts and activities to implement the plan. Chapter 9 identifies monitoring and evaluation tools.

Chapter 1.

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.

Using the above-described 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 EMA's jurisdictions. Solutions and services have to be tailored to the highly concentrated need found in Baltimore City and the dispersed need found in the surrounding counties.

Chapter 2.

This second chapter describes the Baltimore EMA's HIV/AIDS epidemic. Analyzing trends in PLWH/A characteristics such as age, gender, race/ethnicity, and exposure category helps planners understand the changing demographics and emerging developments of HIV/AIDS in the EMA. Chapter 2 presents an analysis of the populations affected by HIV/AIDS over time and identifies emerging trends and populations.

African-Americans and men continue to be most affected by HIV/AIDS in the Baltimore EMA. Men having sex with men (MSM) and heterosexual intercourse have surpassed injection drug use (IDU) as the most common modes of HIV transmission in the Baltimore EMA. While subcategories of gender, race/ethnicity and exposure category all trend in the same direction, age subgroups are moving in markedly different directions.

Chapter 3.

Chapter 3 paints a comprehensive picture of need in the EMA using several sources: HRSA's unmet need framework, the planning council triennial consumer survey, updates from the council's PLWH/A Committee, and stakeholder and community forum feedback.

Using HRSA unmet need framework, it can be estimated that 40.9 percent of PLWH/As in the EMA are not receiving primary medical care. The planning council has analyzed results from the 2010 consumer survey. The most demanded service category is primary medical care, followed by AIDS pharmaceutical assistance, oral health, medical case management, and non-medical case management. The planning council's PLWH/A Committee has reaffirmed the need for support services in the EMA, particularly housing assistance.

Findings from the council's April 2011 stakeholder meeting and the 2009 Ryan White Part B Statewide Coordinated Statement of Need (SCSN) have been evaluated and aggregated into four main areas of consumer need: assistance managing and adapting to legislative changes; improving the linkage between services; consumer empowerment; and a seamless continuum through the lifecycle.

Chapter 4.

The following four goals are addressed in chapter 4, describing the current continuum of care:

- Prevention, to reduce the number of new PLWH/As and maximize the number of individuals that know their serostatus.
- Engagement, to help PLWH/As enter care.
- Stabilization, to keep PLWH/As in care through the provision of core medical services.
- Maintenance, to continue care throughout the lifecycle through the provision of support services.

The HIV service continuum ranges from services for those unaware of their HIV status to those fully engaged in care. Available services in the EMA span from prevention programs to reduce the spread of HIV to hospice services for end-of-life care. Additionally, numerous treatment and support services ensure that HIV-infected individuals are able to live stable and healthy lives. Presented in chapter 4 are the 17 Ryan White Part A-funded service categories that compose the Baltimore EMA's current continuum of care as of fiscal year (FY) 2011.

Chapter 5.

Chapter 5 focuses on four main types of barriers: policy/regulatory-barriers to HIV care, program-related barriers, provider-related barriers, and client-related barriers. Policy/regulatory barriers include routine testing, mandated inflexibility, decreased funding, financial accountability, and other barriers. Programs such as Medicare and Medicaid have eligibility, service and cost barriers to care. Provider-related barriers, such as administrative burdens, funding, third-party billing and provider-patient relationships may obstruct providers from providing PLWH/As with a high quality of care across the ideal continuum. Clients face barriers such as service accessibility, infrastructure, cost sharing, stigma and discrimination.

Vulnerable populations face more barriers accessing the continuum of care described in chapter 4 than the general population. In the Baltimore EMA, the planning council has identified the most vulnerable populations as the formerly incarcerated, MSMs, substance abusers, individuals with mental health problems, the homeless, transgender people, youth, counties residents, and aging adults.

Chapter 6.

This chapter addresses what makes the ideal continuum truly ideal, based on HRSA guidance and planning council input. The planning council envisions a responsive, balanced system of care that meets the medical, social, and supportive needs of PLWH/As. A series of national and local planning documents provide guidance towards building and maintaining an ideal continuum. These plans include:

- National HIV/AIDS Strategy (NHAS).
- Healthy People 2020.
- Patient Protection and Affordable Care Act (ACA).
- Maryland Statewide Coordinated Statement of Need (SCSN).

- Enhanced Comprehensive HIV Prevention Plan (ECHPP).
- *Moving Forward — Baltimore City HIV/AIDS Strategy, 2011: A Report to Mayor Stephanie Rawlings-Blake* (BCHAS).
- Healthy Baltimore 2015.

The chapter also includes a review of the planning council's *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2009-2011.* A progress update and an evaluation of the progress, successes, and challenges of this previous plan are discussed.

The use of innovative models of care based on best practices and national guidelines can be used within the EMA to provide an ideal continuum of care. These models include patient-centered medical homes, a hub/spoke model, community-engagement model, and a wellness-centered model.

Chapter 7.

Chapter 7 contains the strategic plan for reaching the ideal continuum of care developed in the previous 6 chapters. It focuses on the four goals (prevention, engagement, stabilization, and maintenance), with accompanying objectives and strategies for each goal. The objectives are as follows:

Goal 1: Prevention.

- *Objective 1:* Educate the Baltimore EMA about the risk of HIV and how to prevent it.
- *Objective 2:* Reduce the number of people unaware of their HIV status.
- *Objective 3:* Identify PLWH/As earlier in their disease progression.
- *Objective 4:* Using regional and state models, implement targeted prevention initiatives to prevent HIV infection.

Goal 2: Engagement.

- *Objective 5:* Decrease time period between a person's being identified as HIV positive (through the continuum of care) and his or her first primary medical care appointment.
- *Objective 6:* Establish a seamless continuum of care to improve the linkage to care of clients from counseling and testing efforts into treatment.
- *Objective 7:* Identify and remove barriers to care.
- *Objective 8:* Engage disproportionately affected populations in care.
- *Objective 9:* Increase the number of people living with HIV/AIDS re-entering care.

Goal 3: Stabilization.

- *Objective 10:* Increase the number of clients retained in care.
- *Objective 11:* Increase client attendance to medical appointments and support services.
- *Objective 12:* Improve the health status of PLWH/As.

Goal 4: Maintenance.

- *Objective 13:* Increase the number of clients receiving consistent medical care over a two-year period.
- *Objective 14:* Increase the number of clients who transition from Ryan White services for primary medical care (PMC) to an insurance provider.
- *Objective 15:* Support systems-level coordination.

Chapter 8.

Partnerships, coordination, and integration of providers and services are critical to operationalizing the plan set forth in chapter 7 and sustaining the ideal continuum of care in the EMA. This would not be possible without a comprehensive plan for service delivery that includes both partners in funding and partners in service.

Partners in funding, described in the eighth chapter, include all Ryan White-funded programs and U.S. Centers for Disease Control and Prevention (CDC) programs designed specifically for HIV/AIDS care as well as insurance programs such as Medicare, Medicaid, Children's Health Insurance Program and private insurance. The Maryland Infectious Disease and Environmental Health Administration (IDEHA) and the Baltimore City

Health Department also provide funding support.

Within the EMA, there are many roles that need to be filled in order to provide comprehensive and integrated care. The EMA health departments are funded to provide many services to its residents. Other service partners include various prevention programs, Baltimore Homeless Services, Baltimore Substance Abuse Services, sexually transmitted infection (STI) programs, private providers, community health centers, and community-based organizations.

Chapter 9.

Monitoring and evaluation are critical steps in assisting the EMA to assess progress and identify areas of success and weakness. These activities also help create an environment of transparency and accountability among planners and partners in the EMA. Tools such as strategic EMA report cards, client-level data, expenditure and service delivery (ESD) reports, scorecards, HRSA performance measures, and clinical outcomes help the EMA determine how effectively they are achieving the goals and objectives outlined in chapter 7.

The grantee's Clinical Quality Management (CQM) program reviews Ryan White-funded service categories to assess the quality of services and provides technical assistance. Several planning council committees — Comprehensive Planning, Evaluation, and Continuum of Care — serve specific monitoring functions. The planning council further utilizes priority setting and resource allocation, reprogramming, and consumer survey data to evaluate the continuum of care.