CHAPTER 4
ADDRESSING THE NEEDS OF PLWH/AS: THE CURRENT CONTINUUM OF CARE.

4.1. Introduction.

Chapter 4 of this comprehensive plan outlines efforts to meet the needs of PLWH/As in the Baltimore EMA. It does so by describing the continuum of HIV care that is currently available in Baltimore City, and the counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's.

The term "continuum of care" describes "a set of services and linking mechanisms that respond 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 for people at risk for, or living with, HIV and their families within a particular geographic service area, from primary care to supportive services" (IGS 2008).

The HIV service continuum ranges from services for those unaware of their HIV status to those fully engaged in care (i.e., maintaining routine HIV/AIDS primary medical care visits). The ultimate goal is for all HIV-infected individuals to move seamlessly through the continuum, from HIV testing to full engagement in treatment. However, this continuum is fluid — individuals drop in and out of HIV care at any point, thus creating a need for support services to help clients keep HIV medical appointments, as well as receive support for competing needs (IGS 2007a).

This chapter presents the service categories that compose the Baltimore EMA's continuum of care as it is projected to exist for federal fiscal year (FY) 2009. Available services in the EMA range from prevention programs to identify and stem the spread of HIV to services for end-of-life care. In between, numerous treatment and support services ensure that HIV-infected individuals are able to live stable and healthy lives. The continuum of care for the EMA is extensive; it includes 17 services, nearly 50 different service providers and over 200 contracts.

The chapter begins with a review of the requirements and foundations for the continuum of care in the Baltimore EMA. Next, the early stages of the existing continuum, especially those concerned with reducing the number of new PLWH/As and identifying existing PLWH/As, are presented. The chapter then moves to the first steps in the Ryan White Part A continuum of care — outreach and then case management to bring PLWH/As into care. We then describe the provision of outpatient/ambulatory health services (OAHS)[38] and other core services in the EMA. This is followed by a description of the support services provided in the EMA. The chapter concludes by outlining the current quality-management mechanisms in the EMA and introducing additional resources concerning the continuum of care.

4.2. Responding to Legislation and Need.

4.2.1. Continuum Consistent with Legislative Mandates.

To fully appreciate the mix of services that form the continuum, it is important to understand the legislative requirements for HIV services and the needs of the HIV-positive population in the EMA.

[38] OAHS encompasses a variety of subcategories including primary medical care (PMC), co-morbidity, emergency financial assistance (EFA), specialty laboratory services and viral load testing. PMC is the largest of these subcategories, and will often be discussed in this chapter as if it were a stand-alone category within core medical services, though strictly speaking it is not.

4.2.1.1. The 75 Percent Core Medical Requirement.

Since the publication of the last comprehensive plan for the Baltimore EMA, Congress has passed Public Law 109-415, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White). This act, the most recent iteration of Ryan White legislation, re-emphasizes that the focus of the continuum of care must be on OAHS (emphasizing primary medical care) and other core medical services. To reinforce this, Congress, for the first time, mandated that at least 75 percent of total Ryan White Part A funding for direct services be allocated to core medical services.[39] The remaining funds (i.e., up to 25 percent of direct service funds) are available for support services that demonstrably help individuals attain and remain in care.

Approximately ***77 percent*** *of the Baltimore EMA's Part A direct service funds are dedicated to providing* ***core medical services.***

Primary medical care is the focal point of the continuum of care in the Baltimore EMA. For FY 2009, the planning council has set aside approximately 40 percent of the direct service component of the anticipated Part A award for OAHS alone. All in all, the planning council anticipates using 77 percent of direct service funds for core medical services in FY 2009.

4.2.1.2. Short-term Funding of Last Resort.

Another legislative requirement is that Ryan White Part A be treated as funds of last resort. Therefore, those individuals receiving services paid for by Part A dollars must have no other resources to pay for these services. Because Ryan White is not meant to be a long-term entitlement program like Medicaid or Medicare, as individuals begin Ryan White services, planning is also begun to locate long-term or permanent services/entitlements to ensure continuation of life-saving treatments and care.

With limited resources and ever-changing demands on grant funds, planners, providers and consumers must operate under the premise that Ryan White services are for short-term emergency assistance. Allowing and planning for consumers to utilize Ryan White services for extended periods not only depletes resources, but also ultimately reduces the number of people providers are able to serve. To preserve Ryan White funds for individuals who will need the service in the future, consumers must be aware of, and utilize other (more long-term) funding streams available to them.

HRSA provides guidance for the implementation of the Ryan White act: it continues to be a support to planning councils and grantees as they work to refine services, change reporting systems and make other adjustments to meet the requirements of the 2006 legislation.

4.2.2. Continuum Is a Result of Evidence-based Strategic Planning.

In addition to being in compliance with current HRSA directives, the continuum of care in the Baltimore EMA is based on needs identified through the analysis of the EMA's epidemic and data collected on consumer need.

In the previous chapter, the HRSA unmet need framework, the 2007 consumer survey, presentations of the planning council's PLWH/A Committee and various stakeholder meetings were used to identify the most pressing needs of PLWH/As in the Baltimore EMA. The needs identified were for greater access to services that link consumers to care (e.g., case management and outreach); OAHS (especially primary medical care); programs that address mental-health, substance abuse and oral health; and various support services, such as

[39] Ryan White Part A funds HIV emergency relief grants for metropolitan areas of 50,000 people or more with 2,000 cumulative AIDS cases over the last five calendar years for which such data are available.

transportation, emergency financial assistance, legal services and housing.

In conjunction with meeting the needs of PLWH/As found in the paragraph above, the continuum of care must address the following objectives:

- Reducing the number of new PLWH/As.
- Identifying new PLWH/As.
- Engaging PLWH/As in care.
- Providing PLWH/As with adequate care.
- Stabilizing PLWH/As in care.
- Maintaining PLWH/As in care and, where feasible, transferring them to long-term programs.

4.3. Prevention: Reducing the Number of New PLWH/As.

The continuum of care begins with HIV-prevention measures that serve to prevent uninfected individuals from contracting HIV. Maryland and the Baltimore EMA employ a variety of primary and secondary prevention programs to help prevent further spread of HIV. Most of the prevention planning and coordination occurs at the state level.

The Maryland AIDS Administration has an ongoing system for collecting community input for its prevention planning through the Community Planning Group (CPG). The CPG consists of the HIV-infected, HIV-affected, advocates, health departments, community-based organizations, and other entities working to fight the HIV epidemic. The CPG is responsible for collecting information from all five regions in Maryland (i.e. central, western, eastern, southern and suburban Maryland).

The CPG develops a comprehensive HIV-prevention plan for the entire state. The plan identifies populations for priority attention. Prevention activities and projects are planned according to priorities guided by epidemiological data, community input and direction from the CDC. The state's current priorities are HIV-infected persons (prevention for positives), high-risk heterosexual persons, injection drug users, men who have sex with men (MSM) and special populations, including Hispanics, deaf and transgender persons (Gray 2008). For FY 2006, the CDC allocated a total of $9,619,186 to Maryland for HIV-prevention projects (Kaiser 2007).

4.3.1. Primary Prevention in the Baltimore EMA: Focusing on Injection Drug Use.

Injection drug use (IDU) is one of the primary modes of transmission in the Baltimore EMA — 45 percent of the 2006 prevalent cases of HIV/AIDS in the Baltimore EMA were the result of IDU (Flynn 2008). As such, Baltimore City, with its heroin and crack epidemics, poses a unique challenge to organizations looking to prevent the spread of blood-borne diseases among injection drug users.

*Co-infection rates for HIV and hepatitis C run as high as **50 to 70 percent** in parts of the Baltimore EMA*

One such organization is the Baltimore City Health Department, whose needle exchange program (NEP) looks to stem the spread of diseases among drug users and their sexual/needle-sharing partners. HIV is just one of the diseases that the program seeks to prevent. However, with some estimates placing the HIV and hepatitis C co-infection rate as high as 50 to 70 percent in parts of the EMA, efforts to block one blood-borne disease will invariably have a positive effect on the prevention of others (Fantry 2008, Shippee 2008).

NEP also helps with drug-treatment access for injection drug users. Initiated in 1994, it has enrolled over 16,000 individuals. As of June 2007, about 3,350 of NEP enrollees were successfully referred to drug treatment.

Using two vans and one fixed location, NEP serves the 18 sites that are believed to have the most drug use in Baltimore City. BCHD also partners with a community-based organization, Power Inside, to provide wrap-around services to female injection drug users seeking treatment (Serio-Chapman 2008).

The success of prevention programs that concentrate on IDU is evident in the most recent HIV transmission trends for the Baltimore EMA. As chapter two shows, newly reported cases of HIV are dropping throughout the EMA. However, nowhere is the decline greater than it is for IDU as a mode of HIV transmission.

4.3.2. Testing: Identifying PLWH/As.

Throughout Maryland there are many other HIV-prevention mechanisms, such as HIV counseling, testing and referral services, which are often co-located with community health clinics and serve as the initial point of access to HIV-related care (Gray 2008). These sites provide free HIV health education and risk-reduction counseling as well as voluntary HIV antibody testing. Anonymous HIV testing is also available at selected sites, as well as post-test counseling. These prevention programs offer portals to OAHS and other services, as described below.

An estimated ***20 percent*** *of HIV positive individuals do not know that they are infected.*

In 2006, the CDC changed its recommendation on who should be tested in health-care settings to include all patients aged 13 to 64, pregnant women, and any patient who exhibits symptoms consistent with an HIV infection (CDC 2006). It is thought that by offering testing as a routine part of medical care, while allowing individuals to elect not to be tested (opt-out), that it will be possible to capture many of the estimated 20 percent of individuals who are HIV positive and do not know it — this population is a primary source of new infections.

Until 2008, HIV testing in Maryland remained opt in, which meant that it was not done routinely and that patients had to give separate consent to be tested for HIV. The Maryland AIDS Administration held several community forums across the state to solicit local views regarding HIV testing, and presented the information to the state General Assembly. In 2007, Maryland passed legislation to facilitate the adoption of opt-out testing that has recently gone into effect. Opt-out testing means that most adults will be tested for HIV as a regular part of primary medical care unless they choose to opt out.

In addition to the general increase in testing that is expected to result from this legislative change, the Johns Hopkins University School of Medicine has received a grant to do rapid testing of 15,000 inmates at the Baltimore City jail on Monument Street. The program, under the direction of John Bartlett, aims to identify HIV-positive individuals earlier and link them to treatment services sooner.[40]

By identifying and linking individuals with HIV to care sooner through all the new testing initiatives, Bartlett believes that the Baltimore EMA could soon see substantial reductions in the rate of HIV transmission (Bartlett 2008).

4.3.3. Secondary HIV Prevention Measures.

Secondary HIV prevention is the identification of and provision of interventions to individuals living with HIV to ensure that they change behavioral patterns, remain as healthy as possible and do not place uninfected partners at risk. The following paragraphs present secondary prevention efforts that are currently underway in the Baltimore EMA.

[40] John Bartlett, M.D., is the Stanhope Baynes-Jones Professor of Medicine at the Johns Hopkins University School of Medicine.

The Maryland AIDS Administration has several secondary HIV-prevention programs, which aim to fulfill this goal. It operates four Prevention with Positives projects in Baltimore City that aim to help HIV-positive individuals change behaviors that put uninfected partners at risk. The Prevention with Positives program reached 229 individuals throughout Maryland in 2007 (Castner 2008).

The AIDS Administration also offers two intervention models: "interventions delivered to groups" and "comprehensive risk counseling and services," which use the "positive wellness and renewal" (POWER) model for individual-level intervention. Another secondary prevention intervention in Baltimore City uses a modified version of the "healthy relationships" model, which helps HIV-infected individuals cope with the stress of living with HIV, especially African-American men who have sex with men. In 2007, the programs based on the "comprehensive risk counseling and services" model served 201 HIV-positive individuals in Maryland (Castner 2008).

The Health Education and Risk Reduction Division (HERR) of the AIDS Administration oversees prevention initiatives targeting high-risk populations. Individual- and community-level interventions, public information programs, and risk reduction interventions for groups are employed to help reduce the spread of HIV (Gray 2008). HERR helped 207 individuals in 2007 (Castner 2008).

In addition to these programs funded through the Maryland AIDS Administration, the University of Maryland Evelyn Jordan Center received a CDC grant for secondary prevention, which allows them to perform counseling, testing, and referral services in the clinic waiting room. Approximately 10 percent of those successfully reached in the clinic's waiting room test positive for HIV (Fantry 2008). Individuals who test positive are referred directly to the clinic.

4.4. Engaging and Stabilizing PLWH/As in Care.

Helping HIV-positive individuals enter medical care as soon after receiving their HIV test results as possible is important on several fronts. Early entry into services improves medical/health outcomes. Individuals who know their HIV status are more likely to change their behaviors and thus reduce their chances of infecting others (CDC 2008). Also, the economic costs of helping individuals maintain their health are smaller than the costs of restoring, or trying to restore someone to the point where the immune system can fight off opportunistic infections.

The path to full engagement in the continuum of care can be long and arduous — many individuals wait too long before entering care. Currently, about 40 percent of those diagnosed with HIV become AIDS defined within one year (Bartlett 2008). With the average span between HIV infection to AIDS diagnosis being 10 years, this means individuals are going without care for several years, resulting in irreversible damage to their bodies — the sooner that individuals are linked to care, the better their quality of life. There are several services in the Baltimore EMA designed to identify, diagnose and link individuals to care; they fall under the HRSA service categories of medical case management, non-medical case management and outreach services.

*About **40 percent** of newly diagnosed PLWH/As become AIDS defined within one year.*

4.4.1. Outreach.

Outreach services offer information and referral assistance to HIV-positive individuals. Service is often provided in neighborhoods and areas where HIV incidence is known to be high. Outreach workers encounter individuals who know that they are HIV-positive but have not received any HIV medical care as some

individuals, upon learning that they have HIV, have trouble accepting their status and choose to remain out of care. Among the reasons commonly expressed for delaying entry into care are the following: fear of family and friends learning of their status, and fear of discrimination at work or in other public places due to stigma. Outreach services are often the entry point where PLWH/As first receive help addressing these fears.

Non-traditional outreach targets people in high-risk areas, many of whom may have previously received medical services, but are not currently enrolled in HIV primary medical care. Working with host agencies, outreach workers offer general health information, HIV testing services, information and intensive referral services. After gaining the trust of their clients, outreach workers help them make, and accompany them to medical appointments, to ensure that they get back into, and remain in care.

There are nine outreach providers in the EMA.[41] Chase Brexton Health Services and the People's Community Health Center are among those that receive Ryan White Part C funding for outreach through early intervention services, in addition to Part A funding for outreach.[42]

4.4.2. Case Management (Non-medical).

Non-medical case management continues to be the best way to inform individuals about the variety of medical and support services and programs available to them. Non-medical case management often addresses the barriers that clients identify as preventing them from entering care or maintaining themselves in care. This service also assists those who need help and support in applying and completing the lengthy and complex process for housing or social security entitlements. Non-medical case management includes client advocacy services, which are beneficial for individuals confronting a crisis or a single issue (e.g., assistance in applying for subsidized housing).

Non-medical case management is a safety net for HIV-positive individuals who receive medical care through public insurance programs and need the support services necessary to enter and maintain themselves in medical care. Often, client needs are immediately addressed through non-medical case management, and the client does not seek further services until the next emergency occurs. Nevertheless, all clients are referred to HIV medical services if they are not already enrolled in treatment.

Eight providers in the Baltimore EMA offer non-medical case management, which involves coordinating needed non-medical and support services for consumers. Non-medical case management is also available as a service funded through the Minority AIDS Initiative (MAI). Individuals may also be referred to care through non-Ryan White funded programs that treat substance abuse and mental health, and provide other human services. Once individuals are successfully and fully linked to care, services are coordinated around primary medical care by medical case managers.

4.4.3. Medical Case Management.

Medical case management is comprised of services previously classified by HRSA under case management and treatment-adherence services. The medical case manager assesses the patient's needs and provides referrals and support as the client accesses HIV-related medical care. Medical case managers also work with individuals on a continuing basis to address concerns about stigma, and support the individual as he or she copes with the diagnosis and fears about medical treatments and medications.

[41] All mention of providers in this chapter refers to Ryan White Part A-funded providers unless otherwise noted.

[42] Ryan White Part C funds early intervention services related to HIV disease, provided by public and/or nonprofit private entities on an outpatient basis, including counseling, testing, referrals, clinical and diagnostic services and periodic medical evaluations.

The coordination and follow up of medical treatments is another vital component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care through the ongoing assessment of the client's and other key family members' needs and personal support systems.

Integral to successful HIV treatment is medication adherence. Medical case managers address adherence issues by creating a plan for follow up and are often responsible for delivering a full range of adherence services. Since medical case managers create a bond of trust with their clients, they are often included on the team that educates the clients about HIV medications and the management of medication side effects.

Case managers are frequently required to make an assessment of the client's need for mental health or substance-abuse treatment, and may work with the medical provider in supplying referrals for such services. The medical case manager is the linchpin that holds together all the essential services that an HIV-positive person needs to maintain his or her health and ensure his or her quality of life. There are currently 17 agencies providing medical case management services in the Baltimore EMA.[43]

4.5. Outpatient/Ambulatory Health Services (OAHS).

As required by law, the provision of HIV treatment and care under Ryan White is centered on outpatient/ambulatory health services. OAHS includes preventive care and screening, diagnosis and treatment of common physical and mental conditions. The planning council breaks OAHS into five subcategories: primary medical care (PMC), emergency medical (financial) assistance, PMC co-morbidity, viral load testing and specialty laboratory services. Once consumers are engaged in OAHS, specifically primary medical care, they can then access a wide range of other Ryan White services to maintain their well-being.

The Baltimore EMA, home to both the University of Maryland Medical Center and the Johns Hopkins University, is very fortunate to have a wealth of clinical expertise. There are 17 OAHS providers funded through Ryan White Part A and MAI, and the grantee and planning council are currently exploring the possibility of expanding to two additional locations.

The need to address co-morbidities through the Ryan White continuum of care also falls under OAHS. The increase in patients presenting with co-morbid conditions such as diabetes, lung cancer, renal problems and heart disease upon entry into care is an ongoing challenge in the EMA (Fantry 2008).

Baltimore City is home to one of the world's ***most severe hepatitis C*** *epidemics.*

For example, many Ryan White consumers of HIV care also require treatment for liver problems resulting from a co-infection of hepatitis C. For the entire State of Maryland, the Department of Health and Mental Hygiene estimates that there are approximately 100,000 people infected with hepatitis C, two thirds of whom are unaware of the infection (DHMH 2007a). Other estimates suggest that there are 80,000 people with known hepatitis C in Baltimore City alone — making the city home to one of the biggest (per capita) hepatitis C epidemics in the world (Bartlett 2008). Some 50 to 70 percent of HIV-positive patients seen at

[43] These agencies include the health departments of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties; Johns Hopkins University; People's Community Health Center; Bon Secours Baltimore Health System; Chase Brexton Health Services; Family Health Centers of Baltimore; Good Samaritan Hospital; Health Care for the Homeless; Light Health & Wellness Comprehensive Services; and Special Teens At-Risk, Together Reaching Access, Care and Knowledge (STAR TRACK) through the University of Maryland.

Chase Brexton Health Services and the Evelyn Jordan Center are co-diagnosed with hepatitis C (Fantry 2008; Shippee 2008).

Treating HIV-positive individuals with multiple health conditions is complex — often requiring a team of medical specialists. The Baltimore EMA has institutions that are able to address the complexities that arise from treating consumers with co-morbid conditions. Of the 15 agencies funded for primary medical care, 9 are also funded to provide services for co-morbidities.

***Two thirds** of the eligible PLWH/As in Maryland use MADAP.*

With advancements in medicine and technology, individuals with HIV/AIDS are now able to live full, active lives with proper treatment and disease management. These breakthroughs, coupled with the reauthorized and revised Ryan White Treatment Modernization Act, require the planning council to think about HIV services differently. Extensive information about Medicaid and Medicare, the other major providers of primary medical care to PLWH/As in the Baltimore EMA, can be found in chapter 5.

4.6. Other Core Medical Services.

For fiscal year 2008, the Baltimore EMA funded a total of 17 services, consisting of 9 support services and 7 core medical services, in addition to OAHS.[44] These ancillary HIV services funded by the Ryan White Treatment Modernization Act's Part A and MAI funds have been shown to facilitate client access to, and retention in OAHS. Critical to the success of medical treatment is availability of medications necessary for treating HIV and other attendant conditions.

4.6.1. Medication Assistance.

Many of the Ryan White consumers in the Baltimore EMA require HIV medications that they are unable to afford. The Maryland AIDS Drug Assistance Program (MADAP), funded by the Ryan White Part B program, helps consumers purchase these HIV medications that are essential to maintaining treatment, ensuring an improved quality of life and helping individuals manage their HIV/AIDS. MADAP only covers medications listed on its formulary: there are currently 162 drugs on the formulary.

As Ryan White is a payer of last resort, consumers are only eligible for MADAP if all other funding sources have been exhausted. There are about 4,000 potential MADAP consumers — about two thirds of them are currently using the service (Clark 2008). To be eligible for MADAP, consumers must be HIV positive, must earn between 116 and 500 percent of the federal poverty level and must not be eligible for Medicaid (DHMH 2007b).

The typical amount of time it takes to receive MADAP benefits ranges from two weeks to one month. However, for consumers with an opportunistic infection or a CD4 count less than 200, MADAP coverage is available after two days. There is also a temporary assistance program designed to provide gap coverage for Maryland Primary Adult Care Program participants until MADAP begins. Consumers must reapply for MADAP annually. Ryan White Part A funds are not currently used for AIDS drug assistance in the Baltimore EMA. However, the category is prioritized each year so that funds can be quickly shifted into the category should there be a shortfall in the Part B program.[45]

[44] The nine support service categories funded include non-medical case management; child care services; food bank/home-delivered meals; housing; legal services; medical transportation; outreach; psychosocial support; and substance-abuse treatment/residential. The eight core medical services funded include OAHS; medical case management; health insurance premiums & cost-sharing assistance; mental health; substance-abuse treatment/outpatient; medical nutrition therapy; hospice; and oral health care.

[45] Prioritization is the process whereby the planning council deems a service to be needed in the Baltimore

4.6.2. Health Insurance Premiums and Cost-sharing Assistance.

Many HIV-positive clients have ongoing needs for services that assist consumers with co-payments for their medications. To address this need, health insurance premiums and cost-sharing assistance was made a fundable category in FY 2007. However, given the rising cost of health insurance and ongoing adjustments in other funding sources for medication assistance, it has been difficult to plan for services that aid with medical co-pays and deductibles. There are currently eight agencies in the Baltimore EMA that offer this service — the health departments of Anne Arundel, Baltimore, Howard and Harford counties, Chase Brexton Health Services, Bon Secours Baltimore Health System-Imani, the Johns Hopkins University Moore Clinic and the University of Maryland Evelyn Jordan Center.

The Maryland AIDS Administration also has an insurance-premium program, MADAP Plus, which covers health premiums ensuring consumers retain health insurance and continue receiving health care treatment. In order to qualify for MADAP Plus, which is currently funded under Ryan White Part B, consumers must first meet eligibility requirements for MADAP and have a qualifying insurance plan under the Maryland Health Insurance Plan. Only individual policies are covered, and consumers are responsible for paying more than 50 percent of the premium (DHMH 2007c). The average wait-list time is 3 to 4 months, and currently about 2,000 consumers access MADAP Plus (Clark 2008).

4.6.3. Mental-health Services.

A large portion of consumers in the Baltimore EMA face problems with mental health and substance abuse. Louise Treherne of Health Care for the Homeless estimates that 90 percent of her organization's HIV-positive, homeless clients from Baltimore City suffer from mental-health problems and/or substance addiction; about 35 percent of the organization's overall homeless population (including both HIV positive and HIV negative individuals) suffers from chronic mental-health problems (Treherne 2008). Given that there are many addicts with mental-health disorders, there is a demand to create a better linkage between mental-health services and substance-abuse treatment (Merrick 2008).

Mental-health services are a critical component of the continuum of care as mental-health conditions can obstruct the seeking and maintaining of primary medical care. Mental-health services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a licensed professional. There are eight mental-health service providers in the EMA, including two that offer pediatric mental-health services. Organizations such as Chase Brexton have co-located primary care, substance-abuse treatment and mental-health services to better serve dually and triply diagnosed clients.

Baltimore City has also designated a special quasi-public agency to provide mental-health services, the Baltimore Mental Health Systems, Inc. (BMHS). BMHS oversees services to approximately 30,000 residents of Baltimore City who are either uninsured or receive Medicaid (BCHD 2007). Furthermore, a subsidiary of BMHS, Community Housing Associates, Inc. (CHA), works to develop affordable housing options for the many people suffering from mental-health problems who are unable to locate appropriate housing. CHA owns and manages about 250 housing units (BCHD 2007). Maryland also provides state-funded mental health services.[46]

EMA, thus making it eligible for Ryan White Part A funding.

[46] See the Maryland Department of Health and Mental Hygiene's web site for more information (www.dhmh.state.md.us/health/mentalhealth.htm).

4.6.4. Substance-abuse Treatment.

Substance abuse is a major problem in the Baltimore EMA. IDU continues to be a prominent mode of transmission for HIV in the Baltimore EMA; and the number of female intravenous drug users is on the rise (Blattner 2008). Furthermore, according to the 2007 consumer needs assessment for the Baltimore EMA, 21.8 percent of consumers who needed substance-abuse treatment services did not receive it (IGS 2007:34).

Baltimore City has established a public/ private partnership, Baltimore Substance Abuse Systems, Inc. (BSAS). This entity received nearly $44,000,000 in funds to serve the addicted population in Baltimore City. These funds were in addition to over $18,000,000 provided directly to the six surrounding counties (Givens 2007). Significant portions of these funds have special eligibility criteria or are targeted and available to a particular segment of the population, such as funds to support treatment services for youth or to support treatment services rather than incarceration for individuals in the criminal justice system.

*Nearly **22 percent** of the EMA's consumers reporting a need for substance-abuse treatment also reported being unable to access it.*

In order to combat opiate substance abuse and to get addicts into primary medical care, providers have benefited from a collaborative initiative by the Baltimore City Health Department, Baltimore Substance Abuse Systems and Baltimore Health Care Access, Inc. to provide buprenorphine in the Baltimore EMA. There has been a mixed response to the initiative. Some providers have reported problems with getting clients to sign on while others have reported being flooded with client demand for buprenorphine.

There is consensus, however, that providers have yet to identify the client best suited for buprenorphine treatment. Some providers believe that younger clients and those who have not already undergone methadone treatment may be ideal for buprenorphine (Merrick 2008). Compared to methadone treatment, buprenorphine is expensive, averaging between $3 and $12 a day per client as compared to $0.23 per day per client for methadone (Merrick 2008). There are currently 10 providers participating in the initiative.

Residential substance-abuse treatments are also offered through Ryan White Part A funds in the EMA, but can only be funded as a support service. Baltimore Substance Abuse Systems, Inc. serves as a central referral source for numerous residential programs for substance addicts who are eligible for Ryan White-funded treatment. Baltimore has about 4,000 treatment slots to serve its addicted populations.

There are nine Ryan White Part A providers of outpatient substance-abuse treatment in the Baltimore EMA. Although this is a very important service, some providers have received a decrease in funding due to underutilization of slots. Additional substance-abuse services are also provided by the State of Maryland.[47]

4.6.5. Medical Nutrition Therapy.

Consumers with a history of medically related nutritional deficiencies have access to medical nutrition therapy provided through the EMA's continuum of care. The use of nutritional supplements (e.g., Boost or Ensure) is regulated under medical nutrition therapy so that they can be properly integrated into a comprehensive nutritional plan. There is considerable demand for medical nutrition therapy in the Baltimore EMA, as evidenced by the 59.7 percent of respondents who reported

[47] See the Maryland Department of Health and Mental Hygiene's web site for more information (www.dhmh.state.md.us/health/subabuse.htm).

needing this service on the 2007 consumer survey (IGS 2007:38).

This service used to be classified as a support service under "nutritional counseling"; it is now a core medical service. Consumers are referred to the service *via* a primary care physician and are administered services by a registered dietitian. Chase Brexton Health Services, Moveable Feast and the University of Maryland Evelyn Jordan Center are the primary providers of medical nutrition therapy to Ryan White clients in the Baltimore EMA.

4.6.6. Oral Health Care.

Just as nutritional health is critical to the HIV population, so too is good oral hygiene and overall oral health. Oral health care includes diagnostic, preventive and treatment services. Five providers offer oral health care services in the Baltimore EMA: Bon Secours Baltimore Health System/ Imani, Chase Brexton Health Services, University of Maryland Dental Plus Clinic, Johns Hopkins University Otolaryngology Head and Neck Surgery, and Baltimore City Health Department Dental.

Efforts are underway to ensure that every HIV-positive Ryan White client/patient knows about Ryan White-funded oral health services and receives appropriate referrals to services. Another source of oral health care is Medicaid, which covers services for children of recipient families, but offers limited benefits for adults (Middleton 2008a).

4.6.7. Hospice.

Although antiretroviral treatment has reduced the mortality rate for HIV-positive communities, with individuals entering care late, people are still succumbing to HIV and AIDS. There were 294 AIDS-related deaths in the Baltimore EMA in 2006 (DHMH 2008b). Eligible consumers at the end stages of HIV/AIDS may access hospice services provided by Joseph Richey Hospice services.

4.7. Support Services: Maintaining PLWH/As in Care.

Although the Ryan White HIV/AIDS Treatment Modernization Act of 2006 clearly focuses the main body of resources on medical services, the act still allows support services to be funded when the services can be shown to help individuals access or maintain themselves in medical services, especially outpatient ambulatory health services. There are several support services and programs available to PLWH/As in the Ryan White continuum of care. Greater access to these support services positively affects a consumer's chances of accessing and maintaining treatment.

*There were **294** AIDS-related deaths in the Baltimore EMA in 2006.*

4.7.1. Psychosocial Support.

The success of psychosocial support services, much like outreach, is based upon building a trust between the worker and the individual. Once individuals are brought into the Ryan White system, there is an ongoing need for support for PLWH/As, because an HIV diagnosis carries with it many challenges that must be addressed before the individual is ready to fully engage in care. The diagnosis of infection can result in fear of others' finding out about the consumer's status due to the high level of stigma surrounding HIV. Misinformation about HIV and treatment are barriers to seeking care. Addiction and mental health problems, both higher among the populations that are most impacted by HIV, also keep people from seeking care.

Psychosocial support addresses the ongoing psychological and social problems of PLWH/As and those around them; it helps them make informed decisions and better cope with the disease. Over half of the respondents to the 2007 consumer survey reported a need for the types of support groups described under HRSA's psychosocial support service definition (IGS 2007:43). There are five providers in the

Baltimore EMA offering psychosocial support services to Ryan White Part A consumers.

4.7.2. Housing.

Access to housing services continues to be a high priority need in the Baltimore EMA. It is estimated by homeless advocates that there are at least 3,000 homeless persons on any given night in Baltimore City, but only 2,000 beds available to shelter them (Treherne 2008). The findings from the planning council's last consumer survey also suggest a need for more housing services: 53.1 percent of the survey's respondents reporting a need for housing assistance also reported not receiving it (IGS 2007:41). The planning council's PLWH/A Committee also identified housing as one of the most important support services, because PLWH/As without housing or stable living conditions are less likely to seek or maintain treatment.

Ryan White Part A funds are used to provide housing assistance to consumers in the Baltimore EMA. However, there has been a recent change in federal policy concerning the amount of time HIV consumers may access Ryan White housing services. HRSA announced that, effective March 27, 2008, housing services may only be used by consumers for a cumulative total of 24 months per household (NARA 2008). As with other Ryan White services, providers and consumers must work together to find alternative long-term sources of housing support. One such source is the U.S. Department of Housing and Urban Development (HUD).

HUD offers several programs that are potential sources of housing assistance for eligible Ryan White consumers. The Section 8 program provides vouchers to low-income individuals and families so they may be able to afford to rent privately owned housing. The Shelter Plus Care Program provides housing and other support services for homeless persons. HUD's Housing Opportunities for Persons with HIV/AIDS (HOPWA) program is specifically designed to provide comprehensive housing and support services for HIV-positive consumers (HUD 2008). In 2007, HUD allocated $7,803,883 for 554 HOPWA permanent housing units (Bradyhouse 2007). The only eligibility requirements for HOPWA are documentation of HIV/AIDS and low-income status. However, the average wait time for HOPWA is between one and two years, and the access to the wait list is not available for most of the year.

In conjunction with HUD, Baltimore's housing programs, consisting of the Housing Authority of Baltimore City (HABC) and the Baltimore City Department of Housing and Community Development (HCD), provide federally funded housing to low-income residents of Baltimore City. These agencies currently serve over 40,000 residents in more than 14,000 housing units (BH 2008).

4.7.3. Food Bank/Home-delivered Meals.

Food security is critical to successful care. As with a lack of housing, a lack of food will make it difficult for PLWH/As to prioritize their HIV health care. Furthermore, insufficient levels of nutrition can have a direct impact upon the effectiveness of drugs used to combat AIDS. The food bank/home-delivered meals service, formerly known as "food and nutrition" in the Baltimore EMA, is needed by consumers who are physically and medically unable to prepare their own meals or shop for groceries. (A physician must attest to the medical limitations of persons referred to the providers of food services in the Baltimore EMA.)

The food bank/home-delivered meals support service provides household supplies and groceries or vouchers to purchase these products. This service is also closely tied to medical nutrition therapy, as providers in this category also stock and store liquid nutritional supplements. (Nutritional supplements are only released upon the

written request of providers of medical nutrition therapy.)

Fourteen providers offer this service in the Baltimore EMA. One provider delivers bags of groceries to HIV-positive individuals who are unable to shop for themselves. This delivery service is distinct from the other transportation services that help consumers access non-Ryan White food/grocery programs such as the U.S. Department of Agriculture's Women, Infants and Children (WIC) program.[48]

4.7.4. Medical Transportation.

A lack of adequate transportation directly impacts the ability of Ryan White Part A consumers to adhere to treatment. Although residents of Baltimore City and the communities inside interstate highway 695, "the beltway," have a mass transit system, it lacks sufficient stops, routes and service frequency to accommodate many who require transit services in the area. In the EMA's suburban counties, where public transit options are extremely limited, many Ryan White consumers find it nearly impossible to rely upon mass transit for reaching medical and/or support service appointments.

As a result, medical transportation is among the most demanded of support services by consumers in the Baltimore EMA (IGS 2007:26). It funds transportation services, as needed, to all core medical programs and many support programs. Fourteen providers offer medical transportation services to Ryan White consumers in the Baltimore EMA. Furthermore, disabled consumers that are unable to use fixed-route buses and lift-equipped buses are eligible for the MTA Mobility/Paratransit program. This program, which operates in Baltimore City, Baltimore County and Anne Arundel County, provides curbside service within three quarters of a mile of any fixed-route stop in these three jurisdictions (MTA 2008). Additionally, county health departments coordinate Medicaid funded transportation to medical appointments (Middleton 2008a).

4.7.5. Other Ryan White Part A Support Services Funded in the Baltimore EMA.

Consumers are occasionally confronted with unforeseeable (emergency) situations with respect to their ability to purchase needed resources. Emergency financial assistance (EFA) serves as a critical safety net for consumers by preventing eviction and the loss of utilities, and by helping to pay for medication or emergency transportation. EFA is no longer a stand-alone category in the Baltimore EMA: each discrete service has been rolled into its pertinent service category [e.g., housing, OAHS and medical transportation].)

***Medical transportation** is among the most demanded of services in the Baltimore EMA.*

The final two components of the Baltimore EMA's continuum of care are child care and legal services. Child-care services (formerly under the adult day and respite care service category) are provided in the EMA by Light Health and Wellness Comprehensive Services. Legal services are provided by Chase Brexton Health Services and the University of Maryland Evelyn Jordan Center.

4.8. Monitoring the Continuum.

The Baltimore EMA has a number of processes in place for monitoring the continuum of care to ensure that services provided meet the needs of consumers. The planning council determines the overall continuum of care by identifying and prioritizing the service categories to be funded and the amount of funding to be allocated to each category during its annual

[48] WIC provides federal grants to states for supplemental foods, health-care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk (USDA 2008).

priority setting and resource allocation meeting.

The grantee establishes and monitors Part A provider contracts.[49] Providers are required to supply the grantee with monthly reports on program performance and expenditures. The grantee submits reports to the planning council's Evaluation Committee on the fiscal and programmatic performance of each service category. These reports allow the council to adjust its planned allocations through reprogramming of funds to meet the health and supportive services needs as the HIV epidemic changes in the EMA.

The grantee receives five percent of the total grant award to carry out a clinical quality management (CQM) program. The CQM program looks at how well each service category is performing based on standards of care and public health guidelines. The CQM also provides information on an annual basis that the council can use to evaluate its overall service system.

*The planning council maintains a **fully interactive, on-line directory of service providers,** believed to be the first of its kind in Maryland.*

The CQM program is responsible for conducting a sampling of charts of consumers served by Part A and MAI providers in each service category: reviews of each category are scheduled on a revolving four-year cycle. The CQM team sends a report of its findings to the council's Continuum of Care Committee, which uses the reports in the development of service standards.[50] The committee also oversees the performance of the service categories in meeting the needs of HIV-positive consumers by using CQM reports, expenditure and service delivery reports and the latest implementation plan.

In addition to the CQM, the grantee and planning council are able to monitor the continuum of care through an annual client satisfactory survey (CSS) that is administered to Ryan White consumers. The CSS provides the Maryland AIDS Administration and the Baltimore City Health Department with a means to understand HIV and AIDS clients' experience with the services of agencies funded by the Ryan White program and state general funds in Maryland.

4.9. Conclusion.

The Baltimore EMA has a very rich continuum of care that ensures consumers live stable and healthy lives from diagnosis to death. The range of services not only provides treatment services, but also ensures that consumers have the support to remain in medical care. The Baltimore EMA also has a host of non-Ryan-White resources for consumers, thus enabling Ryan White Part A, the payer of last resort, to continue providing services to those most in need.

While the continuum of care was established to address all the needs mentioned in the previous chapter, it is not without flaws. Fully meeting the needs of Ryan White consumers requiring emergency HIV relief, even on a short-term basis, continues to be a challenge in the Baltimore EMA. The next chapter discusses the barriers to service delivery in the EMA. It is followed by a chapter that outlines the planning council's shared vision and values — elements that form the foundation of the ideal continuum of care.

[49] Prior to FY 2008, the grantee contracted with an administrative entity to perform these functions.

[50] Standards of care, based on HRSA service category definitions, are minimum requirements that must be met by providers receiving Part A and MAI funds to provide service in a given category. The standards of care are the basis for the contracts established by the grantee, and for the subsequent evaluation of provider performance.

Figure 4.1.

Baltimore EMA HIV Service Directory

Source: http://www.baltimorepc.org/v2/main/page.php?page_id=79

4.10. Additional Resources.

The planning council undertook an initiative to make a complete listing of services and service providers in the Baltimore EMA available *via* the Internet. The fully interactive service directory, believed to be the first in Maryland, can be accessed at:

http://www.baltimorepc.org/v2/main/page.php?page_id=79.

POZ magazine also has an extensive on-line service directory of HIV care and services, featuring thousands of organizations nationwide — all searchable by ZIP code, company name, organization type, service provided and groups served. The site may be accessed at http://directory.poz.com.

HRSA has links to services on its web site (http://www.HRSA.gov).

For those without access to the Internet, a full listing of service providers in the Baltimore EMA, by service categories, can be found in appendix A.

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