CHAPTER 6: IDEAL CONTINUUM OF CARE.

6.1. Introduction.

In chapter 4, the Baltimore EMA's current continuum of care was discussed. Recall figure 4.1, the current continuum of care and the corresponding service categories. Chapter 5 presented the barriers — policy, program, provider, and consumer — that challenge the continuum of care. This chapter describes the ideal continuum of care. This ideal continuum ensures that HIV-infected individuals are identified as early as possible through coordination with prevention programs. The continuum should then provide continual access to services as PLWH/As engage, maintain and stabilize themselves in HIV care. The planning council envisions a responsive, balanced system of care that meets the medical, social and supportive needs of PLWH/As. This system is in compliance with U.S. Health Resources and Services Administration guidelines and compliments established national and local strategies and resources.

This chapter addresses what makes the ideal continuum truly ideal, based on HRSA guidance and planning council input. A series of national and local planning documents provide guidance towards building and maintaining an ideal continuum. These plans include:

- National HIV/AIDS Strategy.
- Healthy People 2020.
- Patient Protection and Affordable Care Act.
- Maryland Statewide Coordinated Statement of Need.
- Maryland HIV Prevention Plan.
- Enhanced Comprehensive HIV Prevention Plan.
- Baltimore City HIV/AIDS Strategy, 2011.
- 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. In addition, innovative and successful models of care are discussed. Examples of these models include patient-centered medical homes, a hub/spoke model, and community-engagement model utilized by HIV service providers in the Baltimore EMA.

6.2. What Is Ideal?

The Institute of Medicine of the National Academies, Committee on the Public Financing and Delivery of Health Care has stated that the ideal system must ensure the following:

> Early and continuous access to an appropriate, comprehensive set of medical and ancillary services that meet the standard of care; promotion and/or delivery of high quality services; minimal administrative costs for payers and providers and a minimal duplication of effort and accountability for meeting established standards of treatment and health outcomes for all eligible individuals (IOM 2005:15).

Continuous access to comprehensive medical and support services that meet quality care standards is an essential component of the ideal system. Based on guidance from HRSA and planning council input, the 2012-2015 comprehensive plan contains updated goals for planners and providers of HIV prevention and care services.

6.2.1. HRSA Guidance.

HRSA, within the U.S. Department of Health and Human Services, oversees funding and programming for EMAs and planning councils. In this capacity, HRSA provides guidance to EMAs. HRSA published the *Guide for HIV/AIDS Clinical Care* in January 2011 (HRSA 2011). This manual was developed to provide HIV/AIDS clinicians with the information they need to provide quality care to PLWH/As. Topics include: clinic management; testing and assessment; CD4 monitoring and viral load testing; prevention; treatment; and how to address co-morbidities, co-infections, complaints, and other complications that arise from treating patients with HIV and AIDS (HRSA 2011).

Aside from medical expertise and clinical support, HRSA provides the EMA with technical assistance to implement an effective HIV program, manage reporting requirements, clarify Ryan White legislation, and other resources. This assistance helps the grantee and planning council execute a successful continuum of care that is in compliance with grant requirements.

6.2.2. Planning Council's Vision.

The vision of the Baltimore HIV planning council 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 ensuring that the needed services are developed and sustained to keep pace with the HIV epidemic.

Planning council chair Carolyn Massey remarks "the looming sunset of the Ryan White legislation, the implementation of the Affordable Care Act, and the transition of Ryan White patients to Medicaid are all factors with far-reaching outcomes that will challenge us to strive for the best possible solution for the community that we represent" (IGS 2011d).

The planning council's vision for Ryan White Part A service delivery in the EMA incorporates many elements. It includes a combination of HRSA guidance, as well as the national and local plans that are detailed in sections 6.3 through 6.9.

6.3. National Strategy.

On July 13, 2010, President Obama and the White House released the National HIV/AIDS Strategy. The vision of the NHAS is:

> The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination (ONAP 2010).

6.3.1. NHAS Goals.

The NHAS has four primary goals:

- Reducing new HIV infections.
- Increasing access to care and improving health outcomes for people living with HIV.
- Reducing HIV-related disparities and health inequities.
- Achieving a more coordinated national response to the HIV epidemic.

The NHAS urges the United States to take bold action in the face of rising infections and health care costs to serve PLWH/As and their families (ONAP 2010).

6.3.1.1. One: Reducing New Infections.

To reduce new HIV infections, three steps have been identified to strengthen prevention efforts and reduce incidence. First, intensify prevention efforts in communities where HIV is most heavily concentrated. Second, expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches. Third, educate all Americans about the threat of HIV and how to prevent it. With these measures in place, the NHAS anticipates that by 2015 the annual number of new infections will be decreased by 25 percent (ONAP 2010).

6.3.1.2. Two: Increasing Access.

The second goal of the NHAS encourages the nation to expand approaches to connecting people

to services and keeping them in care. The NHAS recommends a seamless system be established to immediately link people to continuous and coordinated quality care upon diagnoses with HIV. Deliberate steps should be taken to increase the number and diversity of available providers of clinical care and related services. Support should be available for PLWH/As with co-occurring health conditions and those who have challenges meeting their basic needs, such as food security. These steps aim to increase the proportion of newly diagnosed patients link to clinical care within three months from 65 percent to 85 percent; increase the proportion of Ryan White clients who are in continuous care from 73 percent to 80 percent; and increase the Ryan White clients with permanent housing from 82 to 86 percent (ONAP 2010).

6.3.1.3. Three: Reduce Disparities.

HIV incidence and prevalence have been — and continue to be — concentrated in populations that have been marginalized and underserved by the health-care system. The third goal of the NHAS attempts to improve a health-care system where different groups have divergent access to services and achieve unequal health-care outcomes. The NHAS proposes three steps to do this. First, reduce HIV-related mortality in communities at high risk for HIV infection. Second, adopt community-level approaches to reduce HIV infection in high-risk communities. Third, reduce stigma and discrimination against people living with HIV. The NHAS expects that the proportion of gay and bisexual men, blacks, and Latinos with an undetectable viral load will increase by 20 percent (ONAP 2010).

6.3.1.4. Four: Coordinated Response.

In order for the NHAS to be successful, coordination of activities across agencies of all levels must be a priority. The NHAS supports increased coordination of HIV programs between federal, state, territorial, local and tribal agencies and governments. Mechanisms must be developed to monitor and report on progress toward achieving national goals (ONAP 2010).

6.3.2. NHAS and the EMA.

The Baltimore EMA has taken great care to incorporate the NHAS into this comprehensive plan and the ideal continuum of care. Many objectives and strategies in this strategic plan are modeled after the NHAS.

6.4. Healthy People 2020.

For the past 30 years, Healthy People, an HHS initiative, has produced an evidence-based, national framework for public health prevention priorities and actions. Healthy People 2020 was launched on December 2, 2010. New 10-year objectives have been created that set an agenda and establish benchmarks to promote a society in which all people live long, healthy lives (HHS 2011). The mission of Healthy People 2020 is to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation and data collection needs (HHS 2011).

Healthy People 2020 identified 28 topic areas that span a variety of health issues, from cancer, to food safety, to oral and sleep health. Each topic has an overview, objectives, data and a resources discussion.

6.4.1. Healthy People 2020 Goals.

Healthy People 2020 has four overarching goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death.
- Achieve health equity, eliminate disparities and improve the health of all groups.

- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages (HHS 2011).

HIV is one of the topic areas identified by Healthy People 2020. Eighteen different objectives are listed in four areas: diagnosis of HIV infection and AIDS; death, survival and medical health care after diagnosis of HIV infection and AIDS; HIV testing; and HIV prevention. The full list of HIV objectives, with targets, baseline data, and date sources is available in appendix C.

6.4.2. Healthy People 2020 and the EMA.

Integrated within the ideal continuum of care are concepts and objectives from Healthy People 2020. The emphasis that Healthy People 2020 places on prevention is evident since prevention is the first goal in the Baltimore EMA's continuum of care.

Healthy People 2020 Objective 16 is to increase the proportion of substance-abuse treatment facilities that offer HIV/AIDS education, counseling and support. Objective 17 is to increase the proportion of sexually active persons who use condoms. Objective 18 is to decrease the proportion of men who have sex with men who reported unprotected anal sex in the past year. These objectives are incorporated into the EMA's strategic plan in chapter 7.

Medicaid eligibility will be expanded so that PLWH/As will not have to become sick and disabled before they are eligible for coverage.

The continuum of care utilizes HIV testing objectives from Healthy People 2020. These objectives are to increase the proportion of PLWH/As who know their serostatus and increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months. Routine and targeted testing strategies within the EMA aim to meet these objectives.

6.5. ACA Law.

The Patient Protection and Affordable Care Act, signed into law on March 23, 2010 and the Reconciliation Act of 2010, signed into law on March 30, 2010 are the nation's health-care reform laws. ACA expands health insurance and will increase the health-care outcomes of PLWH/As, assuming it is not struck down by the U.S. Supreme Court in summer 2012. The Congressional Budget Office (CBO) estimates that ACA will reduce the number of uninsured by 32 million people and reduce the deficit by $124 billion by 2019 (Kaiser 2011).

An individual mandate will encourage people to enroll in coverage. Health insurance exchanges are being set up to make it more affordable for individuals, families and small businesses. New regulations and protections have been established to prevent health insurers from denying coverage and charging what some consider to be unfair premiums (Kaiser 2011).

6.5.1. ACA Goals.

The implementation of ACA will mitigate a number of barriers to care (discussed in chapter 5). Additional protections will help PLWH/As obtain health insurance.

6.5.1.1. Improve Access to Coverage.

Insurers will no longer be able to deny coverage to people for any reason, including those who live with HIV or AIDS (Kaiser 2011). There will no longer be lifetime caps or annual limits on insurance benefits (HHS 2010). Insurers will not be permitted to cancel or rescind coverage, except in cases of fraud. Medicaid will be expanded to cover people who are within 133 percent of the federal poverty level (Kaiser 2011). The Medicare Part D donut hole, described in section 5.3.2, will be phased out and ADAP payments will be considered contributions to individuals' true-out-of-pocket costs.

These changes will improve access to health insurance for PLWH/As (HHS 2010). Medicaid eligibility also will be expanded so that PLWH/As

do not have to become sick and disabled before they are eligible for coverage. Additionally, prescription drugs will be made more affordable, relieving PLWH/As of a large financial burden.

6.5.1.2. Ensuring Quality Coverage.

ACA ensures quality coverage by giving patients access to the information they need to make coverage decisions. Health insurance plans will be required to provide information in a user-friendly way, clearly explaining what is and is not covered. Comprehensive care will be guaranteed, as the new law requires a comprehensive benefit package (HHS 2010). Services that are particularly beneficial to PLWH/As will include prescription drugs, chronic disease management, substance-abuse treatment, and mental health treatment.

Insurance plans will cover recommended preventive care to help patients stay healthy (HHS 2010). ACA makes coordinated, integrated care a priority with investments in patient-centered medical homes. These homes are an effective way to strengthen the quality of care, especially for PLWH/As that need treatment for co-morbidities in addition to their complex, chronic HIV care (HHS 2010).

6.5.1.3. Increasing Wellness.

The new laws promote prevention and wellness, and require insurance plans to offer coverage for HIV screening tests for at-risk individuals (HHS 2010). ACA supports cultural competency training for all providers. These initiatives aim to ensure that all populations are treated equally, helping to reduce health disparities (HHS 2010). PLWH/As will benefit from provider cultural-competency training, as incidence and prevalence burdens fall heavily on racial and sexual minorities.

ACA expands the health-care workforce by increasing the number and diversity of providers and increasing funding for community health centers (HHS 2010). The JACQUES Initiative, a program at the Institute of Human Virology at the University of Maryland School of Medicine, is instrumental in providing training to volunteers and students to expand the health-care workforce. Training and continuing education are provided to students in health-care disciplines, as well as to faith-based and community-based volunteers to increase their capacity to diagnose HIV and link PLWH/As to care (Mignano 2012).

6.5.2. ACA and the EMA.

The increase in PLWH/As that will be eligible for Medicaid will affect how Ryan White services are delivered in the EMA. As ACA is implemented over the next several years, the EMA must remain flexible and responsive to the changes in policy, health-care finance and service delivery.

The ACA requires that states establish health insurance exchanges by January 1, 2014. Maryland's health benefit exchange will allow individuals and businesses in Maryland to compare rates, benefits, and quality among plans to identify and enroll in insurance plans that best suit their needs (DHMH 2012a).

The exact structure and how the exchanges are operationalized will depend on future legislation at the state and federal levels.

The federal government is allowing states to make state-specific decisions about their health exchanges. In preparation for implementation, the Maryland exchange will hire initial staff, establish advisory committees, and analyze key strategic decisions in 2012. Key decisions include whether to create a separate exchange for the small-group market, whether to engage in selective contracting, how to design the navigator program, and marketing decisions. Additional questions, such as how to build upon existing resources in the state (including insurance producers, third-party administrators, health care advocates, and other relevant entities), are being explored by the state legislators (DHMH 2012a).

The exact structure and how the exchanges are operationalized will depend on future legislation at the state and federal levels. As of May 2012, several bills responded to the ACA legislation. The Maryland Health Benefit Exchange Act of

2012 (SB 238/HB 443) defines the broad structure and regulation of the exchanges (LWVMD 2012). Maryland moved forward with health exchanges regardless of national policies by passing this bill. In addition, the Maryland Health Improvement and Disparities Reduction Act (SB 234/HB 439) passed and will set up Health Empowerment Zones in areas where there are health care shortages (LWVMD 2012).

Part of the state's decision will be what the basic health benefits of the exchanges will include. These are referred to as "essential health benefits." It is undecided yet as to what services will be covered and how they will coordinate with Ryan White to maintain the continuum of care. It is critical that services such as oral health and other non-primary medical care services are covered under Medicaid and/or the exchange, otherwise Ryan White funding will be the only payer of these services for public-insurance consumers.

It is likely that at the federal level, the U.S. Centers for Medicare and Medicaid Services (CMS) will provide regulations regarding how Medicaid will expand to cover additional populations by the end of 2012. Medicaid will then be the foundation all other grants and funding streams will complement. This means that states — including Maryland — will have the 2013 legislative session to move policy forward to meet the implementation deadline of January 1, 2014 (DiPietro 2012).

The associate director of the University of Maryland Institute of Human Virology, Dr. William A. Blattner, believes that different service models may be needed to accommodate the high quality services provided by Ryan White funds in the light of ACA and health exchange implementation. Dr. Blattner recommends that the planning council work closely with the state to determine the best way to fund and provide for services within the new landscape of health-insurance exchanges (Blattner 2012). Additional training and innovative structures may be needed to align the Baltimore EMA with ACA implementation goals.

6.6. Statewide Coordinated Statement of Need.

The Statewide Coordinated Statement of Need is a Ryan White Part B requirement mandated by the 2006 Ryan White legislation. The purpose of the SCSN is to serve as a mechanism to address key HIV/AIDS issues. The SCSN identifies emerging trends, special populations, and service needs and barriers. More details about the development and key findings of the SCSN can be found in sections 3.5.2 and 3.5.3.

The ideal continuum of care takes into account the service needs and barriers identified in the SCSN. The SCSN helps to build a cohesive strategic plan through coordinating action across Ryan White programs and parts across Maryland (DHMH 2009).

6.7. State HIV Prevention Plan.

HIV prevention activities in Maryland are guided by the HIV prevention goals and priorities developed by the Maryland Community Planning Group (CPG). HIV prevention activities in the Baltimore/Towson EMA are further informed by the Central Regional Advisory Committee (RAC), one of five regional planning groups which examine HIV prevention and care needs in each of Maryland's regions.

The CPG and RAC are comprised of PLWH/As, members of affected communities, advocates, health departments, community-based organizations, and other stakeholders. IDEHA also partners with the Baltimore Commission on HIV/AIDS, the Anne Arundel Commission on HIV/AIDS and the planning council to collect community input and develop HIV prevention strategies for the Baltimore/Towson EMA (DHMH 2012b).

In partnership with the HIV planning bodies described above, IDEHA developed and in spring 2012 released the Maryland HIV Prevention Plan, which describes the epidemiology of HIV/AIDS in Maryland, and statewide HIV prevention

priorities. The plan identifies populations for priority attention based on HIV and AIDS surveillance data, relevant behavioral literature, and community input. The state's current HIV prevention priority populations are: HIV-positive persons, men who have sex with men (72 percent African-American), heterosexuals (83 percent African-American), injection drug users (86 percent African-American), and special populations at elevated risk for HIV (African immigrants, deaf persons, Hispanics, and transgender persons). Within each risk group, Blacks are emphasized, given the disproportionate impact of HIV on this group (DHMH 2012b).

6.8. Enhanced Comprehensive HIV Prevention Plan.

In September 2010, the Maryland Department of Health and Mental Hygiene received funding from the Centers for Disease Control and Prevention's Division of HIV/AIDS Prevention to develop an Enhanced Comprehensive HIV Prevention Plan (ECHPP) for the Baltimore/Towson metropolitan statistical area (MSA). The MSA includes the same jurisdictions and population as the EMA.

6.8.1. ECHPP Goals.

ECHPP seeks to identify and implement the optimal combinations of prevention, care and treatment activities to: maximally reduce new infections; address gaps in current HIV prevention strategies and coordination of HIV prevention, care and treatment services; and recommend activities to strengthen and refocus current efforts (DHMH 2011a).

The development of the Baltimore/Towson ECHPP included collaboration with public health and community stakeholders throughout the MSA, including the seven local health departments and five HIV/AIDS community planning bodies (the Maryland HIV Prevention Community Planning Group, the Central Regional Advisory Committee, the Greater Baltimore HIV Services Planning Council, the Baltimore City Commission on HIV/AIDS, and the Anne Arundel County Commission on HIV/AIDS) (DHMH 2011a).

In addition to engaging external stakeholders, IDEHA convened an internal workgroup composed of HIV and STI prevention, care/treatment, and surveillance staff to conduct collaborative planning for the MSA. IDEHA partnered with stakeholders to assess and describe the current level of implementation for each of the 24 required and recommended interventions, including data on program funding, activities, reach and outcomes (DHMH 2011a).

IDEHA also collaborated with Dr. David R. Holtgrave, chair of the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health, to conduct resource optimization modeling to inform the allocation of current resources and quantify the additional resources that would be needed to reach the prevention goals of the NHAS (DHMH 2011a).

6.8.2. ECHPP and the EMA.

The findings of Dr. Holtgrave's modeling indicate that there are currently insufficient resources to meet the NHAS HIV prevention goals in the Baltimore/Towson MSA. However, strategic redirections of current resources could significantly increase the number of infections averted and lower transmission rates. Specifically, interventions that increase knowledge of serostatus, increase linkage and adherence to HIV medical care, and decrease risk behaviors among PLWH/As would have the greatest impact on reducing new HIV infections (DHMH 2011a). The assessment of current prevention programming indicated that prevention services are not being sufficiently targeted to high-risk persons in the Baltimore/Towson MSA. Of particular note were

ECHPP seeks to identify and implement the optimal combinations of prevention, care, and treatment activities to maximally reduce new infections.

the low numbers of MSMs served by current HIV-prevention programs (DHMH 2011a).

Based on these findings and the assessment of current programming, the Baltimore/Towson ECHPP describes plans to increase implementation of the following interventions/public health strategies:

- Routine HIV screening in clinical settings.
- Targeted HIV testing in non-clinical settings.
- Initial and ongoing HIV/STI partner services.
- Activities to support linkage to care, retention in care.
- Adherence to antiretroviral treatment.
- Risk reduction interventions for PLWH/As.

In order to increase these interventions, resources for behavioral interventions for HIV-negative persons will be decreased and redirected (DHMH 2011a).

Across all prevention interventions, effective targeting is an essential component in maximizing the impact of HIV prevention interventions, by ensuring that programs serve those at the greatest risk of transmitting or acquiring HIV. IDEHA is partnering with local health departments in the Baltimore/Towson MSA to improve program targeting through increased utilization of local HIV and STI surveillance data and to develop specific implementation plans for each jurisdiction based on the local epidemiology. These plans will focus available resources to achieve the goals of preventing new infections and ensuring PLWH/As are aware of their serostatus and linked to HIV medical care, prevention and support services (DHMH 2011a).

Partnering is key to the success of ECHPP and a major component of the Baltimore/Towson ECHPP is significantly increasing partnerships across funding sources and with private providers to ensure effective coordination of services and leverage additional resources. See chapter 8 for more information regarding partnering and collaboration initiatives.

6.9. Local Plans.

Aside from the national and regional plans that inform the ideal continuum of care, several local plans provide guidance and collaborative support. Baltimore City, the jurisdiction most heavily impacted by the HIV/AIDS epidemic in the EMA, has an active health department that provides leadership and support to all of the surrounding counties.

6.9.1. Baltimore City HIV/AIDS Strategy.

Baltimore City is continually ranked one of the most HIV-affected urban areas in the country, as evidenced by the data in chapter 2. Therefore, a "Baltimore City-centric" plan was thought to be needed by many. In consequence, during the early 2000s, BCHD twice started devising a city-specific prevention plan. In 2010, the project was completed on behalf of the Baltimore City Commission on HIV Prevention and Treatment by InterGroup Services, the planning council's support office contractor. The resulting *Moving Forward — Baltimore City HIV/AIDS Strategy, 2011* was released in September 2011 (IGS 2011c).

6.9.1.1. Baltimore City Strategy Goals.

The Baltimore City HIV/AIDS Strategy (BCHAS) is a framework for excellent and innovative planning, prevention, care and treatment in Baltimore City. This strategy is a result of collaboration between the Baltimore City Commission on HIV/AIDS Prevention and Treatment, BCHD, DHMH and other partners.

The BCHAS is a local adaptation of the NHAS that reflects the specific needs, strengths and challenges of Baltimore City (IGS 2011c). The plan will help Baltimore City maximize its ability to access and effectively implement all resources available (BC 2011).

6.9.1.2. City Strategy and the EMA.

The BCHAS created an implementation table that used SMART goals — specific, measurable, attainable, realistic, and time-bound — for agencies within Baltimore to achieve (IGS 2011c).

Each goal within the NHAS was parsed out into smaller sub-goals with specific actions to be performed, a lead agency, and timeframe. This comprehensive plan incorporates many of these BCHAS goals.

6.9.2. Healthy Baltimore 2015.

Under the leadership of Baltimore City Health Commissioner Oxiris Barbot and Mayor Stephanie Rawlings-Blake, BCHD and the Office of the Mayor released a comprehensive health-policy agenda in May 2011, called *Healthy Baltimore 2015*. The plan highlights 10 priority areas with 36 specific measures that have the largest impact on reducing morbidity and mortality and improve the quality of life for Baltimore City residents (Spencer *et al.* 2011). The plan sets ambitious yet reachable goals for reducing high rates of disease, infections and addictions among city residents.

6.9.2.1. Healthy Baltimore 2015 Goals.

The 10 priority areas of *Healthy Baltimore 2015* are to:

- Promote access to quality health care for all.
- Be tobacco free.
- Redesign communities to prevent obesity.
- Promote heart health.
- Stop the spread of HIV and other sexually transmitted infections.
- Recognize and treat mental health needs.
- Reduce drug use and alcohol abuse.
- Encourage early detection of cancer.
- Promote healthy children and adolescents.
- Create health-promoting neighborhoods (Spencer *et al.* 2011).

Healthy Baltimore 2015 aims to decrease the number of new HIV infections by 25 percent. The plan recognizes the relationship between STI and HIV transmission. It aims to decrease total syphilis cases by 25 percent and decrease adolescent cases of gonorrhea and chlamydia by 25 percent (Spencer *et al.* 2011).

Efforts to address the HIV epidemic require attention to the role that social factors such as poverty, educational attainment, substance abuse, and health literacy play in shaping health opportunities and avoiding premature death. Focusing on these underlying social factors in Baltimore City will augment preventive public health and medical interventions (Spencer *et al.* 2011).

6.9.2.2. Healthy Baltimore and the EMA.

"Where we live, work, and play has as much to do with keeping us healthy as making us sick. Healthy Baltimore is not about what the city Health Department is doing, it's more about what community groups and institutions can do along with the city," says city health commissioner Barbot (Cohn 2011). As a result, BCHD will partner with nearly every community in Baltimore, including medical institutions, neighborhood associations, businesses, non-profits, schools, and faith organizations. (BCHD 2011). A new office of policy and planning has been created. The director will help oversee goals and document and report results every five years (Cohn 2011).

Efforts to address the HIV epidemic require attention to the role that social factors such as poverty, educational attainment, substance abuse, and health literacy play in shaping health opportunities and avoiding premature death.

BCHD encourages partners to contribute to the success of Healthy Baltimore in several ways — communication, facilitation and integration (BCHD 2011). Partners communicate positive health messages by displaying and/or distributing health information materials. They can facilitate a healthy Baltimore by actively participating in interventions such as incorporating wellness at work programs into the business day. Integrating health and healthy approaches in daily life and business is key. Partners should actively consider the potential health impacts of pending business and policy decisions (BCHD 2011).

6.10. Actual v. Ideal.

In the absence of unlimited funding and perfect information, the actual continuum of care differs from the ideal continuum. It is important to review the progress, successes and challenges encountered in the past to adapt to the forecasted policy changes. A contingency plan is also an important function of a sustainable continuum.

6.10.1. Evaluation of 2009-2011 Plan.

A critical step in moving forward in the creation and implementation of the comprehensive plan is to review the previous plan — the *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2009-2011*. An honest review of the progress made is necessary to build the 2012-2015 plan.

6.10.1.1. Progress.

The *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2009-2011* put a focus on collaboration. Conversations with MedChi,[15] the Baltimore housing department, the Housing Opportunities for Persons with AIDS program (HOPWA), the Maryland Department of Health and Mental Hygiene, the Maryland Department of Public Safety and Correctional Facilities, and Ryan White providers were held or are in progress.

The *Greater Baltimore HIV Health Services Planning Council Consumer Survey, Baltimore EMA, 2010* was released in 2011, along with other assessments of need discussed in chapter 3. These important evaluations inform the planning council of the various program, policy, medical, and support service needs of PLWH/As in the EMA. By completing continuous assessments, a comprehensive picture of need in the Baltimore EMA can be developed and utilized by planners.

Other management tools used in the last period include Clinical Quality Management (CQM) reports and service category scorecards. These tools, in conjunction with the assessment of the administrative mechanism, work to ensure that the administration of Ryan White Part A services are efficient and easy for clients to navigate (IGS 2011a). The EMA is making excellent progress in making sure consumers know what services are available to them and how to access these services.

6.10.1.2. Successes.

The planning council and Part A partners had success in targeting high-incidence areas by ZIP code. Epidemiology profiles and reports contain ZIP code data to direct resources and services to highly affected neighborhoods (DHMH 2011b). Outreach standards of care also have been revised to include geographic targeting as a directive.

Over the past three years, many service category standards of care have been revised and ratified by the planning council. In 2011, case management standards of care were reviewed. In 2010, housing, outreach, medical transportation, child care, and oral health were reviewed. In 2009, food bank and home-delivered meals, health-insurance premiums and cost sharing, hospice services, medical case management, medical nutrition therapy, mental health services, outpatient ambulatory health services adult primary care, and psychosocial support were reviewed. As a result, the language in requests for proposals and subsequent contracts was revised to match the updated standards of care and any associated directives (IGS 2010).

The planning council and Part A partners have utilized innovative ways to identify and provide services to underserved PLWH/As. All expenditure and service delivery reports from BCHD include the number of WICY (women, infants, children, youth) and African-American clients served. Creative programs such as SMILE, STAR TRACK (Special Teens at Risk, Together Reaching Access, Care and Knowledge), and other outreach and case-management programs provide specialized, targeted, and intensive services to hard to reach populations to keep them engaged in care (see chapter 4).

[15] MedChi, is the Maryland State Medical Society, a non-profit organization whose goal is to serve as an advocate and resource for physicians, patients and public health in Maryland (originally the Medical and Chirurgical Faculty of Maryland).

The usage of client-level data helps track clients that may have fallen out of care and alert providers when partner notification services are required. The unique client identifier (UCI) is compared against the Ryan White client-level data set to confirm that the person is not in any primary care (BCHD 2010). Additionally, baseline data for many variables across the continuum of care have been identified since 2009.

Through priority setting and resource allocation for FY 2010, 2011 and 2012, the planning council successfully ranked, prioritized and allocated resources to service categories throughout the EMA. During the PSRA preparation process and associated data presentations (see section 9.6.4), planning council members are able to monitor trends within service categories (IGS 2011b). The on-line service category scorecards produced by the planning council support office enable the planning council to evaluate cost efficiency by monitoring average unit and client costs for each service category (see chapter 9 for more information on scorecards).

Collaboration with Ryan White Part D partners has been a highlight of the past few years. Best practices have been discussed to transition youth into adult care (Abraham 2011). The planning council receives reports on youth projected to be entering adult care.

6.10.1.3. Challenges.

Despite all of the success the planning council has made over the past three years, there are still areas that have room for improvement. Identifying PLWH/As that are unaware of their status or not in care is a challenge in the EMA. The Early Identification of Individuals with HIV/AIDS (EIIHA) and Enhanced Comprehensive HIV Prevention Plan (ECHPP) initiatives are projected to strategically improve testing and linkage to care programs in the EMA.

Data collection and reporting have been a challenge to providers and planners. In an ideal world, providers would have the resources to collect any and all variables that health departments and planning bodies would like to track and analyze. Moreover, all of these data could be easily accessed and shared by the health-care team. This, however, is not the reality. The planning council recommends streamlining and centralizing variables, reporting requirements, and data systems used collect and share data. This will help tracking clients through the continuum of care.

Barriers to care still exist within the EMA, as elaborated on in chapter 5. Ideally, the provisions in the Affordable Care Act will help alleviate some of the policy and program barriers. Social networking initiatives and other programs are being implemented to help mitigate some of the barriers created by stigma and discrimination.

Collaborating with other EMAs and utilizing other funding streams is an important step forward — especially with uncertain budgetary constraints.

Technical assistance from HRSA and the CQM program is continual throughout the year. Part A partners are looking to evaluate and consider new best practices in providing services to PLWH/As. Collaborating with other EMAs and utilizing other funding streams is an important step forward — especially with uncertain budgetary constraints. Improved payment practices through the health exchanges, Medicaid and Medicare to all service providers would further reduce funding burdens.

6.10.2. Funding Delays and Decreases.

Global, national and local economies have been volatile over the past few years, making planning for HIV services difficult. Delays in the federal budget have caused instability nationwide. Fiscal 2011 was noteworthy in this respect. Incorrect (and subsequently revised) awards were made by HRSA by some EMAs, including Baltimore. Such confusion can then lead to grantee delays in making final subgrantee awards and processing payments. The summer 2011 assessment of the administrative mechanism in Baltimore revealed that some agencies needed to suspend or decrease services, could not take new patients, or

established waitlists as a result of budget delays and cuts (IGS 2011b).

6.10.3. Contingency Plan.

As a result of funding delays and decreases, part of the upcoming strategic plan is to incorporate contingency plans. Each Part A partner and government agency should develop a plan of action to follow in the event that further budget cuts occur.

6.11. Ideal Care Models.

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, and a community-engagement model. PLWH/As have had success when local providers such as Chase Brexton, the JACQUES Initiative and Health Care for the Homeless have utilized these models.

6.11.1. Patient-centered Medical Homes.

Patient-centered medical homes (PCMHs) are a model of care where patients have a direct relationship with a primary care provider (PCP). The PCP coordinates a cooperative team of health-care professionals, takes collective responsibility for the care provided to the patient, and arranges for appropriate care with other qualified providers as needed (Ndirangu 2012). PCMH programs, coordinated by the Maryland Health Care Commission, accept Medicaid managed care organizations' payments (MHCC 2012).

Benefits of a PCMH include improved quality, reduced costs and improved patient experience. PCMHs emphasize care that is innovative, integrated, client-focused, multi-disciplined, culturally sensitive, and which provides wraparound services (Ndirangu 2012). PCMHs provide opportunities to sustain and expand HIV care under health care reform while integrating HIV/AIDS care, treatment, and providers into broader health-care systems (Ndirangu 2012).

The National Center for Quality Assurance identifies and recognizes medical practices that demonstrate standards for PCMH. Training is available to help health centers and providers meet the criteria and provide the elements of care to be considered a PCMH. Grants are available to help health centers develop and implement a medical home model (Ndirangu 2012).

Chase Brexton, a Baltimore City based community health center, utilizes the patient-centered medical home model. It has developed a "pod" based system, where patients stay in one room, and the health care team rotates to see them. The health-care team includes — but is not limited to — the HIV specialist physician, medical case manager, dietitian, mental health specialist, peer advocate, substance abuse counselor, dentist, etc. This model has been successful and clients benefit from co-located services and integrated care (IGS 2012).

6.11.2. Hub/Spoke Model.

William Blattner, chair of the Baltimore City Commission on HIV/AIDS Treatment and Prevention and the associate director of the Institute of Human Virology at the University of Maryland School of Medicine, envisions that stable patients may receive the majority of their care at community health clinics (spokes) so that HIV specialists (hubs) may increase capacity to see the sickest PLWH/As with the most intense needs (Blattner 2012). As the current United States health-care system continues to grow and change, alterations to Medicare and Ryan White may lessen the ability of larger clinics to provide necessary holistic HIV/AIDS care to each patient. In the Baltimore EMA, smaller community health centers may act as spokes by providing care in a known and inviting environment for local consumers while being able to use to the renowned medical institutions as hubs for complex treatment support (Blattner 2012, Kennedy 2012).

The hub/spoke model has been used in several venues. In the United States, the hub/spoke model has been piloted for specific treatments, usually for stroke or cardiovascular care (White 2008; Schwamm *et al.* 2009; Boden, Eagle and Granger

2007; Demaerschalk *et al*. 2010; Hess *et al.* 2005). Typically in the form of "telemedicine," outlying spokes are able to immediately communicate with specialists at the hub (Demaerschalk *et al.* 2010, Hess *et al.* 2005, Activase 2012, Systems One 2012).

The hub/spoke model, in addition to providing easily accessible care to PLWH/As, provides benefits from linking high-level experts with local health care workers who have a greater understanding of the community (Blattner 2012, Kennedy 2012, Halvorson 2009). This model allows community health care workers to increase their medical knowledge and continue their medical education from large medical institutions. Spoke clinics may connect to the "hub hospitals for the purposes of basic medical training and support for the spoke clinicians and workers, technical support, and a referral system for spoke patients who will need more intense or unusual care at the hub" (Kennedy 2012).

Internationally, the hub/spoke model has been used successfully. In Australia, the model has been used to provide primary health care in rural areas (Wakerman *et al.* 2008). The hub-and-spoke model may allow for better development of health policies and programs, better enforcement of health related laws, and greater evaluation capacity (Collins 2011). The model has been integrated into HIV/AIDS care through the United States President's Emergency Plan for AIDS Relief (PEPFAR) program in Nigeria (Scaling Up 2010, OGAC 2010, PEPFAR 2010).

6.11.3. Community Engagement.

The JACQUES Initiative program is designed to provide a holistic care delivery model that provides long-term treatment success for urban populations infected with HIV. Operated out of the Institute of Human Virology at the University of Maryland School of Medicine, the focus is a "journey to wellness." The program provides early intervention services through activities such as testing, outreach and linkage to care, medical and support services (Mignano 2012, Spencer 2012).

The JACQUES Initiative utilizes a community engagement model to decrease the morbidity and mortality associated with HIV illness by creating safe places throughout the community to talk about HIV and link people living with HIV to a comprehensive continuum of care. The community is broadly defined to include the faith, arts, entertainment, business, civic, social, academia/education, health, and media communities (Mignano and Spencer 2011). The HIV technical experts are health care providers in an academic institution, community based organization, health clinic, or hospital. State and regulatory agencies such as IDEHA and the county and city health departments complete the model (Mignano 2012, Spencer 2012). In this community engagement model, patients are linked to an effective hub — the HIV technical expert — to access a comprehensive continuum of care. All of the outreach provided links the PLWH/As back to the hub that offers holistic services.

Using this approach, Project SHALEM was implemented in 2009 through a phased approach. In phase 1, this model was used to train volunteers from the faith-based community to implement HIV testing and linkage to care with supervision by the JACQUES Initiative. Phase 2 involves partnership with the University of Maryland Schools of Medicine and Nursing to normalize, routinize and integrate HIV testing and linkage to care into the clinical practice of future health professionals (Spencer *et al.* 2011b).

University of Maryland medical and nursing students and faculty have been part of a multi-disciplinary didactic and hands-on curriculum that aims to train future health professionals to integrate HIV testing and linkage to care into their clinical practice. By May 2012, a total of more than 100 students will have participated in the program in addition to over 500 volunteers to provide HIV testing and linkage to care to over 5,500 people through one-day events and 12 sustainable sites in health care settings and the community (Mignano 2012, Spencer 2012).

6.11.4. Wellness-centered Model.

Health Care for the Homeless provides services within a holistic wellness model. Part of its philosophy includes the idea that the most vulnerable populations may need multiple services (ideally in one location) to be well. These services may consist of services for acute issues like substance abuse, HIV/AIDS, mental health, social issues, and homelessness. Chronic issues, however, need to be concurrently addressed. These include maintenance for the acute conditions and treatment for additional chronic diseases (Lindamood 2012, Treherne 2012, DiPietro 2012).

By addressing co-occurring problems, the root cause of many of them may be found and addressed as well.

Health Care for the Homeless strives to integrate services to create a foundation of wellness for its clients. As opposed to providing disease-centric or issue-specific services, the organization has created a place where a consumer may receive services for any of his or her health-related needs. By addressing co-occurring problems, the root cause of many of them may be found and addressed as well. This model suggests that data sharing, service partnering, and resource sharing may be needed across services for vulnerable populations to best treat them (Lindamood 2012, Treherne 2012, DiPietro 2012).

6.12. Conclusion.

The balanced and continued participation of providers, consumers and government agencies continues to define the ever-evolving continuum of care. Established plans such as the National HIV/AIDS Strategy, Healthy People 2020, the Patient Protection and Affordable Care Act, the Maryland Statewide Coordinated Statement of Need, Enhanced Comprehensive HIV Prevention Plan, the Baltimore City HIV/AIDS Strategy, and Healthy Baltimore 2015 have been instrumental in the Baltimore EMA's ideal continuum of care.

Particularly in the Ryan White environment, the participation of the patient as a care partner is an important element in the successful management of disease. Engaged patients who are actively involved in understanding their illness and making decisions about treatment are more likely to follow their medical plan and have better health outcomes.

Although consumers have a unique view of the service delivery system based on their experiences, consumer participation is not enough. Many PLWH/As are less acquainted with the constraints of providing highly demanded services within fiscal realities of competing local, state and federal priorities, with limited public funding (taxes).

The next chapter will outline the council's specific goals, objectives and strategies to address the epidemic in the Baltimore EMA based on the information presented previous six chapters:

- Demographics and social indicators in the EMA.
- Epidemiology of the epidemic in the EMA.
- Needs of PLWH/As in the EMA.
- Current continuum of care.
- Barriers to care.
- Ideal continuum of care based on HRSA guidance, national, local, and regional strategies.

The diverse composition of the planning council includes the perspective of consumers, providers, and representatives of government agencies. The ideal continuum, as envisioned by the Baltimore EMA and described in this chapter, includes an appropriate balance of all three perspectives.

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