



# **Maryland Department of Health & Mental Hygiene**

**Prevention and Health Promotion  
Administration**

## **2012-2014 Maryland HIV Plan**

**Comprehensive HIV Plan  
Statewide Coordinated Statement of Need  
Maryland HIV Prevention Plan**

**September 2012**

# Contents

- Executive Summary..... 4
- Introduction ..... 5
  - Maryland PHPA ..... 6
  - Planning Process ..... 7
- I. Where We Are Now: Our Current Prevention/Care Continuum ..... 9
  - Description of Local Epidemic..... 9
    - Data Collection and Reporting..... 9
    - Regional Breakdowns..... 10
    - The HIV/AIDS Epidemiological Profile for Maryland..... 11
    - HIV/AIDS Data by Region, Race/Ethnicity, and Exposure Category..... 12
    - HRSA Unmet Need Estimate ..... 16
    - EIIHA/Unaware Estimate ..... 17
    - Engagement in the Continuum of HIV Care..... 18
  - Description of Current Continuum of Care ..... 19
    - HIV Prevention ..... 19
    - Targeted Testing Efforts and Linkage to Care..... 20
    - Other HIV Prevention Interventions ..... 21
    - Capacity Building..... 22
    - Ryan White-Funded Care and Service Organizations/Services ..... 22
    - Non-Ryan White-Funded Care and Service Organizations/Services..... 25
    - Interaction HIV Prevention and Health Services to Ensure Continuity of Care ..... 25
    - Effect of State and Local Budget Cuts..... 26
    - Shortfalls in Healthcare Workforce ..... 27
    - Legislation in Maryland..... 27
  - Description of Needs..... 29
    - Assessment of Need ..... 29
    - Prevention Needs..... 33
    - Care Needs/Gaps in Care ..... 35
    - Priority, Special, and Vulnerable Populations..... 40

Barriers to Care .....	43
II. Where Do We Need to Go? .....	51
National HIV/AIDS Strategy.....	51
Vision for System Changes.....	52
Values for System Changes.....	53
How the Plan Will Address Healthy People 2020 Objectives .....	53
2012 Proposed HIV Prevention and Care Goals.....	54
Goals Regarding Individuals Unaware of their HIV Status (EIIHA).....	55
Goals Regarding People Aware of their HIV Status, but Not in Care (Unmet Need).....	55
III. How Will We Get There?.....	56
Goals and Strategies .....	56
Collaboration with Maryland’s ECHPP Initiative.....	61
Local Health Department Planning Process.....	61
Collaboration and Coordination .....	64
Proposed Coordinating Efforts of Part B with Other Programs.....	64
Engagement Process .....	65
This Plan and the Affordable Care Act .....	66
State/Local Budget Cuts.....	66
IV. How We Will Monitor Our Progress: Our Process for Evaluation .....	67
Overview .....	67
Monitoring Progress Toward NHAS Goals .....	67
Monitoring of PHPA-Supported HIV Prevention and Health Services .....	71
Maryland HIV Report Card.....	71
APPENDICES .....	72
APPENDIX A: GLOSSARY OF TERMS AND ABBREVIATIONS .....	73
APPENDIX B: HRSA DEFINITIONS OF SERVICE CATEGORIES.....	75
APPENDIX C: References .....	78
APPENDIX D: STI OVERVIEW .....	80
APPENDIX E: Evaluation of 2009 Comprehensive Plan: Successes and Challenges.....	85
APPENDIX F: Monitoring Quality of HIV Care .....	88

## Executive Summary

Maryland's 2012-2014 Comprehensive HIV Plan and Statewide Coordinated Statement of Need (SCSN) is the first integrated plan that addresses the full continuum of HIV services in the state, from prevention, testing, linkage to care, and treatment of persons living with HIV/AIDS (PLWHA). The plan is the result of community planning efforts involving providers of HIV/AIDS services, staff from the Infectious Disease Bureau (IDB) of the Prevention and Health Promotion Administration (PHPA) at the Maryland Department of Mental Health and Hygiene (DHMH), and community stakeholders, including PLWHA. This plan details the extent of Maryland's HIV/AIDS epidemic, on both statewide and regional levels, identifies impacted communities, and describes the current continuum of care of HIV services in the state. Key barriers to accessing/delivering services, as well as service gaps are identified. This document details Maryland's plan to meet the goals of the National HIV/AIDS Strategy (NHAS) over the next three years.

This plan is organized into four sections that address key planning questions. The first section of the plan addresses, "Where are we now?", describes Maryland's HIV/AIDS epidemic, including estimates of the number of PLWHA who are unaware of their status, as well as those who are aware of their status but not engaged in continuous care. This section also examines available resources for HIV services, including both Ryan White-funded and non-Ryan White funded services, as well as the effect of state and local budget cuts on the current continuum of care. Specific HIV prevention and care needs, gaps in services, and barriers to care are also described. The second section of the plan, "Where do we need to go?", describes the vision and values that guide IDEHA's goals and principles for HIV services and how these goals support the larger objectives of the National HIV/AIDS Strategy. The third section, "How will we get there?", lists the overall goals that guide HIV service programs in Maryland. Healthy People 2020 objectives and the Affordable Care Act-related changes are also addressed in this section. Section three also contains the sub-goals and strategies for meeting the overall goals. The overall goals are:

- Increase the number of persons living with HIV/AIDS who are aware of their HIV serostatus.
- Increase the number of persons living with HIV/AIDS who are engaged in ongoing, high-quality HIV medical care.
- Reduce high-risk behaviors among persons living with HIV/AIDS.
- Reduce high-risk behaviors among HIV-negative persons at high risk for HIV infection.
- Reduce disparities in HIV infection and care and services received between subpopulations.

The final section addresses the question "How will we monitor our progress?". Monitoring and evaluation processes in place to measure progress towards performance goals, quality of care goals/outcomes, and client-level outcomes are described.

## Introduction

Over 34,000 people are living with HIV/AIDS in the state of Maryland. The epidemic remains a major public health challenge in the state, as the number of persons living with HIV/AIDS continues to grow and the state must continue to find the resources to provide ongoing systems of care to meet the needs of their citizens. The Prevention and Health Promotion Administration (PHPA) at the Department of Health and Mental Hygiene is the lead state agency in Maryland for coordination of care and prevention services to address the HIV/AIDS epidemic. The mission of PHPA is to improve the health of Marylanders by reducing the transmission of infectious diseases, helping impacted persons live longer, healthier lives, and protecting individuals and communities from environmental health hazards. PHPA's Center for HIV Prevention and Health Services strives to reduce the transmission of HIV and help Marylanders with HIV/AIDS live longer and healthier lives through the development and implementation of comprehensive, compassionate, and quality services for both prevention and care. PHPA has created this 2012-2014 Comprehensive HIV Plan as a living document to examine Maryland's current prevention/care continuum, the needs of persons living with HIV/AIDS in the state, barriers to care, and a statewide "ideal" continuum. Through coordination and collaboration with representatives from Ryan White Programs, people living with HIV/AIDS, health care providers, and public agency representatives, PHPA has created this Comprehensive HIV Plan to serve as a roadmap for the development of a comprehensive system of HIV care in Maryland. It addresses new legislative and programmatic initiatives including the National HIV/AIDS Strategy, Healthy People 2020, and the Affordable Care Act, and is compatible with existing state and local service plans including the Baltimore-Towson MSA Enhanced Comprehensive HIV Prevention Plan (ECHPP).

This document addresses the guidance of three separate, yet connected plans: Ryan White Part B Comprehensive Plan, Statewide Coordinated Statement of Need (SCSN), and Jurisdictional HIV Prevention Plan. By combining all three plans into one inclusive document, a more complete and thorough strategy is created. This plan reflects PHPA's fullest commitment to actualizing the vision set forth in the National HIV/AIDS Strategy:

***"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."***

### Ryan White Part B Comprehensive Plan

The federal government, through the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ("Ryan White Act" hereafter), provides formula grant funding to the state to ensure access to a comprehensive system of HIV care and medications for those who are uninsured and cannot afford to pay for care. The Ryan White Act directs the Health Resources Services Administration (HRSA) to distribute funding based on the number of people living with HIV/AIDS and provides resources to address the needs of special populations and geographic challenges. PHPA receives dollars from HRSA to cover statewide services (through Part B of the Ryan White Act) and for programs targeting women, infants, children and youth (through Part D of the Ryan White Act). PHPA partners with the other

jurisdictions and agencies that receive Ryan White funds for Marylanders with HIV to develop and ensure a comprehensive prevention/care continuum.

The Ryan White Act requires Part B grantees to draft and implement statewide comprehensive plans, including a description of HIV-related services in the state, available resources, epidemiological data, service needs, goals, and strategies. HRSA's guidelines relating to this legislative requirement indicate that the comprehensive plan should serve as a guide for the design and implementation of a continuum of HIV care over a three-year period. The guidelines state further that the plan should address disparities in HIV care, access and services among affected subpopulations and historically underserved communities, and the needs of those who know their HIV status and are not in care, as well as the needs of those who are currently in the care system.

### Statewide Coordinated Statement of Need (SCSN)

The purpose of the SCSN is to "provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV/AIDS, and to maximize coordination, integration and effective linkages across Ryan White HIV/AIDS Program Parts." HRSA's guidance for this document instructs grantees to integrate the perspectives of various stakeholders, including PLWHA, representatives from all Ryan White Programs, members of a Federally recognized Indian tribe, providers, and public agency representatives.

### Jurisdictional HIV Prevention Plan

Maryland's Jurisdictional HIV Prevention Plan details the collaboration and coordination of HIV prevention, care, and treatment in the state. The Centers for Disease Control and Prevention's (CDC's) guidance for this document instructs grantees (PHPA) to describe the existing resources for HIV prevention, care, and treatment services, the needs of PLWHA, gaps in care, prevention activities, strategies, and timelines for completion. The Jurisdictional HIV Prevention Plan uses current epidemiological data to identify those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition. The plan then focuses on ensuring that those identified populations receive the appropriate allocations of existing prevention resources.

### Maryland PHPA

From 1987 through 2009, the AIDS Administration was the unit of Maryland's Department of Health and Mental Hygiene (DHMH) that had the primary responsibility for tackling the HIV/AIDS epidemic in the state. The AIDS Administration's functions included educating the public and health care professionals about HIV and AIDS, monitoring the disease in Maryland, and providing services for persons with HIV/AIDS. Responsibility for oversight of other infectious diseases including STIs, TB and Hepatitis, as well as the oversight of local health departments was in another Administration within DHMH. Since July, 2009, the Secretary of the Maryland DHMH has conducted several reorganizations of the Department to strengthen Maryland's capacity to focus on a range of related public health programs that impact and improve the health of Marylanders. The Prevention and Health Promotion Administration (PHPA), formed in July 2012, consists of four Bureaus: Maternal and Child Health Bureau; the Environmental Health Bureau; the Cancer and Chronic Disease Bureau and the Infectious Disease Bureau. Reorganizations has allowed for increased integration of HIV, STD, viral hepatitis and TB

prevention efforts and increased coordination with HIV care services, which are all managed within the Infectious Disease Bureau.

The Infectious Disease Bureau (IDB) is dedicated to improving the health of Marylanders by reducing the transmission of infectious diseases, and helping impacted persons live longer, healthier lives. IDB works in partnership with local health departments, providers, community based organizations, and public and private sector agencies to provide public health leadership in the prevention, control, monitoring, and treatment of infectious diseases.

## Planning Process

To achieve a comprehensive HIV plan, input was gathered from several different sources to accurately represent the views of providers, persons living with HIV/AIDS, stakeholders, and other community members. This plan is the synthesis of the work and research completed by these different groups.

### Planning Councils

There are two HIV-services Planning Councils in the state of Maryland: The Greater Baltimore HIV Health Services Planning Council and the Metropolitan Washington Regional Health Services Planning Council. The Greater Baltimore Planning Council is appointed by the mayor of Baltimore City and covers the Baltimore Eligible Metropolitan Area (EMA). The Metropolitan Washington Planning Council is appointed by the mayor of Washington, DC and covers the Washington, DC EMA (including Charles, Calvert, Frederick, Montgomery, and Prince George's counties in Maryland). Both are 40-member, all-volunteer bodies and were formed as required components of the Ryan White Part A Program.

Each Planning Council is responsible for conducting consumer needs assessments and identifying service needs of PLWHA in its respective EMA, setting priorities for the allocation of federal HIV/AIDS service dollars under the Part A Program, and evaluating the efficiency of the administrative mechanism which distributes Ryan White Program funds. It is also responsible for developing a comprehensive plan for delivering HIV services to PLWHA in the EMA, assuring community participation, and developing methods to address conflicts of interest and grievances. The Planning Council is also required to work with other Ryan White Program representatives to develop the Statewide Coordinated Statement of Need (SCSN).

### Community Planning Group

The Centers for Disease Control and Prevention (CDC) mandated in 1993 that state health departments seek input from communities infected with and affected by HIV when planning HIV prevention programs. In response, the Maryland Department of Health and Mental Hygiene formed a statewide Community Planning Group (CPG) at the beginning of 1994. CPG membership is determined by appointment, based on specific criteria designed to ensure that the composition of the CPG reflects the HIV epidemic in Maryland. CPG representation is sought from HIV-infected persons, members of affected communities, families affected by the virus, advocates of target populations, prevention workers at community-based organizations and local health departments, and other professionals working with at-risk populations. The CPG seeks representation from all five regions of Maryland, and meetings are held regularly throughout the year.

The CDC's new HIV Planning Guidance was released in the spring of 2012. Maryland's HIV Prevention Community Planning Group will be restructuring to become the new HIV Planning Group to align the structure to the NHAS and the new HIV Planning Guidance. The priority will be the development of an engagement plan to expand engagement to a broader range of community and public health stakeholders and increasing coordination of HIV prevention and care planning.

### [Regional Advisory Committees](#)

The Regional Advisory Committee (RAC), in partnership with PHPA, reviews and shares information and makes recommendations for HIV/AIDS care and prevention priorities in Maryland. Input from the community is vital to the work PHPA supports statewide. Feedback received during the RAC meetings assists PHPA in developing, implementing programs and procedures that are effective, efficient, culturally sensitive and relevant to the community. In addition, the RAC provides a networking opportunity for community members interested in HIV/AIDS issues. Regional Advisory Committees are located in each of the five regions of Maryland, and meetings are held in each region four times a year.

### [Baltimore City Commission on HIV/AIDS](#)

The Baltimore City Commission on HIV/AIDS Prevention and Treatment was chartered by the Office of the Mayor and the President of the Baltimore City Council as an outgrowth of a report from the Baltimore City Council Commission on AIDS published in the spring of 2002. The Baltimore City HIV/AIDS Commission provides policy guidance, recommendations, and consultation to the city's leadership and health community for improving services and implementing effective prevention education and treatment programs to protect and serve the citizens of Baltimore. Participating members include representation from state agencies, public schools, non-profit organizations, health departments, correctional facilities, churches, businesses, and non-affiliated community members.

### [Anne Arundel County Commission on HIV/AIDS](#)

The purpose of the Anne Arundel County Commission on HIV/AIDS is to promote and enhance the quality of life for people with HIV/AIDS, to provide education and training on the prevention of HIV and AIDS, and to advise the County Executive and the County Council on the coordination and development of government policies, programs, services and allocation of resources for education and prevention, diagnosis and treatment, and community support for persons with HIV/AIDS. Commission members include representation from state agencies, community colleges, non-profit organizations, churches, and federal agencies.

### [Metropolitan Washington Council of Governments](#)

The Metropolitan Washington Council of Governments, known as COG, helps develop regional solutions to various community issues, including the HIV epidemic. Founded in 1957, COG is an independent, nonprofit association comprised of elected officials from 22 local governments, members of the Maryland and Virginia state legislatures, and members of the U.S. Congress. COG is supported by financial contributions from its participating local governments, federal and state grants and contracts, and donations from foundations and the private sector. Within the COG, there is an HIV Committee which coordinates regional planning and response to HIV/AIDS in the National Capitol Region.



## I. Where We Are Now: Our Current Prevention/Care Continuum

### Description of Local Epidemic

#### Data Collection and Reporting

The Maryland HIV/AIDS Reporting Act of 2007 went into effect on April 24, 2007. The law expanded HIV/AIDS reporting and required that HIV cases be reported by name. The following highlights the reporting requirements of Health-General Articles 18-201.1, 18-202.1, and 18-205 of the Annotated Code of Maryland, as specified in the Code of Maryland Regulations (COMAR) 10.18.02.

- Physicians are required to report patients in their care with diagnoses of HIV or AIDS immediately to the Local Health Department where the physician's office is located by mailing the Maryland Confidential Morbidity Report Form (DHMH Form 1140). Reports are also accepted by phone.
- Physicians are required to report infants born to HIV-positive mothers within 48 hours to the State Health Department by mailing DHMH Form 1140. Reports are also accepted by phone.
- Clinical and infection control practitioners in hospitals, nursing homes, hospice facilities, medical clinics in correctional facilities, inpatient psychiatric facilities, and inpatient drug rehabilitation facilities are required to report patients in the care of the institution with diagnoses of HIV or AIDS within 48 hours to the Local Health Department where the institution is located by mailing DHMH Form 1140. Reports are also accepted by phone. Facilities with large volumes are encouraged to contact the State Health Department to establish electronic reporting.
- Laboratory directors are required to report patients with laboratory results indicating HIV infection (e.g., positive confirmatory HIV diagnostic tests, all CD4 immunological tests, all HIV viral load tests, and all HIV genotype and phenotype tests) within 48 hours to the Local Health Department where the laboratory is located, or if out of state to the Maryland State Health Department, by mailing the Maryland HIV/CD4 Laboratory Reporting Form (DHMH Form 4492). Laboratories are encouraged to contact the State Health Department to establish electronic reporting.

Reporting forms and instructions are available on the DHMH website:

<http://ideha.dhmh.maryland.gov/oideor/chse/sitepages/reporting-material.aspx>

## Notes on Data Collection and Interpretation

This report uses the HIV and AIDS surveillance data reported through 12/31/2011. To allow for delays in reporting and the completion of investigations, data included in this report are presented with a one year lag, at which point it is estimated that over 90% of cases for the prior year will have been reported.

The HIV prevalence estimates for race/ethnicity, age, gender, and mode of exposure include HIV cases diagnosed through December 31, 2010, irrespective of whether they have progressed to AIDS, that were not reported to have died, and had been reported by name through December 31, 2011. These data includes only those HIV and AIDS cases that have been diagnosed by a health care provider, were reported by name to the health department, and were Maryland residents at the time of diagnosis. After the transition of HIV/AIDS reporting from a code-based to a name-based identifier in 2007, all previously diagnosed cases needed to be located and re-reported by name using the new system. Although a massive effort was made to re-investigate over 17,000 cases, there was an inevitable under-reporting of the number of living HIV cases. In addition, many of the reported HIV cases were identified by a recent diagnosis that may not be their earliest diagnosis, resulting in an under-reporting of HIV diagnoses before 2001 and an over-reporting of HIV diagnoses from 2001 to 2008. The HIV/AIDS figures in this report are likely to be an underestimation for four reasons. First, HIV tests conducted on Maryland residents at facilities outside of Maryland are not reported to the health department. Second, individuals that tested positive prior to the implementation of HIV reporting in 1994 and have not been re-tested or have developed AIDS since, will not be included. Third, after the 2007 transition from a code-based identifier to a name-based identifier in reporting, not all diagnosed HIV cases previously reported by Maryland's code-based identifier were located and re-reported by name, so the number of living HIV cases is lower than previously reported. Fourth, the CDC estimates that 20% of people infected with HIV are unaware of their status.

## Regional Breakdowns

The PHPA organizes the state into five regions (Central, Eastern, Southern, Suburban, and Western) for HIV/AIDS planning purposes. The regions are composed of the following jurisdictions:

- **Central:** Anne Arundel, Baltimore, Carroll, Harford, and Howard counties; and Baltimore City
- **Eastern:** Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties
- **Southern:** Calvert, Charles, and St. Mary's counties
- **Suburban** (to Washington DC): Montgomery and Prince George's counties
- **Western:** Allegany, Frederick, Garrett, and Washington counties

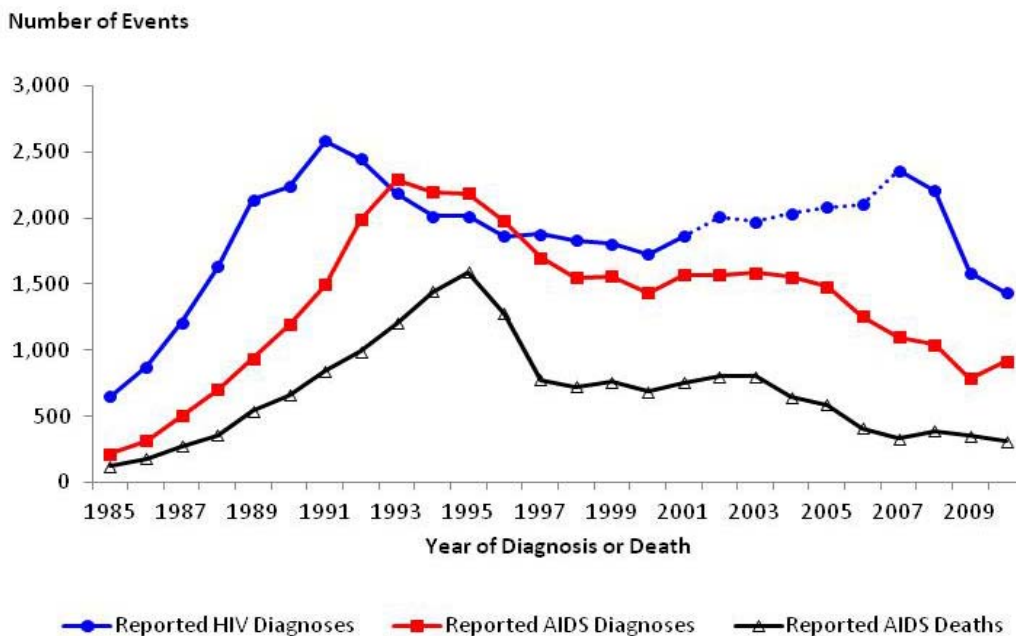
Jurisdictions in Maryland are part of two Eligible Metropolitan Areas (EMAs) and one Transitional Geographic Area (TGA) that receive Ryan White Part A funds. The Washington, DC EMA includes five Maryland counties (Calvert, Charles, Frederick, Montgomery, and Prince George's). The Baltimore-Towson EMA is comprised of Baltimore City and the six surrounding counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's. Cecil County is part of the Wilmington, Delaware TGA. The remainder of the state is primarily rural.

## The HIV/AIDS Epidemiological Profile for Maryland

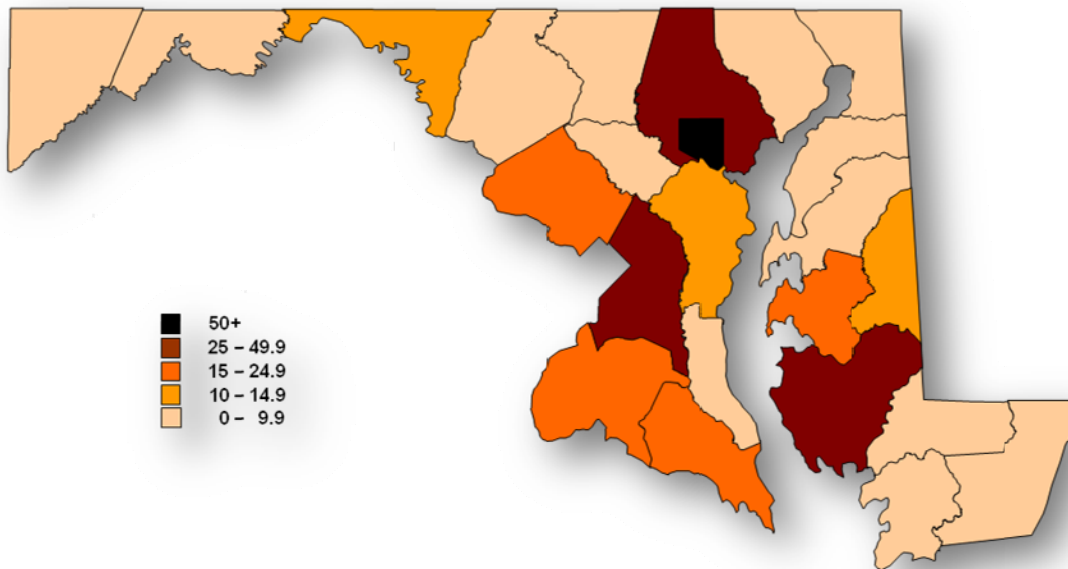
The state of Maryland has been significantly impacted by the HIV epidemic. In 2010, Maryland had the second highest AIDS case report rate (22.1 cases per 100,000 adults) among states and territories and the Baltimore-Towson EMA had the 4<sup>th</sup> highest AIDS case report rank among major metropolitan areas (26.8 cases per 100,000), up from the 10<sup>th</sup> highest in 2009. The Washington, DC EMA, which includes five counties in suburban Maryland, had the 7<sup>th</sup> highest AIDS case report rank among major metropolitan areas (25.1 cases per 100,000), down from the 5<sup>th</sup> highest in 2009. These are in comparison to the national AIDS case rate of 10.8 cases per 100,000 adults. Maryland's case rate is 2.05 times higher than the national rate. The Baltimore-Towson EMA's AIDS case rate is 2.48 times higher than the national rate and the Washington, DC EMA is 2.32 times higher.

The number of new AIDS cases diagnosed in each quarter increased through 1995, with an artificial rise around 1993 due to changes in the AIDS cases definition. During the 2007-2008 transition to name-based HIV reporting as a result of the Maryland HIV/AIDS Reporting Act, many HIV cases were reported by a recent HIV diagnosis and not by their earliest HIV diagnosis, resulting in an artificial upward trend in new HIV diagnoses during the period 2001-2008. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a significant decline in both the number of new cases of AIDS (to 918) and in deaths among AIDS cases (to 309). The combination of these trends was a steady increase in the number reported HIV cases with or without an AIDS diagnosis and reported to be alive at the end of each year (HIV/AIDS Prevalence), a greater proportion of which each year were HIV cases with an AIDS diagnosis. During the three years from 12/31/2007 to 12/31/2010, the number of HIV cases with or without an AIDS diagnosis and reported to be alive increased by 4,042 (15.5%) to 30,132.

**Figure 1. HIV and AIDS Case Trends: New HIV and AIDS Cases by Year of Diagnosis, and Deaths among AIDS Cases by Year of Death, from 1985 through 2010, as Reported through 12/31/2011**



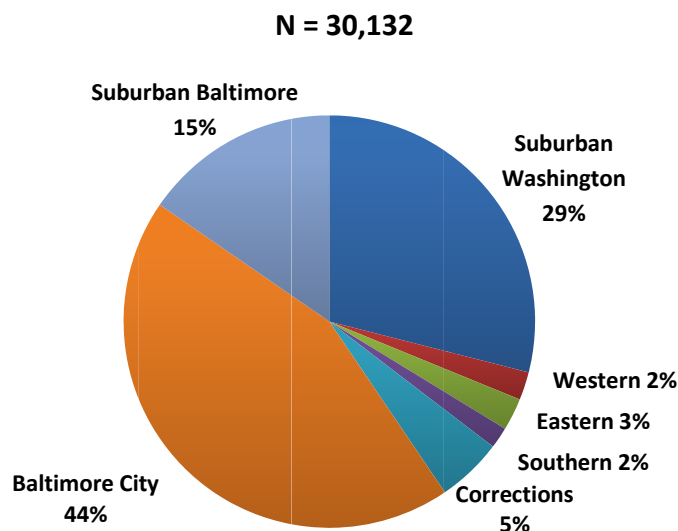
**Figure 2. HIV Cases by Jurisdiction: New HIV Diagnoses during 2010, Age 13+ at HIV Diagnosis, Per 100,000 Population, as Reported through 12/31/2011**



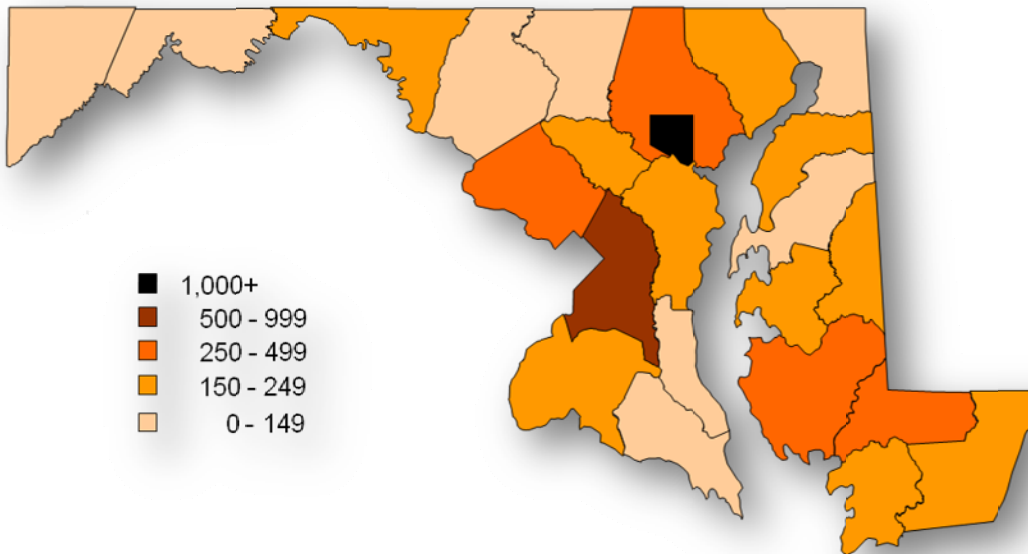
**HIV/AIDS Data by Region, Race/Ethnicity, and Exposure Category**

There were a total of 30,132 persons living with HIV/AIDS in the state of Maryland as of December 31, 2010, of which 12,744 (42.3%) were HIV cases and 17,388 (57.7%) were AIDS cases. The largest percentage (59%) of all reported living HIV/AIDS cases in Maryland were residents of the Central Region at the time of diagnosis, including 44% of which were residents of Baltimore City and 15% were residents of suburban Baltimore counties. The Suburban Washington Region reported a total of 29% of all living HIV/AIDS cases. The other counties in Maryland (comprising the Western, Eastern, and Southern regions), reported 7% of all living HIV/AIDS cases. The remaining 5% of living cases in Maryland were diagnosed while incarcerated in the state correctional system.

**Figure 3. HIV Cases by Region: Living HIV Cases on 12/31/2010 as Reported through 12/31/2011**

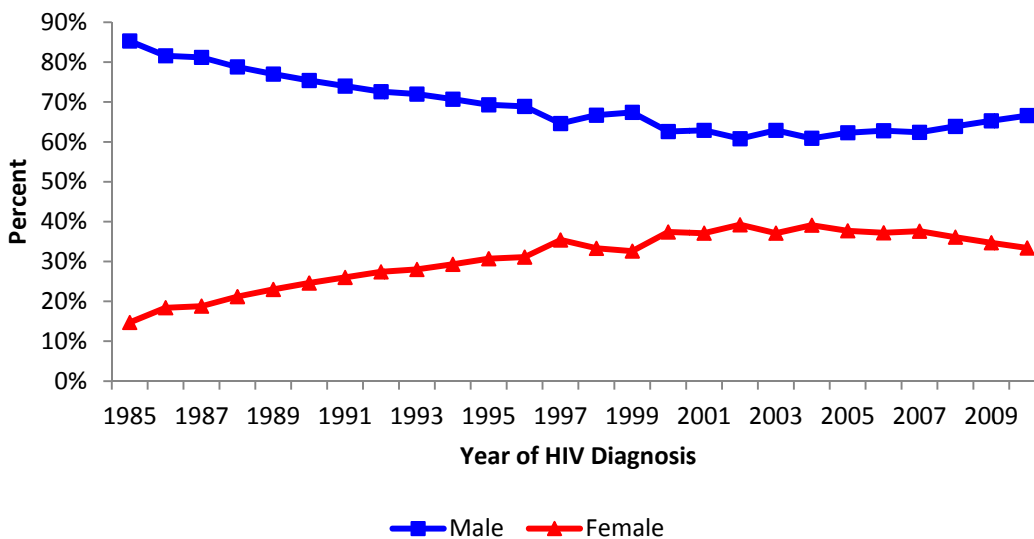


**Figure 4. HIV Cases by Jurisdiction: Living HIV/AIDS Cases on 12/31/2010, Age 13+, Per 100,000 Population, as Reported through 12/31/2011**



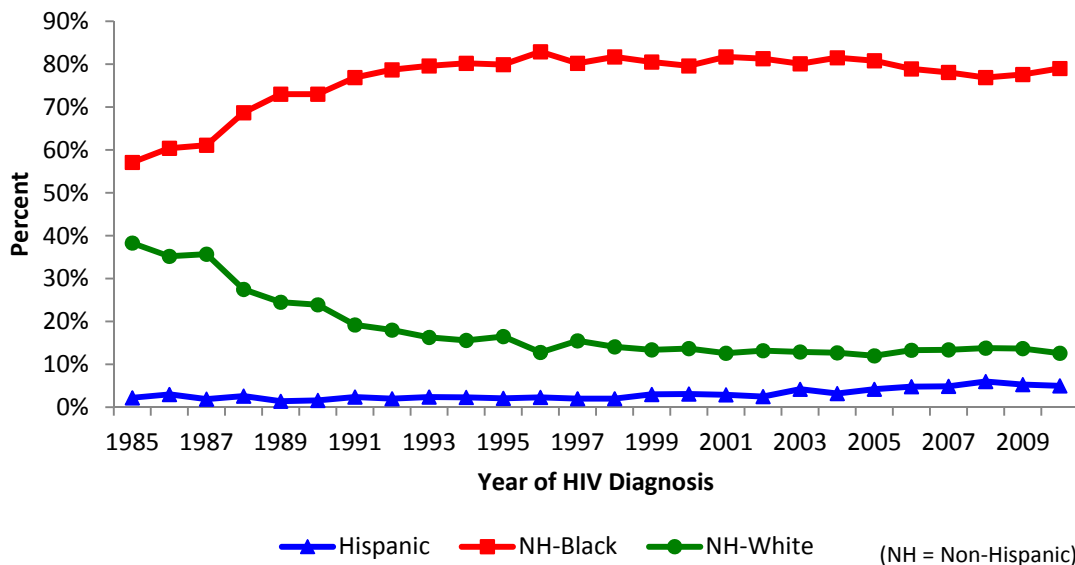
Maryland living HIV/AIDS cases are predominantly African American (80.8%), male (64.2%), and middle-aged (63.4% of cases are 40-59 years old). As shown in Figure 5, the percentage of females among new HIV diagnoses had been gradually increasing over time, but in the last several years that trend has reversed. Of all HIV cases diagnosed in 1985, 12% were female. The proportion has steadily increased until 2000, at which point it stabilized at about one-third female. The Washington, DC MSA has a slightly higher proportion of males (67.1%) than the Baltimore MSA (65.3%).

**Figure 5. HIV Case Trends by Sex at Birth: Percent by Sex at Birth of New HIV Diagnoses, Age 13+ at HIV Diagnosis from 1985 through 2010, as Reported by Name through 12/31/2011**



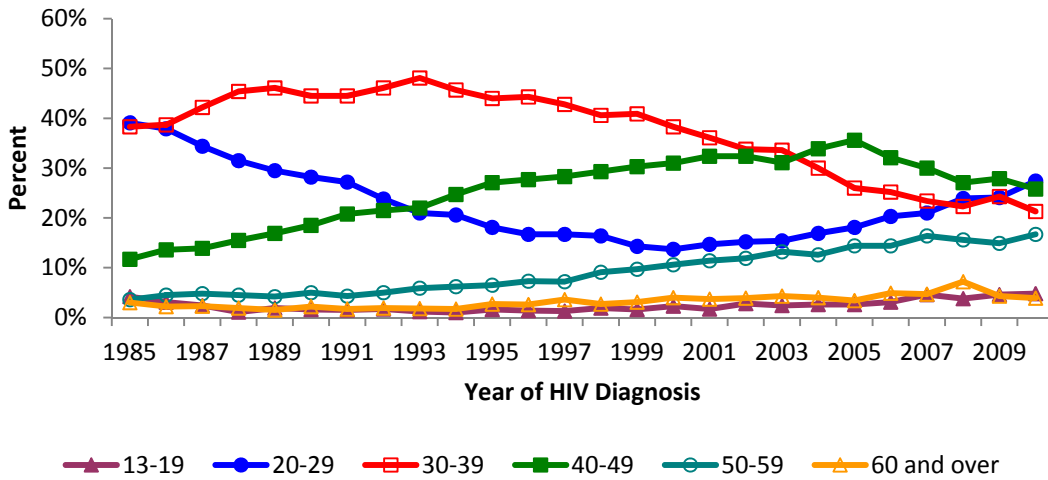
As shown in Figure 6, the percentage of new HIV diagnoses that were non-Hispanic African American steadily increased from 55.6% in 1985 to around 80% in 1996. It has remained stable at this percentage. In 1985, 42% of newly diagnosed HIV cases were non-Hispanic White, but this steadily decreased to 14% in 1996 and has stabilized at this percentage. The proportions of new HIV cases of Hispanic origin or non-Hispanic other races have both been gradually increasing since 1985. Almost eight percent of the Washington, DC MSA's HIV diagnoses are Hispanic, while only 3 percent of diagnoses from the Baltimore MSA are. Both MSAs have approximately the same percentage of non-Hispanic Black diagnoses, at around 80%.

**Figure 6. HIV Case Trends by Race/Ethnicity: Proportions by Race/Ethnicity of New HIV Diagnoses from 1985 through 2010, as Reported through 12/31/2011.**



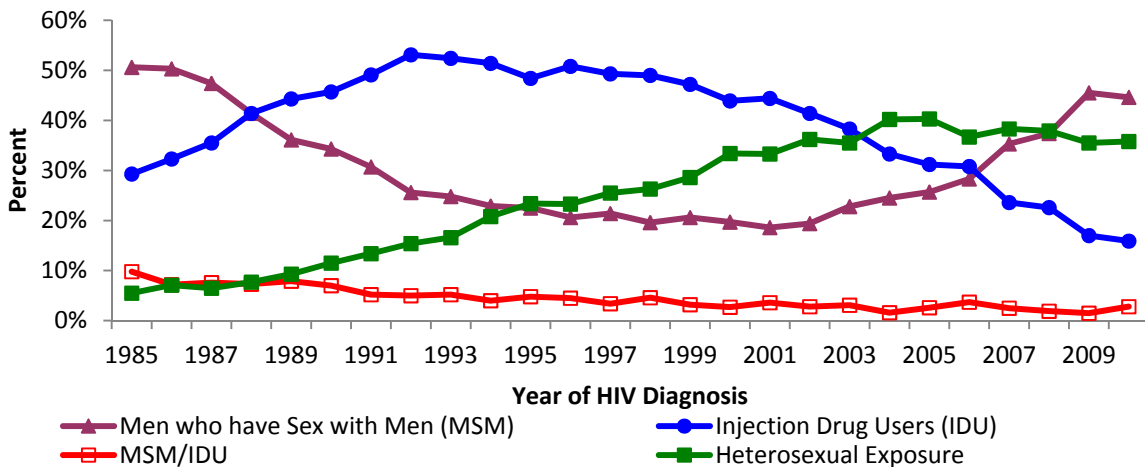
As shown in Figure 7 (on page 15), since 1993, the proportion of new HIV diagnoses in Maryland aged 30-49 have decreased, while the proportion of cases aged 13-29 and 5+ have increased. Due to both increased survival of living cases and an increasing proportion of new HIV diagnoses among older groups, the average age of persons living with HIV/AIDS has been steadily increasing. This held true in spite of a large increase from 2000 to 2010 in the proportion of new HIV diagnoses in persons age 20-29. Age demographics of HIV diagnoses differ somewhat between the two major MSAs. Twenty-seven percent of living HIV/AIDS cases in the Washington, DC MSA are between the ages of 30-39, however only 18% of living HIV/AIDS cases in the Baltimore MSA are in this age bracket. The Baltimore MSA has a slightly older HIV population. Twenty four percent of HIV diagnoses in 2010 in Baltimore were age 50 or older, while in Washington only 17% of cases were 50 or older.

**Figure 7. HIV Case Trends by Age at Diagnosis: Proportions by Age of New HIV Diagnoses, Age 13+ at HIV Diagnosis, by Year of HIV Diagnosis from 1985 through 2010, as Reported by Name through 12/31/2011**



Men Who Have Sex with Men (MSM) was the most common HIV transmission risk group for HIV diagnoses until 1988. In 1989, injection drug use (IDU) became the most commonly reported exposure among newly diagnosed HIV cases. Heterosexual contact (HetSex) has represented an increasing proportion of reported exposure among all new HIV cases, surpassing MSM in 1995 and IDU in 2004. Injection drug use was the predominant mode of transmission for HIV cases. However, by 2004 a greater proportion of newly reported HIV cases reported heterosexual contact as their identified transmission risk behavior and, since 2009 there have been more MSM diagnoses per year than IDU. The introduction of needle exchange in Baltimore City in 1994, and its widespread expansion since, has been a main contributor to the decreasing proportion of new IDU HIV diagnoses. Currently, the most common HIV transmission risk group is MSM (44.6%) followed by HetSex (35.8%), and then IDU (15.9%).

**Figure 8. HIV Exposure Category Trends: Proportions by Exposure Category of New HIV Diagnoses by Year of HIV Diagnosis from 1985 through 2010, As Reported by Name through 12/31/2011**



There are substantial differences between the proportions of HIV transmission groups in the Baltimore and Washington, DC MSAs. While 57.7% of HIV diagnoses in 2010 were MSM in the Washington, DC MSA, only 38.5% of diagnoses in Baltimore were MSM during that same time period. Injection Drug Use was a much more common mode of transmission during 2010 in the Baltimore EMA (22.7%) than the Washington, DC EMA (7.4%). Both MSAs had around the same proportion of HIV diagnoses attributed to heterosexual contact.

### HRSA Unmet Need Estimate

Unmet need is defined by HRSA as the proportion of persons known to have HIV/AIDS and who are not receiving primary medical care. Primary medical care for persons with HIV/AIDS is defined as a patient having received any of the following three components during the prior year: viral load testing, CD4 count, or provision of antiretroviral therapy. Unmet need is calculated using a combination of laboratory reporting and antiviral medication use to identify persons in care and compares that to the number of people living with HIV/AIDS to determine the percentage of PLWHA receiving treatment, and thus identifying the proportion of unmet need for HIV primary medical care. Maryland's unmet need estimate for 2010, using the HRSA/HAD unmet need methodology, is provided below in Figure 9.

**Figure 9. HRSA/HAB Unmet Need Framework, with Data as Reported through 12/31/2011**

Input	Value	Data Source
<b>Population Sizes</b>		
A. Number of Maryland resident cases living with HIV (PLWH) at the beginning of the comparison period	<b>12,738</b>	HIV case registry, prevalence on June 30, 2010, as reported through June 30, 2011
B. Number of Maryland resident cases living with AIDS (PLWA) at the beginning of the comparison period	<b>17,166</b>	AIDS case registry, prevalence on December 31, 2010, as reported through December 31, 2011
<b>Care Patterns</b>		
C. Number of unique persons in Maryland with CD4 of VL tests or receiving antiretroviral medications during comparison period	<b>19,427</b>	1) Laboratory reporting database, test results through December 30, 2010, as reported through December 31, 2011 2) ADAP database, program participants as of June 30, 2008
<b>Calculated Results</b>		
D. Total number of Maryland resident cases living with HIV/AIDS (PLWHA) at the beginning of the comparison period	<b>29,904</b>	A+B
E. Proportion of PLWHA in Maryland receiving primary HIV medical care	<b>65.0%</b>	(C/D)*100
F. Number of Maryland PLWHA not receiving primary HIV medical care	<b>10,477</b>	D-C
G. Percent of PLWHA in Maryland not receiving primary HIV medical care (quantified estimate of unmet need)	<b>35.0%</b>	((D-C)/D)*100



### EIIHA/Unaware Estimate

The Centers for Disease Control and Prevention estimated that 20% of the 1.2 million Americans who are living with HIV are unaware of their infection<sup>1</sup>. Using this national estimate of 20% undiagnosed and the number of adult/adolescents diagnosed with HIV and living as of December 31, 2010 (29,642), it is estimated that there were approximately 7,400 undiagnosed individuals in Maryland at the end of 2010. This method is likely to produce a conservative estimate of undiagnosed individuals in Maryland, due to local evidence of high rates of late HIV testing and undiagnosed HIV infection. During 2010, 29.5% of new adult/adolescent HIV diagnoses in Maryland had an AIDS diagnosis within 12 months of their HIV diagnosis and the median initial CD4 count was 451 cells per microliter, both indicators of late HIV testing. Additionally, data from the National HIV Behavioral Surveillance System showed high rates of HIV infection and substantial rates of unrecognized HIV infection in the Baltimore-Towson MSA. Among the 448 MSM recruited during the 2008 wave of National HIV Behavioral Surveillance (NHBS) in the Baltimore-Towson MSA, 38% were HIV positive and among the positives 78% were previously undiagnosed. Among the 507 IDU recruited during the 2009 wave of NHBS in the Baltimore-Towson MSA, 16% were HIV positive and among the positives 48% were previously undiagnosed. Among the 338 at-risk heterosexuals recruited during the 2010 wave of NHBS in the Baltimore-Towson MSA, 6% were HIV positive and among the positives 62% were previously undiagnosed. These results suggest that the 20% national estimate of people living with HIV who are unaware of their serostatus may be an underestimate for Maryland.

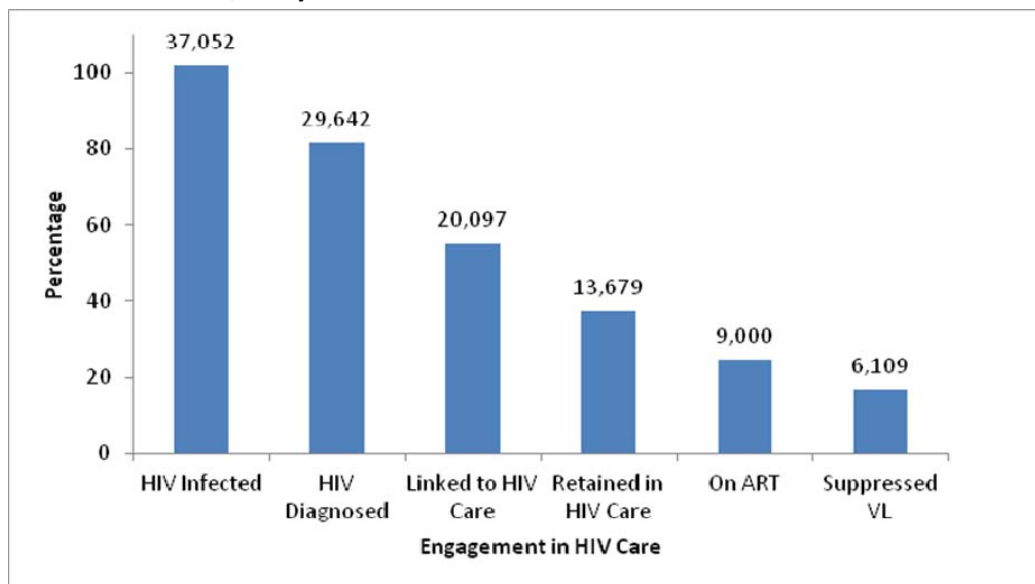
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<sup>1</sup> Centers for Disease Control and Prevention. (2012) HIV In the United States: At A Glance. Retrieved from [http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV\\_at\\_a\\_glance.pdf](http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV_at_a_glance.pdf)

### Engagement in the Continuum of HIV Care

In their 2011 article in *Clinical Infectious Diseases*, Gardner et al. utilize a continuum of care “cascade” to illustrate national estimates of the number of persons living with HIV who belong to each of the stages of engagement in HIV care.<sup>2</sup> Nationally, Gardner et al. estimated that among persons living with HIV in the United States, only 19% have achieved viral suppression.

**Figure 10. Estimated Number and Percentage of HIV Infected Adults Engaged in Selected Stages of the Continuum of Care, Maryland 2010**



The Maryland Engagement in HIV Care Cascade (Figure 10 above) uses the national estimate of the number of undiagnosed persons (20%) to generate an estimated total number of HIV infected persons in Maryland, and then uses local data to describe the number and percentage of persons living with HIV in Maryland who belong to each of the stages of engagement in HIV care. In Maryland, 68% of HIV diagnosed persons are linked to care. Less than half (46%) of HIV diagnosed persons are retained in care. Fewer still (30%) are on antiretroviral therapy, and 21% have achieved viral suppression.

<sup>2</sup> Gardner et al, “The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection.” *Clin Infect Dis*. 2011; 52 (6): 793-800.

## Description of Current Continuum of Care

Since HIV was first detected in Maryland, the state health department, local governments, and community-based organizations have worked together to develop an integrated delivery system of HIV prevention and care services to efficiently tackle the state's rising epidemic. The continuum of care for people living with HIV/AIDS in Maryland is comprised of a wide range of services and providers and represents a partnership of public and private agencies and funding sources. The continuum of care consists of HIV prevention, treatment, care, and support services.

### HIV Prevention

The Maryland Prevention and Health Promotion Administration (PHPA) receives funding from the federal Centers for Disease Control and Prevention (CDC) for a variety of HIV prevention activities, including community planning, counseling and testing, health education and risk reduction programs, public information, capacity building/training, partner services, and monitoring and evaluation.

A major goal of HIV prevention is to provide programs and policies that promote increased access to HIV testing and counseling for all individuals in Maryland. Early identification of HIV through routine testing has been proven to result in better health outcomes for infected individuals, as well as decreased costs to the health care system. As part of its HIV counseling and testing initiatives, PHPA requires linkages to care for those who are newly diagnosed or those who know their HIV status but have not yet engaged with HIV care services. PHPA is also working directly with clinical providers to incorporate general HIV prevention messages into encounters with individuals already living with HIV. Following guidelines set forth by the CDC, health care providers are required to actively engage in or refer individuals to additional services to reduce their risk for transmitting or acquiring HIV. These include, but are not limited to, prevention case management, partner services, reproductive health services, substance or alcohol abuse prevention and treatment, mental health services, and STD screening and care.

PHPA has recently put a particular emphasis on Prevention with Persons Living with HIV/AIDS in a variety of settings across Maryland. Through evidence-based risk-reduction interventions, PLWH served by these programs learn skills for making safer choices, developing healthy relationships, and adhering to their HIV treatment regimens. These programs also help HIV-infected individuals cope with the stress of living with HIV.

The Maryland HIV Prevention Community Planning Group (CPG) works with PHPA to review data and information to determine the priority populations for HIV prevention initiatives. Maryland's HIV Prevention priority populations for the most recent year available (2010-2011) are:

1. Persons living with HIV/AIDS
2. Men Who Have Sex with Men (72% of which are African American)
3. Heterosexual (83% African American)
4. Injection Drug Users (IDU) (86% of which are African American)
5. Special Populations (Deaf, Hispanic, African Immigrants, and Transgender Populations)

These priority populations reflect CDC requirements and the risks associated with new HIV infections in the state. Within all transmission categories, high risk persons (as defined by HIV prevalence or

individual risk behaviors) are prioritized. Within each risk group, African Americans are emphasized, given the disproportionate impact of HIV in this group. Special Populations are defined as those with special linguistic needs and/or those with documented elevated risk of HIV transmission and are unlikely to be served by prevention programming targeting one of the other priority populations, i.e. Deaf Persons, Hispanics, African Immigrant and Transgender populations. Priority and Special Populations are described in more depth later in this document.

### **Targeted Testing Efforts and Linkage to Care**

In Maryland, the Infectious Disease Bureau (IDB) of the Department of Health and Mental Hygiene, in partnership with the Baltimore City Health Department (BCHD), county health departments, and various community-based groups, conducted and supported a variety of programmatic and capacity building activities. These activities allowed IDB to increase the number of persons living with HIV who now know their status and are linked to medical care, support and prevention services. IDB activities involved collaborations between public health, clinical, and community providers to implement a coordinated system that identified, informed, and linked high-risk individuals unaware of their positive HIV status to care.

Through IDB and BCHD we were able to support comprehensive HIV testing programs across Maryland that included routine HIV testing in health care settings and targeted HIV testing in non-health care settings. We also provided routine HIV screening programs which were located in high prevalence health care and correctional settings, including emergency departments, STD clinics, substance abuse treatment centers, correctional facilities, and perinatal settings. IDB and BCHD targeted HIV counseling, testing and referral programs serving high-risk individuals in non-clinical settings through partnerships with local health departments, community-based organizations, and faith-based organizations. Utilizing our population and demographic data, our HIV testing resources were incorporated across all programs and we were able to focus our attention on the most heavily impacted geographic areas and the populations at greatest risk for HIV (African Americans, MSM and high-risk heterosexuals).

The IDB and BCHD testing programs supported HIV/STI partner services to ensure that people living with HIV (PLWH) were aware of their serostatus and their partners notified of potential exposure and provided HIV/STI testing. In addition to directly supporting HIV testing and partner services programs, IDB has built provider capacity to effectively offer HIV testing and link HIV-positive individuals to prevention, care and support services through provider education, technical assistance and capacity building.

HIV testing programs, partner services programs, and HIV medical care providers worked collaboratively and developed mechanisms and referral networks to support timely and effective linkage to HIV care. All HIV-positive clients who were served by the HIV testing programs described above were linked to care through: a) direct linkage to an onsite Infectious Disease or HIV clinic; b) active linkage to a county health department's HIV clinic; or c) active linkage to another HIV medical provider chosen by the client. For clients who receive rapid tests, referral to HIV care was initiated upon receipt of a rapid reactive result. Timely linkages to care were further supported by DIS who assessed engagement in HIV care when offering partner services, and provided active linkage to care for all HIV-positive clients not

engaged in care. Ryan White Minority AIDS Initiative and Part A outreach programs also provided linkage and re-linkage services to HIV medical care for PLWH in Maryland. Lastly, our Ryan White case managers supported PLWH to maintain full engagement in HIV medical care and adhering to their medications.

### **Other HIV Prevention Interventions**

HIV prevention interventions in Maryland are implemented by local health departments, community-based organizations, community health centers, substance abuse treatment centers and universities. These activities include HIV testing, HIV/STI partner services, needle exchange, intensive health education and risk reduction (HERR) interventions, and brief educational interventions. These HIV prevention interventions are targeted to the priority populations identified by Maryland's HIV Prevention Community Planning Group. The geographical areas and risk populations served are determined by the epidemiological data in each region/jurisdiction to ensure that HIV prevention services are provided to individuals at the greatest risk of HIV infection. HIV prevention providers utilize evidence-based health education and risk reduction interventions that are culturally appropriate for the individuals and communities they serve. These interventions are provided to assist persons at risk for HIV transmission or infection in reducing their high-risk sexual and needle-sharing behaviors. Provider education, technical assistance and capacity building assistance are provided to build provider capacity to effectively provide HIV prevention interventions and link HIV-positive individuals to prevention, care and support services. In addition to preparing providers to implement specific evidence-based interventions, capacity building assistance is provided to increase cultural competency and skills for HIV prevention staff working with the targeted communities to ensure clients are provided with culturally appropriate services. IDB provides risk reduction devices (e.g. condoms, dental dams) and informational materials (e.g. brochures) to all funded HIV prevention programs, as well as to other agencies providing services, to increase knowledge of HIV and risk reduction strategies among Marylanders, and assist them in preventing HIV infections. All materials distributed have been approved by a Community Review Panel to ensure that they are culturally, developmentally and linguistically appropriate, as well as sensitive to sexual identity.

IDB implements a number of strategies to reduce perinatal HIV transmission. These include collaboration with public and private health care providers across Maryland to enhance outreach efforts to pregnant women who are not engaged in prenatal care and may be unaware of their HIV status. IDB has funded outreach testing programs to provide HIV testing to pregnant women who are unaware of their HIV serostatus and other high-risk women of child-bearing age. These programs actively linked all pregnant women to prenatal care. IDB has provided training and technical assistance to perinatal providers to promote universal HIV screening of pregnant women and prophylaxis to reduce perinatal transmission of HIV and has worked with partners to ensure that labor and delivery hospitals to initiate and maintain rapid HIV testing programs for women who present at delivery with undocumented HIV status.

## Capacity Building

The Infectious Disease Bureau collaborates with the University of Maryland's Institute for Human Virology (IHV), a local performance site of the Mid-Atlantic AIDS Education and Training (AETC) to offer a diverse menu of workshops and trainings designed to increase the capacity of HIV prevention agencies to implement effective programs in Maryland. The goal of these courses is to increase the knowledge and skills of HIV prevention providers to effectively promote primary and secondary prevention of HIV infection, and to improve the quality of care for persons living with HIV. Available courses include the following topics: culturally competent behavior change counseling; client recruitment and retention; advance case management; Maryland AIDS Drug Assistance Program and Entitlements; HIV testing; and implementation of prevention intervention curricula.

Capacity building assistance is also provided by the Infectious Disease Bureau to support and enhance the provision of evidence-based HIV prevention interventions statewide. These activities include trainings, workshops, program meetings, site visits and follow-up as well as collaborating with capacity-building assistance providers.

## Ryan White-Funded Care and Service Organizations/Services

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was enacted in 1990 as a "payer of last resort" to fund treatment for people with HIV/AIDS when no other resources are available. Over the past 20 years, the legislation has expanded to include 5 separate components, Parts A, B, C, D, and F, each of which aims to address a different aspect of the HIV/AIDS epidemic. The Infectious Disease and Environmental Health Administration at DHMH is the HRSA grantee that disburses, administers, and monitors Ryan White Part B, Part B Minority AIDS Initiative, Part D, and Part D Youth Services Initiative grants.

### Ryan White Part A

Part A of the Ryan White Program provides assistance to Eligible Metropolitan Areas and Transitional Grant Areas-locals that are most severely affected by the HIV/AIDS epidemic. Maryland is home to two Part A grantees, the Baltimore EMA (consisting of Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's Counties) and the Washington, DC EMA (which includes Calvert, Charles, Frederick, Montgomery, and Prince George's counties). Part A funds are used to provide both primary medical and support services for people living with HIV and are administered and disbursed to organizations in accordance with service category priorities established by local Planning Councils.

Grantees must spend 75% of their award on core medical services, which can include outpatient medical care, medical case management, oral health, hospice services, mental health services, and substance abuse outpatient care. Up to 25% of their award may be spent on support services that are linked to medical outcomes, which could include non-medical case management, substance abuse residential services, linguistic services, outreach, and medical transportation. In 2009, the most recent year for which data is available, there were 60 Maryland grantees that received a total of \$20,510,244 in Ryan White Part A funds.

## Ryan White Part B

The Ryan White Part B program has several components: a base grant, the AIDS Drug Assistance Program (ADAP), ADAP Supplemental Drug Treatment Program, and supplemental grants to States with "emerging communities." Part B funds are used to provide medications for the treatment of HIV/AIDS (through ADAP), to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. Ryan White Part B HIV Care funding can only be used for service categories as defined by HRSA (see Appendix B). There are two types of Part B service categories: core services (including outpatient/ambulatory health care, oral health care, mental health services, outpatient substance abuse services, medical case management, and medical nutrition therapy) and support services (including non-medical case management, emergency financial support (including Housing Assistance), psychosocial support services, medical transportation, and treatment adherence.

In Maryland in 2009, there were 48 grantees that received a total of \$36,482,938 in Ryan White Part B funds. Of that amount, \$8,613,844 was the base grant and the remaining \$27,869,094 was dedicated to ADAP and ADAP supplemental programs. There are currently no supplemental grants for "emerging communities" in Maryland. Ryan White Part B Care dollars are allocated and disseminated to all 23 counties and Baltimore City via awards by PHPA to local health departments. The funding allocation is based on a formula that includes living HIV/AIDS cases (60%), a three-year average of newly reported HIV diagnoses (35%) and a rural supplement for jurisdictions that are not part of a Ryan White Part A EMA (5%). Each local health department determines which services will be provided for its clients based upon local needs as determined by the Regional Advisory Committee process (described later). PHPA requires that each jurisdiction ensure the availability of core HIV services to its residents.

An increasing availability of and need for HIV/AIDS drug therapies through ADAP has resulted in Part B being the largest component of the Ryan White Program, both state-wide and nationally. The Maryland AIDS Drug Assistance Program (MADAP) eligibility extends to 500% of the Federal Poverty Level and ensures that PLWHA in Maryland have access to the HIV related medications they need to stay healthy. MADAP offers a formulary of 200 medications to qualified Maryland residents and annually over 125,000 prescriptions for HIV treatment are dispensed to over 6,500 Maryland residents through a network of over 1,000 pharmacies state-wide. In addition to the Part B ADAP earmark, program revenue is generated through pharmaceutical rebates. All rebate income is channeled back into the program.

## Ryan White Part C

Part C of the Ryan White Program provides funds directly to service providers for three main purposes: (1) to support outpatient HIV early intervention services and ambulatory care; (2) to fund planning grants to support organizations in more effectively delivering HIV/AIDS care and services; and (3) to fund capacity development grants to help organizations develop, enhance, or expand access to HIV primary health care services. In 2009, 5 organizations in Maryland received a total of \$2,696,433 in Ryan White Part C funds.

## Ryan White Part D

Ryan White Part D funds programs that provide family-centered primary medical care and support services to women, children, and youth with HIV/AIDS. Primary medical care includes, but is not limited to, outpatient/ambulatory medical care, dental care, HIV care, behavioral health, and obstetrics/gynecology. In addition to the required primary medical care component, funds may also be awarded for support services such as case management and referrals to services such as substance abuse treatment, mental health services, and inpatient hospital services. In 1999, due to the rapidly increasing number of youth becoming infected with HIV/AIDS, a Youth Initiative was added to Ryan White Part D to specifically support youth-centered programs.

Beginning in Fiscal Year 2000, Congress designated a portion of Ryan White Program Part D Coordinated Services for Women, Infants, Children, Youth and Families funding for the Minority AIDS Initiative (MAI). The Minority AIDS Initiative is intended to address the disproportionate impact that HIV/AIDS has on racial and ethnic minorities and to address the disparities in access, treatment, care, and outcomes for racial and ethnic minorities, including African Americans, Alaskan Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders. The goal of MAI is to help reduce this burden by increasing the number of persons from racial and ethnic populations receive and stay in HIV care. MAI funds are granted to health care organizations that provide culturally and linguistically appropriate care and services to racial and ethnic minorities.

The Ryan White Program Part D is being adapted in order to respond to the changing HIV epidemiology and the National HIV/AIDS Strategy. Based on evaluation by HRSA'S HIV/AIDS Bureau (HAB) and the NHAS, there has been a change in the focus of the Ryan White HIV/AIDS Program Part D. The NHAS and recent research findings emphasize the importance of effectively using scarce resources to provide clinical care and treatment to PLWHA and to ensure that those resources are being directed to the populations most in need. Today, children comprise only about 1 percent of the HIV epidemic in the United States. Women, especially women of color, now comprise 25 percent of all people living with HIV in the U.S. The greatest increases in HIV incidence are occurring in adolescents and young adults with 34 percent of new HIV infections in those ages 13-29.

PHPA Part D Network has reevaluated their current funding and target populations, and has made adjustments to reflect these changing trends and priorities. The Part D Program will continue the 2008-2010 trend of serving additional HIV-positive Youth, with a particular focus on Black MSM Youth. Given that Men Who Have Sex with Men are disproportionately affected by the HIV epidemic at every stage across the life course, beginning in adolescence, particularly in the African American populations, PHPA Part D Network will re-direct a portion of the award funding to the young Black MSM population. The Ryan White Part D Program seeks to continue to provide services to pregnant HIV-positive Women, age 25+, but not to all Women, age 25+. Services to these Women are adequately covered by the Ryan White Part A and Part B Program funded providers, as well as by the Medicaid program. Part D funding will fill gaps in other Ryan White programs by focusing on special populations that need more comprehensive and intense services.



## **Non-Ryan White-Funded Care and Service Organizations/Services**

Within the Department of Health and Mental Hygiene, additional agencies provide an array of health services to people living with HIV/AIDS. These agencies, which include Alcohol and Drug Abuse Administration, the Office of Minority Health and Health Disparities, the Mental Hygiene Administration, Family Health Administration, and Medical Care Programs, collaborate with PHPA and with each other in providing integrated care for PLWHA. HIV affects many aspects of a person's life, and therefore many individuals must access several services for treatment and care to effectively meet their health and support needs. For example, in order to engage in and adhere to medication regimes for HIV treatment, an individual may first need to access mental health or substance abuse services to address issues that may impede their ability to fully comply with the treatment protocol.

IDB works with the PHPA's rural health and maternal/child health programs to assure access to primary care, prenatal and family planning services. Maryland's mandatory Medicaid managed care program, HealthChoice, was implemented in 1997 and provides risk-adjusted rates to provide care to PLWHA. This program ensures that individuals with HIV/AIDS have access to case management services, HIV/AIDS-specialized primary care (not including antiretroviral drugs used for HIV/AIDS treatment), and substance abuse treatment within 24 hours of request. The Veterans' Administration provides comprehensive health care services for veterans with HIV/AIDS, including primary care, antiretroviral drugs, and other HIV/AIDS-specific services. In 2009, over 24,000 HIV infected veterans received health care in through the Veterans' Administration.

The state of Maryland provides medical assistance through several other non-Medicaid programs as well. The Primary Adult Care (PAC) Program, which serves low-income adults, provides prescription coverage, including HIV/AIDS treatment medications, at no or low-cost. The Maryland Children's Health Insurance Program (MCHIP) provides low-cost health coverage for children of low-income families. Because MCHIP's main responsibility is for primary medical care, there remain many gaps for HIV-infected children to receive comprehensive HIV/AIDS care and treatment. It therefore falls to other funding streams, such as Ryan White Part B and/or Part D programs, to fill those gaps.

PHPA is also responsible for the Housing Opportunity for Persons with HIV/AIDS (HOPWA) program, funded by the Department of Housing and Urban Development (HUD), which provides housing assistance services to low-income persons with HIV/AIDS and their families. HOPWA was created to help clients maintain stability, avoid homelessness, and improve client's access to treatment and healthcare needs by providing housing assistance. In the state of Maryland, approximately 100 clients are currently receiving housing assistance through HOPWA. The other program option for PLWHA is the Tenant-Based Rental Assistance (TBRA), which provides monthly rental subsidies to assist clients in maintaining current housing.

## **Interaction HIV Prevention and Health Services to Ensure Continuity of Care**

A number of mechanisms are in place to enhance collaboration and coordination of services among Ryan White funded providers and non-Ryan White services. Many of the providers of Ryan White funded services also offer a range of services that are funded by other sources. The Greater Baltimore HIV Health Services Planning Council and its committees are composed of Ryan White and non-Ryan

White representatives, including health-care agencies, medical clinics, social and mental health services, local health departments, AIDS service organizations, public health institutions, community leaders and people who are HIV positive. In addition, the HIV Community Planning Group (CPG) which includes representatives from PHPA, Ryan White providers, non-Ryan White providers, and community members, meets monthly. This community planning process facilitates collaboration between planners and providers and encourages local, state, and federal partnerships. In addition, the Greater Baltimore HIV Health Services Planning Council and its committees are composed of Ryan White and non-Ryan White representatives, including health-care agencies, medical clinics, social and mental health services, local health departments, AIDS service organizations, public health institutions, community leaders and people who are HIV positive. The Regional Advisory Committees (RACs) in each of the five regions of the state also provide a forum for prevention and care issues to be presented and community input to be gathered to strengthen programs. RAC meetings are mandatory for Ryan White Part B providers.

A provider grid that delineates HIV providers in the state and cross-references both CDC prevention and HRSA Ryan White funding reveals that over 40 partners are funded for prevention services such as HIV counseling, testing, referral, and treatment and support services throughout the state. In fact, testing activities of the majority of Ryan White Part B providers statewide are supported with DHMH/PHPA's HIV testing funds. Currently, 6 local health departments, numerous Baltimore Substance Abuse Systems sites, 3 community-based organizations, 5 community health centers, 8 hospital clinics, and 1 obstetrics /perinatal clinic offer both PHPA-supported HIV testing and Ryan White Part A services.

Given the limitations of Ryan White funding, PHPA uses State General funds to fund HIV care clinics in two of the rural areas of the state where HIV specialty care is not otherwise available. PHPA contracts with two HIV care providers from Baltimore to travel to and provide these regional seropositive clinics.

### **Effect of State and Local Budget Cuts**

Federal funding for HIV health services in Maryland has been relatively stable in the past few years. However, the recession and state fiscal crisis resulted in cuts to state funds previously allocated for HIV prevention and 35% reductions in core funding to local health departments. In response, PHPA has worked with its partners in the local health departments to ensure that the most highly prioritized services are continued for those that need these services most. Strategies have included elimination of lower priority services, seeking additional sources of funding whenever possible, establishing improved mechanisms for program collaboration to provide services more efficiently, cross training staff, conducting continued monitoring activities to ensure that funding is utilized appropriately, and implementing measures to promote efficiency in the delivery of services.

Maryland has always supported the provision of HIV care in the State with state and county funds. PHPA expends over \$400,000 in state general funds to support regional HIV specialty clinics in rural regions of the state and approximately \$2,000,000 in State funds to enhance HIV case management provided by local health departments. The infusion of state funds has enabled local health departments to better facilitate the enrollment of eligible clients into other public benefits and entitlement programs, such as Maryland Health Insurance Program, Primary Adult Care, COBRA, Medicare as well as mitigating HIV related issues with private insurance coverage.

With reduced funding available via the 2012 Ryan White Part D program, Maryland's Part D Network is responding to reduced resources for the Ryan White Part D-Youth award monies. To address this challenge, the Network has begun planning a realignment of projected funding that mirrors trends in new infections among youth, in particular young African American males having sex with males and the increased incidence of African American heterosexual women. Ongoing collaboration with RW Parts A and B will allow the Network of Part D providers to maintain success with prevention of perinatal transmission of HIV. Network providers are encouraged to seek additional funding support from other sources to meet the growing service demands. The decrease in the funding will not impact the continuum of care for PLWHA. With significant planning and re-allocation of funding, Maryland will continue to provide services that will impact the emerging population.

### **Shortfalls in Healthcare Workforce**

According to the federal Health Resources and Services Administration (HRSA), on February 29, 2011, there were 13,962 Health Professional Shortage Areas (HPSAs) in the United States, 131 of which were in Maryland. In order to be classified as an HPSA, there must be shortages of primary medical, dental or mental health providers in a specific geographic location (a county or service area), demographic community (low income population) or institutional facility (comprehensive health center, federally qualified health center or other public facility). For each designation, the ratio of population to providers must display a severe shortage of health professionals. Of the 131 HPSAs in Maryland, 45 were granted in primary care, 39 in dental, and 47 in mental health.

In the Baltimore-Towson EMA, which includes Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County, Howard County, and Queen Anne County, there are 57 designated HPSAs. Of those, 18 were in primary medical care, 16 in dental, and 23 in mental health. In the Maryland region of the Washington DC EMA, which includes Calvert, Charles, Frederick, Montgomery, and Prince Georges Counties, there are 13 designated HPSAs. Of those, 5 were in primary medical care, 4 in dental, and 4 in mental health. In the other 12 counties in Maryland, there were 62 designated HPSAs. Of those, 20 were in primary medical care, 21 in dental, and 21 in mental health.

### **Legislation in Maryland**

Maryland has enacted several pieces of legislation that addresses the needs of people living with HIV/AIDS and those who are at risk of acquiring the disease. The statutory response has focused on three main areas: (1) transmission prevention, (2) treatment, and (3) HIV testing and linkage to care.

#### **Maryland HIV/AIDS Reporting Act**

In response to the new requirements to qualify for federal funding under the Ryan White Act, Maryland enacted the Maryland HIV/AIDS Reporting Act of 2007. Of primary importance, the Act changed the state's HIV surveillance system from a code-based HIV reporting system to a name-based system. The Act required physicians who care for patients who are HIV positive or AIDS-defined to report surveillance information to Maryland's Secretary of Health and Mental Hygiene and to local health officers. Additionally, the Act required laboratories to report information on positive HIV test results to the Secretary. Further, the Act required certain institutions to report information on patients in their care who are HIV positive or AIDS-defined to the Secretary and to local health officers.

### HIV Testing – Informed Consent and Treatment Act

In April 2007, the Maryland General Assembly passed legislation (HB781/SB746) that required the AIDS Administration to form a work group to review the CDC's *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings*, best practices, research and data on HIV counseling and consent processes. The workgroup was comprised of HIV-infected individuals, HIV/AIDS advocacy organizations, HIV service providers and other stakeholders. The process yielded a comprehensive set of recommendations on potential changes to current Maryland law for HIV counseling and testing processes, which was given to the Maryland General Assembly in December 2007.

During the 2008 legislative session, the General Assembly passed House Bill 991/Senate Bill 826, entitled "HIV Testing-Informed Consent and Treatment Act," in an effort to increase access to HIV testing by removing reported barriers. This act alters the requirements for informed consent for HIV testing. Under the act, if testing is ordered at a health care facility, informed consent no longer needs to be documented on a separate, written form, but must be documented in the medical record. Testing performed at any other location requires a separate written informed consent form.

The act also provides that an individual administering pretest counseling may utilize a wider array of communication methods based on the client's needs and testing history. Additionally, the act requires that an individual with a positive test result must be referred to treatment and supportive services. Further, the act requires health care providers of prenatal care to notify pregnant patients that they will be tested for HIV as part of routine, prenatal care, unless they decline such testing. Providers of labor and delivery services are required to consider offering rapid HIV testing to women with unknown HIV status, and to offer antiretroviral prophylaxis to those who test positive for HIV.

### Affordable Care Act

Maryland continues to be at the forefront of health care reform implementation. On March 24, 2010 Maryland Governor Martin O'Malley announced an Executive Order that created the Maryland Health Care Reform Coordinating Council to advise the administration on policies and procedures to implement the recent and future federal health care reform legislation. On March 30, 2012 the Maryland General Assembly passed the Maryland Health Benefit Exchange Act of 2012, legislation that establishes Maryland's Exchange – the next step in fully implementing the provisions of the Affordable Care Act (ACA). Maryland is also working collaboratively with an advisory committee of stakeholders to identify "essential health benefits" that must be covered by all health insurance plans sold inside and outside health benefit exchanges in the small group and individual markets by 2014, according to the ACA.

The Maryland Health Benefit Exchange Act of 2012 will affect the ability of PLWHA to access private health insurance. Maryland's Health Benefit Exchange will allow Marylanders to compare rates, benefits, and quality among plans to help individuals and small employers find an insurance product that best suits their needs. Reform means that more Marylanders, including PLWHA, will have access to quality, affordable health insurance. The most up-to-date information regarding the Exchange and Health Care Reform in Maryland can be found at <http://www.healthreform.maryland.gov/>.

## Health Enterprise Zone

In April 2012, legislation was passed in Maryland to create a pilot program which offers tax breaks, credits, and other incentives to local health departments and community groups for their programs in underserved areas – labeled as Health Enterprise Zones (HEZs). The zones were the result of the Maryland Health Quality and Cost Council Health Disparities Workgroup, chaired by University of Maryland School of Medicine Dean Dr. E. Albert Reece. The workgroup's goal was to look for ways to address the health disparities that minorities face in the state and the disproportionate toll such disparities take on the health care system.

HEZs will be established in areas with significant health disparities, poor access to primary care and high rates of chronic illness. Primary care physicians would be encouraged to practice in HEZs through a range of incentives to include loan repayment assistance, tax credits and help in installing health information technology. To be eligible, clinicians would have to participate in the Medicaid program and meet voluntary standards for community service. Community-based organizations would apply to create the zones, and proposals with matching funding would be given priority. Local health groups and offices will submit proposals to the Department of Health and Mental Hygiene and the Community Health Resources Commission outlining their targeted communities and their plans. Subsidies would likely be capped in the tens of thousands of dollars. The Legislation also includes the creation of a Maryland Health Innovation Prize, which would provide a significant financial reward and public recognition for a new intervention or program that successfully reduces or eliminates healthcare disparities.

## Description of Needs

### Assessment of Need

The needs of people living with HIV/AIDS in Maryland were determined using a variety of different methods in order to obtain a fully comprehensive assessment. The sources used in the needs assessment are described in more detail below.

### Regional Advisory Committees

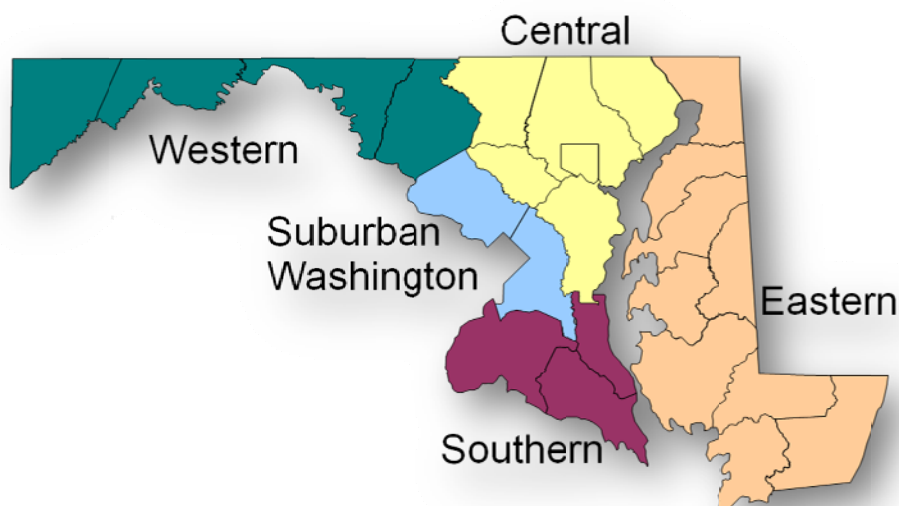
For PHPA, the Regional Advisory Committees (RACs) serve as the public advisory planning bodies that provide input and advice to the State of Maryland in the development and implementation of the State's HIV/AIDS Comprehensive Plan. RACs provide an opportunity for community members interested in HIV/AIDS to network, discuss needs, and develop a comprehensive continuum of care and prevention that effectively leverages funding from multiple streams and reduces duplication of resources. RACs are located in each of the five Maryland Regions (Central, Eastern, Southern, Suburban, Western) and meet four times a year. Each committee includes representatives from every major area of PHPA, HIV infected and/or affected community members, providers of services and/or prevention programs related to HIV, and representatives from community, government and faith based organizations. All agencies across the State that receive Part B funding to serve PLWHA are required to participate as active members of the RAC in their region. The co-chairs for the RACs provide leadership to the planning body through coordination, planning, organization, and representation of the interests and

concerns of the RAC. Leadership and planning efforts are also coordinated through quarterly teleconference meetings with co-chairs to review and discuss development of the RAC process.

The providers actively enlist the participation of community stakeholders and those infected with and/or affected by HIV. Membership to the RAC is open—anyone who would like to attend is welcomed and is able to fully participate in the meetings. A brochure is used to recruit new members by describing the importance and purpose of the RAC, the dates and locations of the various RAC meetings and the funding available to assist in consumer attendance. Recruitment is an ongoing process throughout the year. Transportation and reimbursement of childcare expenses are available for PLWHA to attend meetings. This strategy has been successful in enlisting infected and affected individuals as RAC members who are representative of the epidemic. Participation in RACs by other Ryan White Act Parts occurs in several ways. Since many health departments and community-based organizations receive both Part A and Part B funds, there is excellent representation of these two Parts in RAC attendance. Several Part A and B grantees, located in the Baltimore EMA, are also Part C and/or Part D grantees.

A key role of the RACs is to provide information on the unique needs of each region in order to ensure that the needs of all populations are addressed in the Comprehensive Plan. Through the meetings held throughout the year, RAC attendees review the various services currently being provided in the region, review the allocation plan and provide feedback, consider epidemiological data, identify newly emerging underserved populations, review the various funding streams currently in place, and prioritize service categories to fit the identified needs of the region. RACs also often provide regional reports and discussions on emerging trends and populations at the RAC meetings.

**Figure 11. Maryland Regional Advisory Committee Regions**



### Community Dialogues

Community Dialogues are held annually at each region’s RAC meeting to provide the community, especially consumers of services, the opportunity to discuss needs, service gaps and potential solutions. In March 2012, PHPA staff attended the five regional meetings and facilitated Community Dialogues with consumers and providers of services around the state to gather feedback as part of the SCSN process. Efforts were made to include a wide range of participants for the open forums, successfully

drawing a total of 200 PLWHA, community members, and providers. Representatives from Ryan White Part A-, B-, C-, and D-funded programs and AIDS Training and Education Centers participated. These forums served as a venue to hear consumers and provider voices. Both were given the opportunity to share concerns, suggestions and experiences about their HIV care and service needs.

The following multi-step process was used to complete the SCSN:

**Step One: Collect needs assessment documents and review information that identifies service needs and barriers to care on a regional and state level.** PHPA staff began a comprehensive review of needs assessment documents from various sources throughout the state in an effort to amass information delineating needs and barriers in specific regions or special populations. Documents varied in content, format, and timeframe, ranging from statewide needs assessment to regional public input summaries to agency survey results. Also included were articles published in medical journals, research and evaluation summaries, surveillance study analyses, focus group reports, and consumer knowledge survey results. A complete list of the documents included in the review can be found in Resource Inventory (Appendix C). Identified needs, including prevention and policy issues are summarized in this document.

**Step Two: Conduct regional community dialogues.** To solicit the input from required entities for completing the SCSN, five regional advisory meetings were held in March 2012. Efforts were made to include a wide range of participants for the open forums, successfully drawing a total of 200 PLWHA, community members and providers. Representatives from Ryan White Part A-, B-, C-, and D-funded programs and AIDS Training and Education Centers participated. These forums served as a venue to hear consumer and provider voices. Both were given the opportunity to share concerns, suggestions and experiences about their HIV care and service needs.

**Step Three: Summarize and compare HIV/AIDS epidemiological data.** The Center for Surveillance and Epidemiology at PHPA produced graphic and tabular data on reported HIV and AIDS cases and persons living with HIV and AIDS, which are presented in the Epidemiological Profile. These data highlight variables such as race/ethnicity, gender, age, and mode of HIV transmission, and trend information on cases and deaths. This information is presented on a statewide and regional basis.

**Step Four: Summarize emerging trends, special populations, and service needs and barriers.** All needs assessment documents, Regional Advisory Committee minutes, and priority setting results were collected and synthesized, culminating in a comprehensive list of service needs and barriers that will be given high priority in future planning. Discussions regarding special populations that are disproportionately affected by the HIV/AIDS epidemic are discussed in more detail later in this document.

**Step Five: Prepare, finalize, and distribute the SCSN document.** Using the synthesis of information gathered above, the care needs assessment was written and used as a guide to create priority goals for the Comprehensive HIV Plan.

## Client Satisfaction Surveys

PHPA also assesses need through specific questions on the statewide Client Satisfaction Surveys (CSS) administered each year to clients receiving HIV/AIDS services through Ryan White or state general funds. The survey was conducted over the last three years (2009-2011) in Part A-funded programs in the Baltimore EMA, all Part B and State funded agencies, and all Part D funded sites in Maryland. Clients are asked about what HIV-related services they receive, barriers to receiving or accessing services, unmet needs, and levels of satisfaction with numerous services. In the 2009 survey, specific questions were asked regarding clients' unmet needs and why they felt their unmet needs were not being met. In the 2010 and 2011 surveys, these unmet-need related questions were omitted in order to preserve data quality and integrity, because it was discovered that some clients had difficulty understanding and answering the questions properly. PHPA also utilizes the MADAP client satisfaction survey to assess client satisfaction with the MADAP program, which is administered every two years.

## Other

A Consumer Survey for the Baltimore EMA was conducted in 2010 by InterGroup Services, Inc. (IGS) for the Greater Baltimore HIV Health Services Planning Council.<sup>3</sup> The survey was conducted in and around Baltimore, Maryland and targeted area clients (or "service consumers") of the Ryan White program, Part A. The survey contained three sections: (1) questions on core medical services, which collected information about respondents' demand for and use of services such as HIV primary medical care, medical case management and substance-abuse treatment; (2) questions on support services, which collected information about respondents' demand for and use of services that enable them to remain in care, such as transportation and housing; and (3) questions on demographics, which collected information about consumers' income, race/ethnicity, jurisdiction of residence, mode of HIV transmission and much more. It also captured information on key subpopulations and their specific needs, including Hispanics, those in care for less than six months, and five high-HIV-incidence "hotspot" ZIP codes identified by the Baltimore City Health Department.

On January 10, 2011, Governor Martin O'Malley and Lt. Governor Anthony G. Brown held the Governor's Forum on Children and Health. The purpose of the Forum was to bring stakeholders together to provide input to the O'Malley-Brown Administration as it entered its second term. The Forum included a break-out session on HIV, which focused on the National HIV/AIDS Strategy from the policy, programmatic, and partnership perspectives. The break-out session participants included a wide range of stakeholders, including healthcare providers, consumers, faith leaders, researchers, policy makers, and educators. Feedback from small group discussions within the session identified (1) key policy issues needed to overcome structural barriers; (2) programmatic interventions needed to increase prevention among high-risk populations; and (3) partnerships that need to be in-place to insure success for each goal.

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<sup>3</sup> InterGroup Services, Inc. (IGS). (2011). The Greater Baltimore HIV Health Services Planning Council Consumer Survey: Baltimore EMA, 2010. Baltimore, MD: IGS.



## Prevention Needs

### Prevention Education

Despite successes in providing prevention education, RAC participants reported a continued need to incorporate prevention education into HIV primary care. Clients from both rural and urban areas reported receiving minimal or no prevention information from their doctors. Community Dialogue participants also identified a need for basic HIV/AIDS education in other settings such as schools, churches, and community based organizations. Participants also indicated that there was a continued need for both clients and providers to receive updates on new information around HIV/AIDS. Utilizing media for a widespread HIV/AIDS awareness and prevention campaign was mentioned at several RAC meetings. Some participants felt that “people don’t seem to worry about it anymore,” and that through the use of television, radio, billboards, and social networking sites, the HIV epidemic and the importance of prevention can be brought back into the public’s eye. The CPG identified the need for more population-specific and appropriate group- and individual-level health education/risk reduction interventions.

### HIV Testing

People living with HIV are less likely to transmit the virus to others if they know they are infected and if they have received counseling about safer behavior. RAC participants mentioned numerous times the lack of HIV testing in the medical setting as a prevention need. Clients and providers both agreed that HIV testing should be routine in primary care visits. Respondents suggested using social media tools such as websites, blogs, and social networking sites to advertise HIV testing locations and events. Simply getting an HIV test is not enough however – it is important for clients to fully complete the HIV testing process. Providers in Community Dialogues reported that if the client has to wait to get the results of an HIV test back, it is often difficult to locate the client and ensure they receive their results. RAC and CPG participants expressed a need for resources to address intimate partner violence to be integrated into HIV testing process. Participants felt testing provides opportunity to interact with a healthcare worker who may be able to provide tools and resources to address the violence. Additionally, disclosure of HIV status to a violent partner could lead to further injury.

### Prevention with Persons Living with HIV/AIDS

Prevention with PLWHA was highlighted as a major need in all RACs. A number of studies have shown that an HIV-positive person on antiretroviral treatment with an undetectable viral load has a very low risk of transmitting HIV to someone else.<sup>4</sup> Medication/treatment adherence can therefore be considered a form of prevention. Research suggests that clinicians often avoid talking to HIV-positive patients about prevention because of a simple lack of time, discomfort in discussing intimate (often gay) sex, or the belief that counseling will not change a patient’s behavior. Providers need additional training on how to effectively provide ‘Prevention with PLWHA’ services. In Maryland, many of these strategies are already in place. Prevention with PLWHA programs in the state use both individual and group interventions to teach HIV-positive individuals the skills to develop healthy relationships, make safer

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<sup>4</sup> Attia, S., Egger, M., Müller, M., Zwahlen, M., & Low, N. (2009). Sexual transmission of HIV according to viral load and antiretroviral therapy: systematic review and meta-analysis. *AIDS*, 23 (11), 1397-1404.

choices, and help them maintain the difficult treatment regimen associated with HIV disease. Curricula used in Maryland include Healthy Relationships and Positive Wellness and Renewal (POWER).

### Needle Exchange Programs

Needle exchange programs have been proven to drastically reduce the transmission rate of HIV among injection drug users.<sup>5</sup> These programs distribute clean needles and safely dispose of used ones, and also offer related services such as referrals to drug treatment centers and HIV counseling and testing. Since its introduction in Maryland in 1994, the rate of transmission through IDU has decreased significantly. AVERT, and international HIV/AIDS charity, reports that “with an estimated 1 in 5 injecting drug users worldwide infected with HIV and 30 percent of HIV infections outside sub-Saharan Africa resulting from injecting drug use, such programs are key to bringing the global epidemic under control”<sup>6</sup>. A needle exchange program exists in Baltimore City. Community members and HIV prevention providers frequently discuss the need for similar programs in areas outside Baltimore City.

### Partner Services

Individuals who test positive for HIV have the daunting responsibility of informing their past, present, and future sexual and/or needle-sharing partners of their status. Partner counseling and notification services often make this intimidating task much more manageable. The CDC reports that “by identifying infected persons, confidentially notifying their partners of their possible exposure, and providing infected persons and their partners a range of medical, prevention, and psychosocial services, partner services can improve the health not only of individuals, but of communities as well.” Given that approximately 20% of the 1-1.2 million persons living with HIV infection in the United States are unaware of their infection, and that these 20% account for 54%-70% of new infections, partner notification is an integral element in identifying individuals who were previously undiagnosed.<sup>7</sup> The CPG suggested that the current system of partner services be expanded to use more internet notification. Recognizing that not everyone knows or understands what partner services does, campaigns to increase awareness around STI/HIV partner services were also suggested.

### Other

Prevention education materials and programs need to be offered in other languages, such as Spanish and American Sign Language (ASL), in order to reach monolingual populations, which are often at highest risk for acquiring or transmitting HIV. Youth-specific and MSM-specific outreach and prevention strategies need to be utilized in order to be effective for their intended populations.

In 2010, CPG members identified the need for increased trauma-informed mental health services targeted for specific populations. Many of those at risk for infection are also dealing with trauma either

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<sup>5</sup> Kerr, T., Small, W., Buchner, C., Zhang, R., Li, K., Montaner, J., & Wood, E. (2010). Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. *Research and Practice*, 100 (8), 1449-1453.

<sup>6</sup> AVERT. (2012). Injecting Drugs, Drug Users, HIV & AIDS. Retrieved from <http://www.avert.org/needle-exchange.htm>.

<sup>7</sup> Centers for Disease Control and Prevention. (2008). Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection. *Morbidity and Mortality Weekly Report*, 57 (RR09), 1-63. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm>

presently or in their past. Traumatic situations include physical abuse, verbal abuse, and sexual assault. Addressing such traumas may decrease the behaviors that increase the risk for infection.

Condoms are distributed by the state of Maryland to various organizations to provide to individuals. The RACs and CPG provided feedback that condoms should be distributed in places other than the traditional venues of local health departments, other health care providers, and community-based organizations.

**Care Needs/Gaps in Care**

This section describes documented and perceived needs and gaps in care. Documented needs are those supported by specific evidence and/or quantitative information from sources outlined in Appendix C. Perceived needs were compiled and analyzed from Client Satisfaction Surveys, statements made by RAC meeting attendees, community dialogues, and community prevention forums. Whether formally or informally documented, all accounts reflect the awareness of consumers and caregivers with direct experience accessing the delivery system and providers and case managers on the forefront of service delivery.

On an annual basis, the five RACs prioritize the Part B service categories to best meet the needs of people living with HIV in their region. The planning cycle includes local community meetings in each Part B region where epidemiologic data, information about available health services, and the results of needs assessment and evaluation activities are presented. Feedback is then provided by the RAC attendees to PHPA staff. The regional planning cycle culminates in a meeting held in the fall to establish service priorities that serve as a guide to plan for and fund HIV services specific to each region for the subsequent year. All providers of Ryan White Part B services, local health departments and community-based organizations are required to show how priorities are met in submitting annual budget and performance measures. The rankings of Ryan White Part B funding priorities by service category for FY2012, seen below, did not change substantially from prior years.

**Regional Priorities for Ryan White Part B Services for FY2012**

<b>Core Services</b>	<b>Support Services</b>
<b>Central Region</b>	
1. Primary Medical Care (Outpatient Ambulatory Health Services)	1. Food Bank/ Home Delivered Meals
2. Medical Case Management	2. Childcare Services
3. Medical Nutrition Therapy	3. Non-Medical Case Management
4. Oral Health Care	3. Psychosocial Support Services
5. Mental Health Services	4. Housing Services
6. Substance Abuse Services Out-patient	4. Medical Transportation
	4. Outreach Services
	5. Emergency Financial Assistance
	5. DOT/Pharmacy Support and Education

<b>Core Services</b>	<b>Support Services</b>
<b>Southern Region</b>	
1. Primary Medical Care (Outpatient Ambulatory Health Services)	1. Childcare Services
2. Mental Health Services	2. Outreach Services
3. Substance Abuse Services Out-patient	3. Case Management – Non-Medical
4. Medical Case Management	3. Medical Transportation
4. Oral Health Care	3. Emergency Financial Assistance
4. Medical Nutrition Therapy	3. Housing Services
	4. Psychosocial Support Services
	4. Food Bank/Home Delivered Meals
	5. Other: Legal
<b>Suburban</b>	
1. Primary Medical Care (Outpatient Ambulatory Health Services)	1. Emergency Financial Assistance
2. Medical Case Management	2. Psychosocial Support Services
3. Oral Health Care	3. Housing Services
4. Medical Nutrition Therapy	4. Medical Transportation
5. Mental Health Services	5. Case Management – Non-Medical
6. Substance Abuse Services-Outpatient	6. Food Bank/Home Delivered Meals
	7. Childcare Services
	8. Outreach Services
<b>Western Region</b>	
1. Medical Case Management	1. Emergency Financial Assistance
2. Outpatient Ambulatory Health Services	2. Medical Transportation
2. Mental Health Services	3. Non-Medical Case Management
4. Oral Health Care	4. Housing Services
	5. Medical Transportation
	6. Psycho-social Support
	7. Food Bank/Home Delivered Meals
	8. Childcare Services
<b>Eastern</b>	
1. Medical Case Management	1. Non-Medical Case Management
2. Oral Health Care	2. Medical Transportation
3. Mental Health Services	3. Emergency Financial Assistance
3. Substance Abuse Services	3. Psychosocial Support Services
4. Primary Medical Care (OAHS)	4. Outreach Services
5. Medical Nutrition Therapy	4. Housing
	5. Food Bank/Home Delivered Meals
	6. Childcare Services

## Core Services

### Primary Medical Care

According to the most recent unmet need estimate for Maryland, 35% of PLWHA in the state are not currently receiving primary HIV medical care. The client-led RAC priority setting process ranked primary medical care as the top core service needed. When an HIV-infected individual is not engaged in care, they are not receiving the beneficial medical care, prevention, core and support services that help them improve their health outcomes by reducing morbidity and mortality associated with HIV disease. In addition, persons who are engaged in primary medical care are less likely to practice risky behaviors than those not engaged in care, therefore decreasing their risk of transmission to others.<sup>8</sup>

### Case Management

Case management services are crucial for PLWHA to access HIV care and support services. According to the 2010 and 2011 Client Satisfaction Surveys, over three-fourths of clients in all regions receive case management services. Despite its importance, RAC participants reported numerous problems with case management that prevented them from effectively providing or accessing services. From providers' viewpoints, these included high turnover rates due to large case loads and difficulty in finding qualified staff to fill positions, often due to low salary structure of case managers. Both issues were consistent with previous SCSNs results, as well.

From the viewpoint of community members and PLWHA, many felt that case managers lacked the knowledge of available services, possibly due to an ineffective referral system, that the case managers need to show more cultural sensitivity, and that those hired need to be more reflective of the population they are serving. Participants suggested that an effective referral system, training on cultural competency, and more collaboration between providers would help to enhance case management services and HIV care for PLWHA.

### Dental care

Although it is often overlooked, people living with HIV/AIDS need to understand the importance of receiving on-going, quality oral care as part of their health care regimen. Providers also have a responsibility to integrate oral health into their clients' treatment plans and encourage coordination between primary medical care and oral health care sites. Oral health providers also need to be knowledgeable about HIV/AIDS and the unique oral health needs of clients living with HIV/AIDS. In RAC meetings, providers mentioned that dental care is a high priority for many PLWHA because the number of oral lesions and cancers has increased over the years, requiring the need for more specialized dental care.

Consistent with the findings from previous SCSNs, the most recent Client Satisfaction Surveys and RAC meeting participants reported a great need for more extensive oral health services. Between 10-20% of respondents from the 2009 Client Satisfaction Survey felt they needed, but did not receive, oral health

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<sup>8</sup> Metsch, L., Pereyra, M., Messinger, S., del Rio, C., Strathdee, S., Anderson-Mahoney, P., Rudy, E., Marks, G., & Gardner, L. (2008). HIV Transmission Risk Behaviors among HIV-Infected Persons Who Are Successfully Linked to Care. *HIV/AIDS*, 47, 577-584.

care. In the RAC Community Dialogues, participants also noted that many dental providers do not want to treat HIV-positive persons.

In the Baltimore EMA Consumer Survey, oral health was ranked third among the most demanded services, with 44.7% of clients reporting an unmet need. Of those who needed this service and did not receive care, 19.7% said they did not know how to obtain it and 12.7% said they could not afford the co-payments. As PLWHA live longer, it will only become more important that they have access to quality oral health care.

### Prevention and Education

As a result of people of people living longer with HIV/AIDS, there is a greater need for prevention education and counseling for HIV-positive persons in the medical care setting. In 2003, CDC issued recommendations on *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, which noted that “medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors, communicating prevention messages, discussing sexual and drug-use behavior, positively reinforcing changes to safer behavior, referring patients for services such as substance abuse treatment, facilitating partner notification, counseling and testing, and identifying and treating other sexually transmitted diseases (STDs).”<sup>9</sup> PHPA, in accordance with this guidance, has been integrating prevention with primary care.

Providers in the Community Dialogues supported an increase in prevention efforts, but felt that they needed to receive additional training on incorporating prevention education into HIV primary care. They also reported that there is limited time during appointments to provide prevention services. Providers, PLWHA, and other community members also mentioned the lack of HIV prevention messages in the media, such as TV, radio, and billboards. They suggested that to increase the visibility of prevention messages, social media strategies could be employed to inform clients about where to go for HIV testing and care services.

Currently, the most common HIV-transmission group is Men Who Have Sex with Men. RAC participants reported that with the increasing prevalence of HIV in the MSM population, there is a need for more prevention resources to address the needs of MSM and transgender populations.

Rural communities stated that they need more prevention education but there is limited or no funding in their areas because of budget cuts. Because of lack of funding for prevention, their condom supplies and staff who perform prevention services is limited. It was suggested that one way of increasing accountability of providers regarding prevention delivered in the medical care setting is to increase collaborations between providers and local health departments to establish practice standards and monitor implementation.

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<sup>9</sup> Centers for Disease Control and Prevention. (2003). *Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America*. *Morbidity and Mortality Weekly Report*, 52 (RR12), 1-24. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>.

## Support Services

### Housing Assistance

In the Community Dialogues, RAC participants in all regions ranked housing as one of the top priorities and needs. Respondents of the 2009 Client Satisfaction Survey also reported housing assistance as the service they needed most and were not receiving. The 2010 Baltimore EMA Consumer Survey found that although the proportion of clients needing temporary housing services has decreased, the proportion of clients with an unmet need for those services has increased. In 2004, over 58.6% of total clients needed such services, and 46.2% of those had an unmet need. By 2010, only 33.9% of total clients were requesting temporary housing services, but 53.4% of those clients had an unmet need.

Although programs like HOPWA (Housing Opportunities for Persons with AIDS) and TBRA (Tenant-Based Rental Assistance) exist, such programs are underfunded and unable to meet the housing needs of PLWHA in the state.<sup>10</sup> There is a lack of affordable and decent housing for low-income individuals and families in general throughout Maryland; and those infected with or affected by HIV/AIDS are particularly susceptible to the consequences of a lack of stable or adequate housing. In addition, there is a deficiency of housing assistance services. Regardless of HIV status, clients experience long housing waitlists and shortages in beds in existing transitional shelters. Furthermore, even if a client is able to find safe and affordable housing, they often do not have the means to provide the needed security deposit. It is obvious that additional resources and strategies are needed to meet the increasing demand for housing and housing assistance for PLWHA in Maryland.

### Transportation

In the last two consecutive SCSNs and the current client priority rankings, RAC participants consistently identified transportation as one of the top five support service needs for their area. In the most recent Community Dialogues, participants across all five regions identified transportation as the third greatest need for PLWHA and the overall greatest problem that clients face while trying to access care.

Forty-one percent of participants in the 2011 statewide Client Satisfaction Survey reported that public transportation was the most common form of transportation utilized to access their care site, followed by personal vehicle (31.3%), and relying on a friend or relative (9.6%). Twenty-eight percent of respondents take up to one hour to reach medical care facility for appointments. Transportation difficulties coupled with the great amount of time required to obtain needed services can affect adherence to treatment regimens.

In the Baltimore EMA's 2010 Consumer Survey, 33.6% of those who needed medical assistance in obtaining transportation to attend medical or social services appointments (whether from special contractor/volunteer programs or taxi/bus fare subsidy programs) did not receive it. This number has been steadily increasing over the years. Among those with unmet transportation needs, about half cited not knowing how to access transportation services as a barrier to receiving necessary medical services.

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<sup>10</sup> Alderman, E. (2012). State of Maryland's Housing Opportunities for Persons with AIDS (HOPWA) [PowerPoint slides]. Presentation to Eastern Regional Advisory Committee (RAC) Meeting. March 6.

### Emergency Financial Assistance

Clients depend on Emergency Financial Assistance (EFA) to help pay for services not covered by insurance, co-pays, rental assistance and utility bills. Client satisfaction surveys show yearly increases in the percentage of clients who need help paying bills from 20% in 2010 to 37% in 2011. In four out of five regions, emergency financial assistance was listed as the top priority for service needs. During a RAC meeting, one provider stated that about 80% of their annual EFA budget was already depleted a third of the way through the year, leaving clients' requests for help to pay for necessities such as food, housing and utility bills unmet.

### Priority, Special, and Vulnerable Populations

Special populations that are uniquely affected by the HIV epidemic have been identified by Maryland's Community Planning Groups and the Baltimore EMA's Comprehensive Planning Committee. The CPG has worked with PHPA to review data and information to determine the priority populations for HIV prevention initiatives. Maryland's HIV Prevention priority populations for the most recent year available (2010-2011) are:

1. Persons living with HIV/AIDS
2. Men Who Have Sex with Men
3. Heterosexual
4. Injection Drug Users
5. Special Populations

Currently, the most common HIV transmission risk group is MSM (44.6%), followed by Heterosexuals, (35.8%), and then IDU (15.9%). The percentage of African American cases has been increasing over time as well. Eighty-one percent of all HIV cases in 2010 were African American, up from 75% in 2007. Because of this disproportionate impact, special attention and emphasis are given to services for African Americans.

Special Populations are defined as those with special linguistic needs and/or those with documented elevated risk of HIV transmission and are unlikely to be served by prevention programming targeting one of the other priority populations. Special Populations for the most recent year available (2010-2011) are: Deaf Persons, Hispanics, African Immigrants, and Transgender People.

The Baltimore EMA's Comprehensive Planning Committee has identified several Vulnerable Populations that have been shown to face additional barriers accessing the continuum of care than the general population. These Vulnerable Populations are: the formerly incarcerated, MSM, substance abusers, individuals with mental health issues, the homeless, transgender people, youth, counties residents, and aging adults.

Meeting the diverse needs of special populations of PLWHA in Maryland – those that have a disproportionate need for HIV-related services – is a primary goal of PHPA, in accordance with HRSA's emphasis on eliminating disparities in access and services. The issues faced by several of the priority, special, and vulnerable populations listed above are described in more detail below.



## Deaf Persons

The deaf population does not have accurate national epidemiological data about prevalence rates of HIV/AIDS. The Centers for Disease Control and Prevention does not collect information on individuals' deafness. Maryland was the first state to include questions about deafness in its HIV counseling and testing forms. Of those tested in Maryland, 4.3% of the deaf population is HIV positive.<sup>11</sup> Between 2003 and 2007, deaf people were twice as likely to test HIV+ as their hearing counterparts. African American deaf people have been particularly hard hit, with a prevalence of above 6% among those tested in Maryland.<sup>12</sup>

According to RAC participants in rural communities, they believe that the deaf population incidence of HIV is twice that of the hearing populations due to lack of literacy, education and targeted prevention messages. The National Coalition of the Deaf Community and HIV reports that 70% of deaf people consider ASL their first language and English as their second language. It is essential for deaf individuals living with HIV/AIDS to have ASL interpretation and for medical personnel to have access to interpretation technology to be able to communicate important medical and support services information.

## Injection Drug Users/Substance Abusers

As stated earlier, HIV transmission via IDU is a major mode of transportation in Maryland. Both non-IDU and IDU substance users are reported to be far more likely to engage in high-risk behavior and have more challenges with appointment and treatment adherence. Treating substance abusers who are HIV positive involves more complex service needs and requires greater supportive services. There is generally a high incidence of co-morbidities and this population often needs housing, emergency financial assistance and transportation.

## African/ Hispanic Immigrants

Maryland has growing African and Hispanic immigrant populations, particularly in the counties surrounding Washington, D.C. RAC participants indicated that the lack of knowledge about accessing health care and the need for translators and culturally competent staff makes it difficult for immigrants who are living with HIV/AIDS to access necessary health care. Additional barriers to obtaining necessary care faced by immigrant populations include stigma, fear of disclosure of their HIV-positive status, poverty, and fear of deportation. Undocumented immigrants' fear of deportation is often related to their residency status. RAC participants in both rural and urban regions stressed the difficulty of communicating with persons that have with limited English proficiency. They identified translators and cultural competency training as top priority unmet needs to improve immigrant care. Finally, RAC participants indicated that case managers are often not knowledgeable regarding immigration laws and standards of care.

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<sup>11</sup> Center for AIDS Prevention Studies at the University of California at San Francisco. (1999). What are Deaf Person's HIV Prevention Needs. Retrieved from <http://caps.ucsf.edu/factsheets/deaf-persons>

<sup>12</sup> Monaghan, L. (2009, June 1). Spreading the word on HIV/AIDS and the Deaf Community. HIV/AIDS Deafness and Disability.[Web log comment] Retrieved from <http://hivdeaf.blogspot.com/2009/06/spreading-word-on-hiv-aids-and-deaf.html>

## Transgender, MSM, and Other Sexual and Gender Minorities

Men Who Have Sex with Men are disproportionately affected by the HIV epidemic at every stage across the life course, beginning in adolescence. MSM represent the highest transmission risk group for HIV. In the most recent Maryland HIV/AIDS epidemiological surveillance data, among adults and adolescents, MSM accounted for 44.6% of newly diagnosed HIV infections. A group of specific concern is Young Men Who Have Sex with Men (YMSM), especially African American YMSM, who is among the fastest growing subpopulation of newly reported HIV infections in Maryland. In 2000, less than 20% of reported HIV cases among MSM were between ages 20 and 29 when diagnosed. By the end of 2009, young men between the ages of 20 and 29 made up 51% of reported HIV diagnoses in MSM.

In wave three of the National Behavioral Surveillance Research Study (BESURE), conducted with MSMs in Baltimore city, YMSM reported higher rates of HIV than their older MSM counterparts. African American MSMs, regardless of age, were five times more likely to test positive than non-African Americans. The study found an overall HIV prevalence rate of 42%, but of those who tested positive, 69% were unaware of their HIV-positive status. These findings underscore the need for more prevention and care services for the MSM population.

2012 RAC participants reported that there are not sufficient services for MSM and transgender persons, especially in rural communities. The needs of sexual and gender minorities in these communities and others often go unmet. They suggested that providers would benefit from training from educators from the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community. Barriers confronting PLWHA who identify as lesbian, gay, bisexual, transgender, or queer include a lack of targeted resources and a lack of cultural sensitivity. Community Dialogue participants noted that this is a tough community to reach for HIV outreach and prevention because of their unstable housing issues and risky sexual behaviors. They also have diverse service delivery needs and suffer from societal homophobia, racism, and stigma; all contributing to their inability to access appropriate and adequate health care.

## Youth

Adolescence is a period of transition and adolescents diagnosed with HIV have special needs. To determine the needs of adolescents as a whole, an accurate picture of their HIV infection rates is needed. As of 2010, the Maryland epidemiological data no longer separates adolescents living with HIV/AIDS from others. They are now grouped with adults for HIV incidence and prevalence reports which categorize persons 13 years of age or older.

According to CDC estimates in 2009, young persons accounted for 39% of all new HIV infections in the US.<sup>13</sup> Adolescents comprise an increasing percentage of new HIV infections in Maryland as well. In 2010, adolescents aged 13-19 accounted for 4.8% of new infections in the state and have the highest rate of HIV diagnoses in the state, with 33.7 diagnoses per 100,000 population. Over 50% of Maryland's youth living with HIV reside in Baltimore City. An estimated 826 infected youth ages 13-24 lived in the Baltimore-Towson EMA in 2006.

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<sup>13</sup> Centers for Disease Prevention. (2011) HIV among Youth. Retrieved from <http://www.cdc.gov/hiv/youth/pdf/youth.pdf>

The increase in HIV infections among young people is largely driven by increases in incidence among MSM, particularly young black MSM. RAC participants indicated a great need for more providers who specialize in treating HIV-infected youth, and who are both clinically and culturally competent. Providers indicated that with the increasing incidence of young black MSM contracting HIV, there is a need to increase providers' familiarity with obstacles to care in this particular population. Providers felt that it is often hard to get young black MSM into care. There is a belief that many youth in general may believe they are invincible.

## Barriers to Care

Many barriers to care were recognized by providers and consumers of HIV care and services in the state of Maryland. Listed below are those barriers identified as the most prominent current obstacles for delivering and/or accessing HIV care and services in Maryland.

### Provider Shortages

There is a scarcity of providers for healthcare services in Maryland, and this shortage is particularly impactful on PLWHA. For HIV care, there is a need for primary care doctors, infectious disease specialists, dentists, nurses, and other specialty HIV care providers. According to HRSA, Maryland has 131 designated Healthcare Professional Shortage Areas, where the ratio of population to providers indicates a severe shortage of care providers. Of the 131 HPSAs in Maryland, 45 were granted in primary care, 39 in dental, and 47 in mental health.

Due to the increased number of people living with HIV, the work load for service providers has increased, resulting in burn out and provider turnover. Despite this increased demand for providers, RAC participants noted difficulty in finding qualified staff to fill positions, often due to low salary structure of positions such as case managers. As a result of the recent economic environment, there have been reductions in staff and hiring freezes which lead to heavier caseloads for their remaining staff. These same issues have been seen in previous SCSNs as well. Providers in the 2012 Community Dialogues reiterated these concerns by commenting that although they have noticed an increase in patient demands for services (e.g. the number of requested appointments), recent funding cuts and a general lack of providers/case managers has made it significantly tougher to keep up with clients' needs for quality care.

Participants in the Eastern and Southern RACs reported that they have difficulty attracting providers to their rural areas, due to a smaller population of clients and potentially smaller income for the provider. In the rural communities, where case management is frequently performed at the client's home, distance was often a prominent issue. Many case managers spend more time traveling than they do providing services to patients.

As in previous SCSNs, there was considerable discussion in the 2012 Community Dialogues about the lack of specialty care providers who are also knowledgeable about HIV/AIDS. This includes specialties such as co-morbidities, OB/GYN, dermatology, emergency, and pediatric care. In addition, Community Dialogue participants reported difficulty finding providers who are representative of the populations they serve, particularly for the LGBTQ, MSM, and multi-lingual communities.

Community Dialogue participants suggested offering incentives such as loan forgiveness or housing compensation to lure providers to rural regions. 2012 RAC participants also recommended using technology to better utilize providers' limited time. Despite funding cuts, it was almost universally agreed that current case managers' caseloads were too heavy and that additional case managers need to be hired to keep up with rising clients' demands.

### Provider Collaboration

Many 2012 RAC participants commented that the referral system that exists between providers, if one exists at all, is ineffective and outdated. Rather than combining resources to provide the best comprehensive care for PLWHA, clients report little-to-no collaboration between providers. Some even mentioned a "competitive" feeling between providers, due to limited resources and recent funding cuts.

Suggestions from both providers and clients included establishing an effective referral system across programs (Ryan White and non-Ryan White) and providers, as well as increased collaboration between providers to enhance case management services and HIV care for PLWHA. Particularly in the Suburban RAC, Community Dialogue participants believe that more cross-jurisdictional care with providers in DC is necessary in order to ensure PLWHA in Maryland have the best possible care. If cross-jurisdictional care was provided however, clients mentioned that service may increase the demand for medical transportation between counties to appointments. RAC participants in Southern regions suggested that HIV service organizations should partner with transportation service agencies.

### HIV Testing

Although currently there are no state or local legislative barriers for routine HIV testing in Maryland, the state is working to resolve barriers related to insurance company reimbursements for testing that have hindered making HIV testing a routine procedure in some settings. This inability to establish routine HIV testing in all clinical settings is a major programmatic, systemic and logistical challenge associated with making individuals aware of their HIV status. At RAC meetings in rural areas, participants reported that if emergency room staff thinks that a person should be tested for HIV, the emergency room staff will refer the person to the local health department instead of performing the test at the emergency room. The individual often does not end up getting a test done at all.

Because many individuals do not seek an HIV test on a regular or consistent basis, increasing HIV screening as a part of routine medical care is a key strategy to reach HIV-positive individuals who are unaware of their status. In addition, many individuals at highest risk for being HIV-positive and unaware of their serostatus are unlikely to be engaged in ongoing healthcare and therefore are often not reached by HIV testing programs in clinical settings. For these individuals, community-based HIV testing is a key strategy for getting a test result.

Social media was suggested as a potential solution by RAC participants, who recommended using websites, blogs, and other social media tools to contact harder-to-reach groups such as the youth, MSM, and transgender populations. These methods could be used to advertise HIV testing events, promote prevention and education messages, and help link HIV-positive individuals to care. Home-HIV testing kits to increase testing rates, particularly among those populations who may be more private, such as

MSM, were recommended by community members. Respondents of all types across all regions were in agreement that HIV testing needs to become standardized procedure in all medical settings.

### Accessibility and Availability of Services

In the 2009 Client Satisfaction Survey, accessibility and availability of services was one of the primary reasons identified for why clients did not receive needed services. Clients reported that oftentimes a needed service was not available (5.8%), or, if it was available, they did not qualify for it (6.8%) or the wait time was too long (4.7%). In rural communities, RAC participants reported that some counties lack Infectious Disease (ID) doctors and those that do exist are only available on a part-time basis to see patients, ranging from few hours to one day a month. This limited availability of ID doctors, makes it difficult for clients to get an appointment. As identified in previous SCSNs, there is a growing need for increased days and hours and expansion of clinic locations and services due to the rising number of PLWHA who live longer and are able to return to the workforce. Providers with limited time also have less ability to provide prevention services. Hence, prevention education regarding transmission and therapy adherence is often brief and ineffective.

Clients also consistently reported difficulty with accessing their care sites. Unsurprisingly, there is a high demand for transportation assistance. Fifty-five percent of clients in the Baltimore EMA identified needing medical transportation, but over one-third of those clients had an unmet need. Without reliable, affordable transportation options, clients cannot consistently access the services that are available to them. Transportation is consistently a higher ranked priority in the rural Maryland regions, where there are longer distances between counties to access medical care and services. Clinics are not within walking distances and public transportation and cabs are extremely limited in these areas.

To remedy the issue of transportation, Community Dialogue participants suggested increased funding for transportation as well as increasing the number of vendors that provide medical transportation. Similarly, in the 2010 Baltimore EMA Consumer Survey, clients identified an increase in, or better access to, public transportation as the service that would best help individuals get to their appointments. RAC participants also suggested having programs for clients to drive organization vans, helping out with both the barrier of transportation and unemployment. Clients also mentioned how difficult it can be to navigate the often confusing realm of HIV service providers, so that something akin to peer navigators would be beneficial to individuals who are newly engaged in care.

### Quality and Cultural Competency of Providers

Even if a client can access services, if the services are not delivered in a clinically and culturally competent manner, clients may not receive necessary services. In both rural and urban regions, a need for linguistic translators and competencies was identified as a necessity. Particularly for monolingual clients, language services are integral in allowing them to utilize all available services. The Deaf, Hispanic and African Immigrant populations were specifically highlighted as requiring more language capabilities and cultural sensitivity in care from their providers. In the 2010 Baltimore EMA Consumer Survey, only 4.3% of clients indicated a need for linguistic services. However, 58.8% of those who needed such services had not received them within the past 12 months.

In the rural regions, many RAC participants mentioned that it appeared that primary care doctors and infectious disease providers do not have the proper training or knowledge about the disease of HIV, available services, or the proper referral processes. In addition, clients believed because providers often do not fully understand the unique needs of HIV-positive clients, they were not receiving the best possible care.

Both clients and providers believed that providers need to be given more in-depth HIV training on a routine basis. Clients in particular requested that providers receive training on cultural competency, the unique needs of HIV-positive clients, and customer service. Providers were more focused on receiving training around how to integrate prevention messages into care and the most up-to-date medical/case management practices. This need for training is nothing new, and has been mentioned in previous SCSNs, as well as in all 2012 RAC meetings.

Participants also mentioned administering HIV Testing in non-traditional settings and/or faith-based organizations and events, as well as having providers conduct culturally tailored HIV outreach. Clients requested that providers try to hire staff who reflect the population they are serving in order to put clients at ease and provide the most culturally competent care.

#### Lack of Client Knowledge of Available Services

In the 2010 Baltimore EMA Consumer Survey, the most commonly cited barrier for accessing care was not knowing how to get a particular service. This mirrored the results of the 2009 Client Satisfaction Survey, in which the most frequent barrier identified to obtaining needed services was the client's lack of knowledge of where to go for services. In the March 2012 Community Dialogues, one provider pointed out that people "have no idea" what is available and suggested that more knowledge on the part of both clients and providers is needed to move forward past this all too common barrier.

This general barrier of not knowing how to obtain an available service can be a result of several different factors, such as not knowing that the service exists, knowing that the service exists but not knowing how to access it, not understanding the eligibility criteria for that service, or being unable to navigate that service's systems to effectively access it. An increased effort on behalf of providers to inform clients about service availability, access processes, eligibility criteria, and navigation methods are all suggested methods to overcome this barrier.

A potential solution suggested by many clients was to utilize technology to make it easier for clients to understand what services are available to them and to effectively access those services. They recommended the use of websites, e-mails, blogs, and social media pages to inform clients what services are available and how to access them. Also, providers suggested using text messaging to communicate information to clients, because many have cell phones, even if it is a pay-as-you-go plan, and are more responsive to texting than phone calls.

#### Stigma

Stigma is one of the strongest barriers to HIV-positive persons accessing and remaining engaged in HIV care. A report written on the Baltimore EMA, but applicable to all, stated that "HIV/AIDS-related stigma has been found to play a significant role in whether infected persons access or maintain primary medical

care. One study examined the level and impact of HIV-related stigma in a culturally diverse sample of persons attending an urban HIV clinic. Using a combination of quantitative and qualitative methods, the researchers found that stigma emerged as an insidious deterrent to integrating HIV primary care (e.g. medications, clinic appointments) into daily life.

Providers and clients both consider stigma an important issue to address because it creates barriers for HIV testing and care. According to RAC participants, stigma causes clients to have fear of disclosure and often makes them avoid seeking treatment. In the 2011 Client Satisfaction Survey, for those clients who waited more than a month to get into care, 10.1% said they waited because they did not want friends/family to know their HIV status, and 7.9% because they were embarrassed. In rural communities, some clinics are only HIV-service specific, and therefore often clients avoid going to them for treatment, for fear of people in the community discovering their HIV-positive status.

Stigma can be of particular concern to the priority and special populations. In the 2012 Community Dialogues, providers commented they have seen numerous instances of stigma around HIV in the African American and MSM communities. Individuals who identify as lesbian, gay, bisexual, transgender, or queer confront homophobia and transphobia in the larger society and in the health care system.

RAC participants suggested that more awareness of HIV in the community would help to combat stigma among the public, particularly through some sort of media campaign. Participants commented that they rarely saw anything about HIV in the media, and that if there was some sort of large-scale, sustained campaign across television, radio, billboards, and social media venues, it would help to break down some of the barriers that exist.

### Substance Abuse

In 2010, about 15% of newly diagnosed HIV cases were categorized as having been exposed through injection drug use; this percentage has steadily declined and is the lowest new infections for this transmission risk exposure group since reporting began in 1985. Studies have shown that substance abuse is associated with delays in accessing HIV care, difficulty establishing care, poor adherence to medications and poor adherence to appointments once in care. According to the Alcohol and Drug Abuse Administration's Maryland Epidemiology Profile, the rate of substance abuse in the general Maryland population is 5,947.3 per 100,000. This report estimates that there were 315,000 illicit substance users monthly in Maryland between 2002 and 2004. In 2003, Baltimore Substance Abuse Systems Inc. estimated that there were up to 59,000 chronic illicit substance users in Baltimore City alone.

In the 2011 Client Satisfaction Survey, for those clients who waited more than a month to get into care, 8.2% said it was because they were using drugs or alcohol. Drug or alcohol abuse can interfere with a client's treatment adherence, preventing them from consistently taking their medication and helping them to minimize their risk of transmission to others. Many HIV providers therefore will not start persons on antiretroviral therapy until they are no longer drug and/or alcohol dependent. Treating substance abusers who are living with HIV involves more complex service needs and requires greater

supportive services. There is generally a high incidence of co-morbidities and this population often needs housing, emergency financial assistance and transportation.

A major challenge in Maryland, as also cited in the earlier SCSNs, is the lack of substance abuse treatment slots. When persons are ready to enter treatment, it is critical that beds are available to them. In the 2011 Baltimore EMA Consumer Survey, 13.3% of respondents indicated that they needed residential substance abuse treatment, but 38.1% of those individuals did not get this need met. SCSN participants also identified several other needs for substance abusing PLWHA, including education for providers and communities on substance abuse and other co-morbid conditions, a statewide resource list to assist in making appropriate referrals, and more intensive case management services.

### Cost

Clinical service fees, even on a sliding scale, may be a significant barrier for many clients. This is especially true for the working poor and near poor who earn too much for Medical Assistance services. In many cases, individuals who are working will opt out of a medical insurance plan if the premiums are too costly. In the 2011 Baltimore EMA Consumer Survey, 53.9% of respondents identified health insurance premium and cost sharing assistance (financial assistance for PLWHA to help maintain health insurance or medical benefits ) as a demand, but one-third of those did not get that need met (32.2%). Sixty-four percent of respondents in the Consumer Survey identified emergency financial assistance (to help them manage short-term, temporary crises by paying for food, utilities and/or medicines) as a need, but almost half of those individuals did not get this need met (44.5%).

### Housing

Housing and homelessness have a direct impact on both the incidence of HIV/AIDS in Maryland and the health of its citizens who are living with HIV/AIDS. In 2010, the U.S. Department of Housing and Urban Development (HUD) estimated that 10,845 or 0.2% of Maryland's population were homeless. The Baltimore City Health Department estimated that 4,088 or 0.7% of the city's population were homeless.

Being unstably-housed interferes in a number of ways with successful care and treatment for PLWHA. Without a home, stress levels may increase, further compromising already fragile immune systems. In a 2009 study, Buchanan and colleagues found that people who are housed are more likely to have higher survival rates and better immunological outcomes than people without housing.<sup>14</sup>

Stable housing is particularly important for PLWHA, many of whom struggle with co-morbid conditions that make the tasks of daily living even more challenging. The homeless are more likely to be unemployed, to have less access to health care, and, if HIV positive, to not be receiving or adhering to treatment regimens. Services to homeless PLWHA must start with meeting basic living needs to stabilize their lives and to stay in care. The co-morbid conditions that often accompany homeless persons complicate and add increased costs in keeping persons in medical care.

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<sup>14</sup> Buchanan D., Kee R., Sadowski L.S., & Garcia D. (2009). The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial. *American Journal of Public Health*, 99(Suppl 3), S675–80



Some PLWHA reported having to choose between attending medical appointments or standing in line to assure a place in a housing shelter for the night. Complex treatment regimens become difficult to monitor and frequently derail when a patient is faced with unstable living situations. Appointments with health care and human service providers are more likely to be missed or not scheduled at all, and outreach workers are less likely to find their clients to offer ongoing support and treatment. In addition, homeless clients often do not have proper storage for HIV/AIDS prescriptions and other medications.

One suggestion to help tackle this barrier is to integrate HIV support services, such as life skills, medication management, and budget management, and housing services into housing facilities. Accurate assessments of a client's readiness for housing are also needed. Treating other issues that may affect them, such as mental illness, substance abuse and lack of transportation, would build a more comprehensive approach to existing service delivery systems.

### Capacity Development Needs of Historically Underserved Communities

The HIV epidemic in Maryland is very diverse, having significant impact on specific priority populations identified, such as sexual minorities, injection drug users, heterosexuals and people of color. The HIV prevention and care continuum systems have developed expertise in identifying, testing, and linking to care affected subpopulations and historically underserved communities. PHPA's Comprehensive HIV Plan specifically targets resources to high incidence/prevalence communities and racial and ethnic minorities disproportionately impacted by HIV/AIDS. The most recent data is consistently used in the planning, implementation and evaluation of HIV prevention and care services.

To determine the capacity needs of underserved communities, review of epidemiology data confirms that the most common HIV transmission risk groups among new HIV diagnoses are MSM (47%, including both MSM and MSM/IDU) followed by Heterosexuals (36%), and then IDU (19%, including both IDU and MSM/IDU). The Maryland HIV Community Planning Group (CPG) reviewed current HIV prevention services for each priority population to identify statewide gaps in the availability, accessibility, and cultural competency of behavioral and community-level HIV prevention interventions. Gaps in service coordination and integration, along with gaps in related social services such as mental health and substance abuse treatment, were also included. Finally, the RAC participants also reported on the needs of PLWHA from these underserved communities.

People living with HIV/AIDS in underserved communities are particularly affected by limited or complete lack of access to HIV care and other social services. Many gaps in care and services exist both within and across priority populations in Maryland. Findings from the Community Service Assessment revealed that persistent service gaps emerged across all priority populations including HIV partner services, HIV Testing and Linkage to Care, Health Education and Risk-Reduction (HERR) programming, and mental health services.

A steady increase in the proportion of new HIV diagnoses over the past seven years is attributable to sexual transmission among Men Who Have Sex with Men (MSM). The MSM population is disproportionately affected by HIV/AIDS, and is currently the most common mode of HIV exposure in Maryland (45% MSM, 3% MSM/IDU). Specific interventions suggested by the CPG to improve access to

HIV related services for MSM population include increasing condom distribution, large scale marketing specifically for harm reduction, and improving access to HIV care, including culturally appropriate care. A lack of culturally sensitive providers and services for MSM and transgender populations, especially in rural communities are commonly reported.

Heterosexual contact represents the second most common mode of HIV exposure, accounting for approximately 36% of newly reported adult/adolescent HIV diagnoses annually. One recommended intervention for the heterosexual population is increased public awareness through evidenced- based interventions at the community level, with a focus on developing community leaders. RAC participants also commented that in the heterosexual population, especially among African American males, there is very little leadership around HIV/AIDS issues.

The proportion of new HIV cases transmitted through injection drug use has steadily decreased since the introduction of needle exchange programs in 1994. In 2010, approximately 16% of newly diagnosed adult/adolescent HIV cases were attributable to injection drug use and 3% to MSM/IDU. Injection drug users are in need of more group-level HERR programming, with added HIV education components. Providers and clients mentioned the lack of needle exchange programs in rural communities and also a lack of substance abuse treatment and meeting spaces across all regions. Planning and implementing many of the above capacity development strategies will help increase the number of underserved PLWHA that receive prevention and treatment services in Maryland.

## II. Where Do We Need to Go?

The continuum of HIV care in Maryland is a collaborative effort between federally-, state- and privately-funded services and agencies. PHPA is committed to remaining consistent with the goals and strategies of the National HIV/AIDS Strategy. PHPA works to meet the goals and strategies through the development and implementation of comprehensive, compassionate and quality services for both prevention and care. The three characteristics of the service delivery system are: (1) comprehensive – meeting the range of needs presented by a person living with HIV so that treatment can be optimized; (2) compassionate – understanding of the emotional, physical, and social impact HIV can have on those who are infected and affected; and (3) quality – respecting that everyone deserves excellent care and treatment, regardless of their ability to pay for the service. The following vision and values guide the ongoing development and implementation of the continuum of care for Marylanders living with HIV/AIDS.

### National HIV/AIDS Strategy

PHPA is committed to achieving the goals of the National HIV/AIDS Strategy. All care needs, potential solutions, and goals and objectives outlined in this report ultimately support one of the three NHAS goals:

#### **NHAS Goal 1: Reduce the Number of People who become Infected with HIV**

The first goal of the National HIV/AIDS Strategy is to reduce the number of new HIV infections. Specifically, the Federal Government aims to achieve three particular objectives by 2015: (1) lower the annual number of new infections by 25 percent; (2) reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent; and (3) decrease the percentage of people unaware of their HIV-positive status from 21 percent to 10 percent.

#### **NHAS Goal 2: Increase Access to Care and Optimize Health Outcomes for People Living with HIV**

The second goal of the National HIV/AIDS Strategy is to increase access to care and improve health outcomes for people living with HIV. Specifically, the Federal Government aims to achieve three particular objectives by 2015: (1) increase the proportion of newly diagnosed clients linked to clinical care within three months of their HIV diagnosis from 65% to 85%; (2) increase the proportion of Ryan White clients who are in continuous care from 73 percent to 80 percent; and (3) increase the number of Ryan White clients with permanent housing from 82 percent to 86 percent. To be in continuous care, the client has to have at least two visits for routine HIV medical care in 12 months at least 3 months apart.

#### **NHAS Goal 3: Reduce HIV-Related Health Disparities**

The third goal of the National HIV/AIDS Strategy is to reduce HIV-related health disparities. Specifically, the Federal Government aims to achieve three particular objectives by 2015: (1) increase the proportion of HIV diagnosed gay and bisexual men by 20 percent; (2) increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent; and (3) increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.

## Vision for System Changes

IDHEHA's vision is a Maryland with no new HIV infections. Our vision for those already living with HIV is based upon needs assessment data, epidemiological analyses of HIV/AIDS in Maryland, input from the community and national standards. The following vision guides PHPA's HIV Services Programs:

- Have a collaborative system of HIV care across all Parts of Ryan White and with other service providers that ensures access to the full range of services needed by Marylanders with HIV/AIDS to live longer and healthier lives.
- All HIV-positive individuals learn their HIV status early and engage and stay in health care.
- All people living with HIV/AIDS live longer, healthier lives regardless of race, ethnicity, gender or sexual orientation.

**Figure 13. Ideal Engagement in HIV Care Cascade**

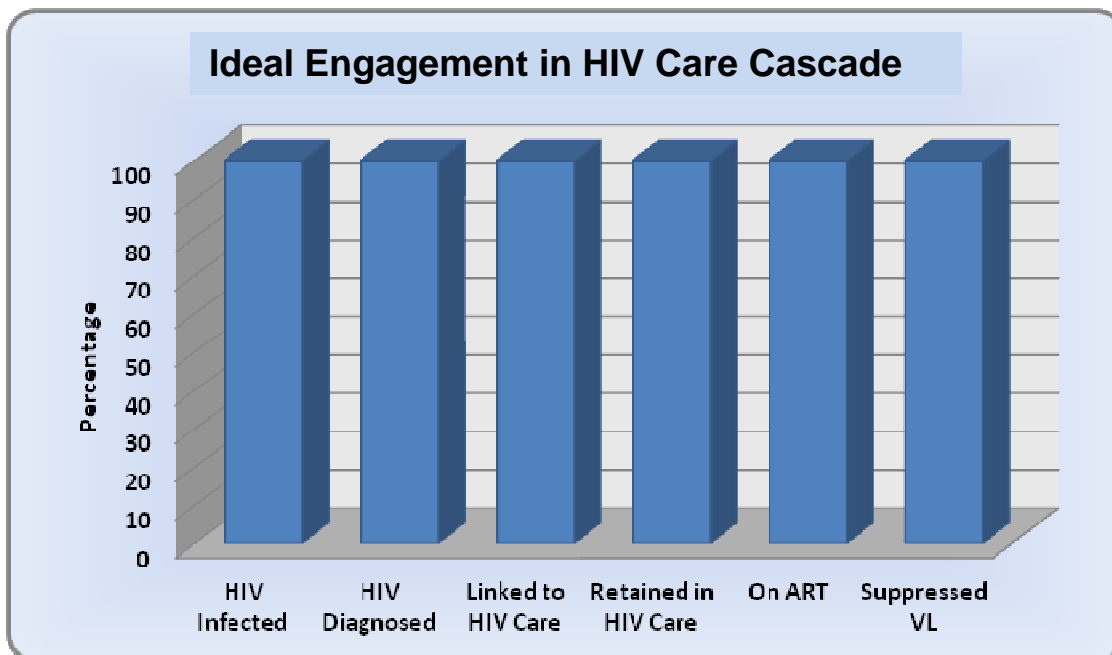


Figure 13 shows an ideal Engagement in HIV Care Cascade, in which 100% of people living with HIV are aware of their status, linked to care, retained in care, on antiretroviral therapy, and have a suppressed viral load. This is the model that Maryland aims to achieve in its attempt to tackle the HIV epidemic. It is also important to note that although not included in graphic, preventing new infections is of the highest priority as well.

## Values for System Changes

The following values guide the development and implementation of service delivery program models to achieve the goals described above:

- All HIV treatment and prevention programs and policies must be based on science and have as their foundation the latest scientific knowledge about HIV epidemiology, transmission and clinical care.
- The HIV health care continuum must be accessible to individuals and families regardless of their ability to pay.
- Methods for routine monitoring and assessment of the outcome of HIV care and supportive services must be in place for all HIV service providers.
- Policy and program design must reflect input from a broad range of people affected by HIV/AIDS, including persons living with HIV and providers engaged in direct care. Communities of color must be central to this collaboration, given the disproportionate impact of HIV on persons of color in Maryland.
- All HIV care and supportive services should provide HIV care in a culturally competent manner.
- Patient privacy and confidentiality should be maintained for persons living with HIV through the service delivery process

The Maryland State Health Improvement Process (SHIP) aims to increase life expectancy and health equity in Maryland by providing a framework for accountability, local action, and public engagement. Objective 20 of the SHIP is to Reduce New HIV Infections Among Adults and Adolescents. This plan supports this objective.

## How the Plan Will Address Healthy People 2020 Objectives

The overarching goal of the HIV component of Healthy People 2020 is to prevent HIV infection and HIV-related illness and death. Eighteen measurable objectives are targeted to achieve this goal. The activities and objectives outlined in the Maryland HIV Comprehensive Plan are in accordance with the goals of Healthy People 2020. Specifically, PHPA's goals are: (1) to ensure access to existing and emerging HIV/AIDS treatments that are accessible and delivered according to established HIV-related treatment guidelines and recommendations; and (2) to decrease the unmet need for HIV primary medical services by identifying disparities that are barriers to HIV-positive individuals not in care, particularly those in underserved racial and ethnic groups, and facilitating their entry into HIV/AIDS medical care and treatment.

The care component of PHPA's continuum provides continued funding for HIV medical and support services include ambulatory outpatient medical services, medical and non-medical case management services, oral health, mental health client advocacy, outpatient substance abuse services, psychosocial support, treatment adherence, transportation, emergency financial assistance, HIV-specialty obstetrical/gynecological services, medical nutritional therapy, nutritional supplements, and diagnostic testing such as viral load and genotype resistance testing. All PHPA-funded HIV care and treatment programs are required to incorporate HIV prevention messages into each clinical visit. Many of these programs are also funded by PHPA to provide Prevention with Positive intervention. These services are

consistent with the Healthy People 2020 objectives by increasing condom use, increasing the number of substance abuse treatment facilities that offer HIV testing, counseling and education, reducing deaths from HIV infection, extending the interval of time between initial diagnosis of HIV and AIDS diagnosis to increase the years of life of an HIV-infected person, and reducing new cases of perinatally-acquired HIV infection.

PHPA programs seek to decrease the unmet need for HIV primary medical services by identifying minority PLWHA not in care and facilitating their entry into HIV/AIDS medical care and treatment. Through the Part B Minority AIDS Initiative, PHPA supports treatment readiness groups and individual interventions to assist clients' entry into care and enroll new clients into either MADAP or the state's pharmacy assistance program. These objectives support progress toward achieving the Healthy People 2020 objectives of reducing the number of new AIDS cases among MSM and IDU, increasing the number of PLHWA who know their status, reducing the deaths from HIV infection, and continuing to address the disproportionate impact of HIV/AIDS among certain racial and ethnic groups.

## **2012 Proposed HIV Prevention and Care Goals**

In order to achieve the vision and goals of the NHAS in Maryland, the following are the overall goals of the Maryland HIV Plan:

- Increase the number of persons living with HIV/AIDS who are aware of their HIV serostatus.
- Increase the number of persons living with HIV/AIDS who are engaged in ongoing, high-quality HIV medical care.
- Reduce high-risk behaviors among persons living with HIV/AIDS.
- Reduce high-risk behaviors among HIV-negative persons at high risk for HIV infection.
- Reduce disparities in HIV infection and care and services received between subpopulations.

PHPA plans to work with its partners in accomplishing the following:

- Increasing collaboration between HIV prevention and care services (across Ryan White Parts);
- Increasing public awareness of the HIV epidemic and the availability of care and treatment services in the state;
- Increasing the availability of testing, especially routine testing and testing for partners of persons living with HIV who are enrolled in the Ryan White program; and
- Strengthening the role of Disease Intervention Specialists (DIS) within both HIV prevention and care systems to increase persons who are linked into care, retained in care, and remain adherent to treatment.

## **Goals Regarding Individuals Unaware of their HIV Status (EIIHA)**

The vision of Maryland's Early Identification of Individuals with HIV/AIDS (EIIHA) initiative is that all individuals in Maryland infected with HIV learn their HIV status early and are engaged in the appropriate level of care for their stage of infection. The EIIHA goals focus on three main areas: identifying individuals with HIV infection, successfully referring these individuals to HIV care, and retaining HIV-positive individuals in care. The HIV Prevention and Care Collaboration workgroup continues to work on developing the specific EIIHA goals. Initial discussions have resulted in the following preliminary goals:

1. Increase HIV screening in all health care settings;
2. Ensure availability of testing for high risk individuals;
3. Ensure the provision of test results; and
4. Increase availability of HIV care and support options to HIV-positive individuals.

The Maryland EIIHA preliminary goals align with the goals of the National HIV/AIDS Strategy. The two goals addressing increasing HIV screening and testing, as well as the goal to ensure the provision of test results, relate to the NHAS goal of increasing the percentage of people who know their HIV status. The goal to increase availability of care services for PLWHA relates to the NHAS goal of increasing access to care and improving health outcomes. All of the Maryland EIIHA preliminary goals address the NHAS goal to reduce health disparities as Maryland's HIV epidemic disproportionately impacts African Americans so all efforts to increase testing and access to care will impact this population.

## **Goals Regarding People Aware of their HIV Status, but Not in Care (Unmet Need)**

Maryland follows the NHAS goal of increasing the proportion of newly diagnosed clients linked to clinical care within three months of their HIV diagnosis from 65% to 85% and increasing the proportion of Ryan White clients who are in continuous care from 73% to 80% by 2015. PHPA's HIV testing programs require all HIV-positive clients be referred to HIV medical care and support services. Additionally, PHPA plans to encourage testing programs to establish Memorandums of Understanding (MOUs) and information sharing agreements with referral agencies, connect clients to a peer counselor who is living with HIV to provide support for engagement in care, and provide transportation assistance, childcare and other support services funded through Ryan White as much as possible.

### III. How Will We Get There?

#### Goals and Strategies

To support the overall goals of the National HIV/AIDS Strategy, Maryland has developed the following sub-goals and strategies:

Maryland Sub-Goal	Strategies
<p><u>Routine HIV screening in clinical settings</u></p> <p>Increase the number of Maryland residents who receive HIV screening as part of their medical care.</p>	<ol style="list-style-type: none"> <li>1. Work with key stakeholders to create recommendations for third party payers and Maryland’s Insurance Administration related to reimbursement in order to maximize HIV screening.</li> <li>2. Provide training, capacity building and technical assistance to providers to increase routine HIV testing /screening in clinical settings.</li> <li>3. Support expanded HIV testing in federally qualified health centers (FQHCs) located in high prevalence areas.</li> </ol>
<p><u>Targeted HIV testing in non-clinical settings</u></p> <ol style="list-style-type: none"> <li>1. Ensure HIV testing resources are focused on the most effective geographic areas, settings, agencies and testing strategies.</li> <li>2. Increase HIV testing among the populations at greatest risk for HIV infection.</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase utilization of epidemiological and surveillance data for program targeting.</li> <li>2. Increase accountability for HIV testing resources (both funding and rapid test kits) through enhanced program monitoring.</li> <li>3. Work with PPHA -supported HIV testing programs to develop strategies to increase reach to high-risk populations.</li> <li>4. Continue to fund community-based organizations for new/expanded outreach testing programs serving the populations at greatest risk for HIV infection.</li> <li>5. Increase coordination of HIV testing programs.</li> </ol>



Maryland Sub-Goal	Strategies
<p><u>Initial and ongoing HIV/STI partner services</u></p> <ol style="list-style-type: none"> <li>1. Increase the number of newly-diagnosed HIV-positive persons who are provided with HIV/STI partner services.</li> <li>2. Increase the quality and effectiveness of HIV/STI partner services.</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase the availability of trained HIV/STI partner services field staff.</li> <li>2. Increase supervision staff in jurisdictions with the highest morbidity to ensure appropriate oversight and management of HIV/STI partner services.</li> <li>3. Increase staff at PPHA for HIV partner services program monitoring and quality assurance.</li> <li>4. Transition to PRISM, a statewide integrated HIV/STI data system customized to meet local STI surveillance and HIV/STI partner services data collection, data management, program implementation, program monitoring and quality assurance needs.</li> <li>5. Conduct provider outreach and education with private providers and Medicaid MCOs in high prevalence areas.</li> </ol>
<p><u>Ensure people who are newly diagnosed HIV-positive and those not in HIV care enter HIV health care by collaborating with HIV Testing and Linkage to Care programs and facilitating connections to care and support services.</u></p> <p>Increase the percentage of HIV-positive clients who are successfully linked to HIV medical care and support services.</p>	<ol style="list-style-type: none"> <li>1. Support additional linkage-to-care staff to assist clients in accessing HIV medical care and support services, and maintaining ongoing HIV care.</li> <li>2. Provide training on evidence-based linkage-to-care models to linkage-to-care staff.</li> <li>3. Increase coordination between HIV testing programs, linkage-to-care programs and HIV care providers to support effective referral and linkage to care.</li> <li>4. Support linkage-to-care staff to maintain contact with newly identified HIV-positive individuals referred into care to ensure the client has attended at least two medical appointments before closing the linkage-to-care case.</li> </ol>

Maryland Sub-Goal	Strategies
<p><u>Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the importance of retention in care, treatment adherence support, and prevention with HIV-positive individuals.</u></p> <ol style="list-style-type: none"> <li>1. Increase the percentage of HIV-positive clients who are engaged in ongoing, comprehensive HIV medical care and support services.</li> <li>2. Increase the percentage of HIV-positive clients who are adherent to their antiretroviral treatment regimen.</li> <li>3. Ensure that PLWHA are linked to appropriate medical and social services.</li> <li>4. Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Maryland</li> </ol>	<ol style="list-style-type: none"> <li>1. Support additional case management staff to assist clients in remaining engaged in ongoing HIV medical care and adherent to antiretroviral treatment regimens.</li> <li>2. Train providers in best practices for treatment adherence support.</li> <li>3. Implement system-level utilization of HIV surveillance data, including CD4 and viral load results, to (a) increase our ability to effectively prioritize and properly assign HIV partner services and linkage-to-care (LTC) staff follow-up activities, and (b) trigger active follow-up on clients who have fallen out of HIV medical care, with a focus on Maryland’s four high morbidity areas: Anne Arundel, Baltimore, Montgomery and Prince George’s counties.</li> <li>4. Continued investment in Maryland’s strong HIV care delivery system, including a safety net system of care provided through Ryan White funds, a state-funded pharmacy assistance program (PAC), a high-risk insurance plan for those with pre-existing conditions (Maryland Health Insurance Plan), Medicaid, the Maryland AIDS Drug Assistance Program (MADAP). Currently, any person with HIV with an income up to 500% of the federal poverty level has free access to all available antiretroviral medications.</li> <li>5. Provide mental health, substance abuse treatment, psychosocial support, non-medical case management, medical nutritional counseling, housing assistance, transportation, and emergency financial assistance, and treatment adherence services through the Ryan White care system.</li> </ol>

Maryland Sub-Goal	Strategies
<p><u>Expand provision of risk assessment and risk reduction interventions for PLWHA in partnership with HIV care providers</u></p> <ol style="list-style-type: none"> <li>1. Increase the percentage of PLWH who receive ongoing risk assessment and risk reduction counseling (when applicable) as part of HIV medical care and support services.</li> <li>2. Increase the percentage of high-risk PLWH who receive intensive behavioral interventions to support them in reducing their high-risk sexual and needle-sharing behaviors.</li> </ol>	<ol style="list-style-type: none"> <li>1. Provide education and training to HIV care staff on skills for assessing risk and providing client-center risk reduction counseling.</li> <li>2. Increase the availability of individual and group-level behavioral interventions for high-risk persons living with HIV.</li> </ol>
<p><u>Increase condom distribution and social marketing/education efforts targeted to PLWHA and persons at highest risk for HIV infection</u></p> <ol style="list-style-type: none"> <li>1. Increase the number of condoms distributed to HIV-positive persons and persons at the highest risk of acquiring HIV infection.</li> <li>2. Utilize social marketing campaigns to: Increase knowledge of HIV transmission and prevention strategies; Build perception of HIV risk among African Americans; Encourage African Americans to know their HIV status; Combat HIV stigma; and Increase awareness of the availability of HIV prevention, care and treatment services.</li> <li>3. Increase knowledge of knowledge of HIV transmission and prevention strategies, and increase awareness of the availability of HIV prevention, care and treatment services.</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase the number of agencies and sites distributing condoms to HIV-positive persons and persons at highest risk of acquiring HIV infection.</li> <li>2. Implement the Greater Than AIDS, Testing Makes Us Stronger, Take Charge and HIV Stops With Me campaigns.</li> <li>3. Purchase and distribute culturally, developmentally and linguistically appropriate HIV/AIDS educational materials in the Baltimore-Towson MSA.</li> </ol>
<p><u>Increase HIV testing and risk reduction interventions with HIV-negative persons at high risk for HIV infection</u></p> <ol style="list-style-type: none"> <li>1. Ensure that resources for behavioral interventions for HIV-negatives persons are targeting to persons at highest risk for HIV infection.</li> <li>2. Maximize the reach of HIV prevention interventions for HIV-negative persons at highest risk for HIV infection.</li> <li>3. Increase the number of Maryland residents who receive HIV screening as part of behavioral health services (mental health and substance abuse).</li> </ol>	<ol style="list-style-type: none"> <li>1. Partner with Health Education/Risk Reduction (HERR) providers to more effectively target HERR interventions for HIV-negative clients to persons at highest risk for HIV infection.</li> <li>2. Expand the implementation of brief, evidence-based interventions with evidence of effectiveness for HIV-negative persons in high-risk communities and populations.</li> <li>3. Use funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to work with substance abuse and mental health providers to establish protocols to integrate risk assessments, risk reduction counseling/interventions, and HIV testing services into existing services.</li> </ol>

Maryland Sub-Goal	Strategies
<p><u>Decrease the number of perinatally acquired pediatric HIV cases</u></p> <ol style="list-style-type: none"> <li>1. Increase the percentage of pregnant women who receive HIV testing during their first trimester.</li> <li>2. Increase the percentage of women at high-risk for HIV infection during pregnancy who receive repeat testing in the third trimester.</li> <li>3. Increase the percentage of women who present for labor and delivery with undocumented HIV status who receive rapid testing.</li> <li>4. Increase the percentage of women at high-risk for HIV infection during pregnancy who receive rapid testing in labor and delivery (regardless of maternal HIV testing history).</li> </ol>	<ol style="list-style-type: none"> <li>1. Continue to work with the AIDS Education and Training Center (AETC), the state’s medical society (MedChi), the Regional Perinatal Advisory Group (RPG) and the Family Health Administration (FHA) to educate perinatal providers regarding Maryland laws and regulations for HIV testing during pregnancy and clinical recommendations.</li> <li>2. Work with the AETC, MedChi, RPAG and FHA to develop and disseminate guidelines for repeat testing in the third trimester for women at high risk for HIV infection during pregnancy.</li> <li>3. Work with the AETC, Medical Society, RPAG and FHA to develop and disseminate guidelines for rapid HIV testing in labor and delivery (regardless of maternal HIV testing history) for women at high risk for HIV infection during pregnancy.</li> <li>4. Continually assess, monitor, and work to improve service systems and community resources for women, infants, and families using an action-oriented community process.</li> </ol>
<p><u>System-wide coordination of HIV prevention and care services</u></p> <p>Increase collaboration between HIV prevention and care across all Ryan White parts and with other service providers.</p>	<p>Continue monthly meetings that include statewide HIV prevention and care staff, statewide HIV surveillance staff, and representatives from Ryan White Parts A, B, and D to share information on existing services and initiatives and to explore opportunities to increase coordination and collaboration between HIV prevention and care services.</p>
<p><u>Reduce disparities in access and services among affected subpopulations and historically underserved communities</u></p>	<p>Using epidemiological data, specifically target testing and other resources to high incidence/prevalence communities and racial and ethnic minorities disproportionately impacted by HIV/AIDS.</p>

Implementation plans and specific objectives in support of these sub-goals and strategies are described in Maryland’s HIV prevention and health services funding applications. These applications are developed annually and submitted to CDC and HRSA for HIV prevention and HIV health services funding, respectively.

## Collaboration with Maryland's ECHPP Initiative

The development of the Baltimore-Towson ECHPP involved extensive collaboration with public health and community stakeholders, including seven local health departments and five HIV/AIDS community planning bodies (the Maryland HIV Prevention Community Planning Group, the Greater Baltimore HIV Health Services Planning Council, the Baltimore City Commission on HIV/AIDS, the Anne Arundel County Commission on HIV/AIDS, and the Central Regional Advisory Committee). Additionally, PHPA convened workgroups composed of HIV and STI prevention, care/treatment, and surveillance staff to conduct collaborative planning for the MSA. PHPA continues to collaborate with these local health departments, planning bodies and workgroups throughout ECHPP implementation. The PHPA staff who plan and oversee HIV prevention and health services and HIV service providers are key members of the planning bodies and workgroups that participated in the development of the Baltimore-Towson ECHPP and partner in the implementation of Maryland's ECHPP strategies. The programmatic priorities and directions outlined in the Baltimore-Towson ECHPP are a foundation for Maryland's statewide response to NHAS, and provide a framework for the HIV services supported by HIV prevention and care funds in Maryland.

## Local HIV Prevention Planning and Implementation

HIV prevention program direction evolves in a dynamic national context of HIV treatment, research, advocacy, funding, and social change. State health department HIV programs are further informed by state leadership, regulation, funding, data, and expertise. It is important for state health department HIV programs to:

- Monitor the environment and remain current with both national directions and developments in their local epidemic (e.g., via active surveillance);
- Critically analyze these inputs;
- Summarize and disseminate this information to local partners; and
- Align priority setting, resource allocation, and program planning accordingly.

One of the themes in the current national HIV dialogue is the promise of HIV treatment for HIV prevention. I.e., when a person living with HIV/AIDS achieves viral suppression, their likelihood of transmitting the virus to someone else is dramatically reduced. Consequently there is considerable attention to interventions that support persons living with HIV in achieving viral suppression—testing, linkage to care, retention in care, supportive services (e.g., housing, substance abuse treatment), and adherence support. Among the multiple implications of this direction are the urgency of ending prevention/care silos, and aligning planning, resource allocation, and programming to support a seamless prevention/care continuum. PHPA recently reorganized to help realize this integration: the formerly discrete Center for HIV Prevention and Center for HIV Care Services were merged into one Center for HIV Prevention and Health Services. PHPA is using the opportunity of the consolidation to pursue structures which support more integrated prevention/care programming and capacity building.

As another step toward increasing the coordination of HIV services across the prevention/care continuum, PPHA has discontinued the use of two, separate prevention and care allocation formulas. For State Fiscal Year FY2013 (July 1, 2012 – June 30, 2013), PPHA developed one single HIV allocation formula for prevention and care resources comprised of living HIV/AIDS cases (60%), a three-year average of newly reported HIV diagnoses (35%) and a rural supplement for jurisdictions that are not part of a Ryan White Part A EMA (5%). Socioeconomic variables such as population and poverty had been included in the previous formulas. By changing to using one joint formula comprised exclusively of HIV data to allocate both HIV prevention and care resources at the jurisdictional level, PPHA has increased the alignment between HIV funds and the geographic distribution of the HIV epidemic in Maryland.

To operationalize current federal and state HIV prevention program directions including the National HIV/AIDS Strategy and CDC’s High Impact Prevention priorities, and ensure that HIV prevention and care resources support comprehensive HIV prevention and health services across the continuum, local health departments funded by PPHA were provided with Guidance for Local Health Departments in Developing FY13 Implementation Plans for HIV Prevention and Health Services (hereafter Guidance).

The Guidance tasked LHD with developing three products:

- 1) An overall FY13 Implementation Plan for HIV Prevention and Health Services. This Plan was to describe how the jurisdiction would use available sources of HIV prevention and/or care funding to support one integrated HIV service continuum. The Plans included a summary of the HIV epidemic in the jurisdiction, planned partnerships with local providers and constituents, and any capacity building needs anticipated in achieving the Plan.
- 2) An FY13 HIV Prevention Spending Proposal. This Proposal was to delineate how HIV prevention resources would be allocated in accordance with the local epidemiology and with spending guidelines reflective of the burden of HIV (high, medium, or low) in the jurisdiction, as follows:

HIV Morbidity	High	Medium	Low
HIV Testing / Linkages	60%	70%	100%
Prevention with PLWH	20%	15%	
HERR w Seronegatives	20%	15%	
Targeting, Promotion	Up to 5%	Up to 5%	Up to 5%

Note: PPHA maintained its funding for HIV/STI Partner Services at the same level as in FY12. The remainder of each jurisdictional amount for HIV prevention was awarded to the County Health Department to support HIV Prevention Services according to the guidelines above.

- 3) An FY13 HIV Health Services Spending Proposal. This Proposal was to delineate how HIV care and treatment resources would be allocated in accordance with the Regional Advisory Committee priorities for the region to which the jurisdiction belongs.

A common directive from the National HIV/AIDS Strategy and CDC’s High Impact Prevention framework is to target HIV resources where they are most needed. This targeting should address both where HIV is concentrated and who is most at risk for transmission. The jurisdictional resource allocation formula provides the first level of assurance that resources go where they are most needed. PPHA set up the FY13

planning process to also ensure that resources went where they were most needed within a jurisdiction and to who needs them most. LHD were required to identify the populations most impacted by HIV in their jurisdictions based on epidemiological data provided by PPHA. LHD were then required to identify those venues at which they would offer—or at least promote—HIV services in order to reach risk populations in proportions that matched their epidemics.

PPHA took several steps to support Local Health Departments in developing these three planning products, including: conducting a statewide Grantee meeting to explain the evolving national context and the jurisdictional Guidance; holding conference calls; providing regional and jurisdictional epidemiological profiles and a Staff Epidemiologist for help in applying the data; program data summaries; prevention spending grids pre-populated with local epi and the allocation parameters above; and technical assistance.

County Health Departments completed their Implementation Plans, HIV Prevention Spending Proposals, and Services Spending Proposals, over the summer of 2012. Based on LHD selection of Health Education/Risk Reduction curricula, PPHA staff created a calendar of curricula training in early fall 2012 in order for LHD to begin this portion of their work in mid/late fall. Many LHD share challenges in serving Men who have Sex with Men in proportions which reflect the burden of HIV on MSM in their counties. Thus, PPHA is providing capacity building assistance for finding, reaching, recruiting, and serving MSM. This CBA is being provided to high and medium-morbidity jurisdictions by Project Health, part of the STARTRACK Program at the University of Maryland, Baltimore, an agency with a reputation for exceptional cultural leadership in serving MSM and young, African American MSM in particular. CBA is also being provided to low and medium-morbidity jurisdictions by PPHA staff.

Considering the LHD in aggregate, the FY13 implementation planning process had the following outcomes:

- Continued redirection of LHD effort from intensive behavioral interventions serving HIV-negative clients to behavioral interventions serving persons living with HIV.
- Continued redirection of LHD effort from multi-session behavioral interventions to shorter- or single-session interventions.
- Continued redirection of LHD effort from passive to active targeting of HIV testing efforts, i.e., less “walk-in” testing and more strategic partnerships by which LHD bring testing to venues where high-risk persons are likely to be found.
- Increased attention to linkage to HIV care and supportive services.
- Increased support to LHD in building their understanding of and capacity to reach risk populations, especially African American MSM.

## **Collaboration and Coordination**

The state of Maryland continues to foster partnerships with providers and community members to improve HIV prevention, care and treatment services. At least fourteen planning bodies for HIV care and prevention exist in Maryland: the Maryland HIV Prevention Planning Group; five Regional Advisory Committees; the Greater Baltimore HIV Services Planning Council; the Baltimore City Commission on HIV/AIDS; the MSM Response Team; the Transgender Response Team; the HIV Perinatal Team; the Anne Arundel Commission on HIV/AIDS; the Washington D.C. Planning Council; and the Faith Based Initiative. Seven of the planning bodies were created in response to federal mandates that require community and provider input for care and prevention services. Baltimore City will be developing its own jurisdictional HIV Planning Group. The Maryland Hepatitis Coalition and the Sexually Transmitted Infections Community Coalition (STICC) for the Washington D.C. Metropolitan area are additional planning groups that focus on reducing infectious diseases in Maryland.

The Infectious Disease Bureau actively supports planning groups through data sharing, providing staff support and coordinating planning activities. The partnerships foster opportunities to improve programming and establish priorities with limited resources. Sharing information has also reduced duplicative planning efforts, which has saved valuable time and resources. The related nature of STI and HIV prevention led to increased collaboration between those centers tasked with prevention work. An explanation of how STI and HIV are linked, the epidemiology of STIs in Maryland, and how prevention efforts could be further integrated for Maryland can be found in Appendix D.

## **Proposed Coordinating Efforts of Part B with Other Programs**

The Ryan White Part B grantee has representatives on the Ryan White Part A Planning Councils for both Part A grantees in the state (Baltimore-Towson and Washington, DC EMAs). Representatives from the Ryan White Part A grantees participate in the state's Ryan White, HIV prevention, and HIV surveillance regional planning processes. The state HIV surveillance program provides detailed epidemiological data and presentations to all Ryan White grantees, and provides in-depth data reports and analysis on request. In addition, the Ryan White Part B grantee conducts a monthly HIV prevention and care collaboration meeting with representatives from Ryan White Parts A, B, and D, HIV prevention from the state and Baltimore City health departments, and the state HIV surveillance program that addresses sharing information and collaborating on:

- a) Identifying HIV-positive unaware individuals;
- b) Informing HIV-positive unaware individuals of their status;
- c) Referring HIV-positive unaware individuals to care;
- d) EIIHA data collection and sharing.

PHPA partners with over 40 agencies to provide HIV counseling, testing and referral services in Maryland. These agencies include local health departments, the Department of Public Safety and Correctional Services, hospital clinics, emergency departments, community-based organizations, substance abuse treatment centers, community health centers, and OB/perinatal providers.



## Engagement Process

Input around HIV treatment and prevention activities from various interested groups in previous years was sought by the state of Maryland. The state of Maryland engages stakeholders through various channels, including the HIV Prevention Community Planning Groups (CPG), the Regional Advisory Committees (RAC), and annual stakeholder meetings with care and treatment providers. Such groups allowed the state health department, health providers, community members, and other interested stakeholders to learn information from the state and to provide feedback on various processes and decisions to the state.

One of the main goals of the HIV Planning Group, according to the 2012 HIV Planning Guidance, is to develop an engagement plan to inform the development or update of the health department's Jurisdictional HIV Plan. In order to meet this goal, the HIV planning group will be tasked with determining the goals of the engagement plan and will to engage; developing engagement and retention strategies for both new and existing partners; prioritize engagement activities; and develop, implement, monitor, and maintain those relationships.

The state health department will continue to partner with these groups, as well as seek new groups to participate to assist in reaching the jurisdiction's goals for HIV prevention, care, and treatment. The jurisdiction will seek to include input from all regions and counties within the jurisdiction. The Infectious Disease Bureau will also partner with other state agencies, including the Alcohol and Drug Abuse Administration and the Maryland State Department of Education.

Strategies and processes that kept current partners engaged in the work of HIV prevention will continue, but will be evaluated on an annual basis to determine if the strategies should be changed. Current stakeholders will be asked to suggest additional engagement strategies and stakeholders to engage. Feedback and input from community members will continue to be an integral part of HIV prevention for the jurisdiction.

Engagement activities will be prioritized based on the relevance to the jurisdiction's HIV prevention goals. The state health department seeks to maintain current relationships with relevant local, state, and federal stakeholders, in both the private and public sectors. During the 2012-2013 planning year, the health department will solicit input from advisory groups to determine the best strategies to expand the stakeholders engagement to private and public sectors that will promote the the continuum of HIV prevention, care and treatment services. This will include restructuring the current advisory bodies to further align with the HIV planning goals and objectives.

## **This Plan and the Affordable Care Act**

The Maryland Health Benefit Exchange Act of 2012 will affect the ability of PLWHA to access private health insurance. Maryland's Health Benefit Exchange will allow Marylanders to compare rates, benefits, and quality among plans to help individuals and small employers find an insurance product that best suits their needs. Reform means that more Marylanders, including PLWHA, will have access to quality, affordable health insurance. The most up-to-date information regarding the Exchange and Health Care Reform in Maryland can be found at <http://www.healthreform.maryland.gov/>.

As healthcare reform advances, more and more clients will have more options for payments of care they receive, including HIV care. Any savings due to healthcare reform will be used to meet any shortages in funds for essential HIV services. In addition, the more clients enrolled with increased drug utilization per client will result in increased proportional rebate returns, thus may provide for shortfalls in funding for core HIV services given that MADAP does not require the funds.

## **State/Local Budget Cuts**

To respond to unanticipated budget cuts in the future, PHPA will work with its partners to implement to ensure that the most highly prioritized services are continued for those that need these services most. Strategies include elimination or reduction of lower priority services, seeking additional sources of funding whenever possible, establishing improved mechanisms for program collaboration to provide services more efficiently, cross training staff, conducting continued monitoring activities to ensure that funding is utilized appropriately, and implementing measures to promote efficiency in service delivery.

Should any unanticipated local budget cuts impacting HIV care occur, PHPA would explore the use of additional state funds to address any core service gaps. PHPA would also explore the possibility of redirecting unspent Part B base funding to cover core medical services and treatment adherence services. Part A programs in both Baltimore and Washington DC would also be contacted to request undesignated unspent funds in case of a funding shortage in any counties within the respective EMAs.

## IV. How We Will Monitor Our Progress: Our Process for Evaluation

### Overview

PHPA has established formal systems to evaluate progress in meeting its goals and objectives. This section will briefly describe the systems and mechanisms that are in place to monitor progress towards meeting the goals of the 2012-2014 Comprehensive HIV Plan. In order to monitor our progress, we will use the 18 strategic goals developed through the NHAS. The Leadership and M&E Team will monitor progress on the NHAS goals using the performance measures included in the chart below. Work teams are set up to address both the collaboration of the oversight and provision of prevention and care services with a particular emphasis on using surveillance data to monitor progress.

In addition to monitoring the NHAS goals, the final section briefly describes the monitoring and evaluation processes in place for measuring progress towards performance standards, quality of care provided, and client-level outcomes.

### Monitoring Progress Toward NHAS Goals

#### Local Measurement Plan

<b>NHAS Goal 1: Reduce the Number of People who become Infected with HIV</b>			
<b>Goal #</b>	<b>NHAS Strategic Goal</b>	<b>Local Data Source</b>	<b>Local Measurement Data</b>
1a	By 2015: Reduce the annual number of new infections by 25%	HIV surveillance (as proxy)	Number of new diagnoses as a proxy measure, assuming no changes in HIV detection rates, surveillance reporting system, or underlying epidemic curve. PHPA will work with the CDC to estimate number of new infections.
1b	By 2015: Reduce the HIV transmission rate by 30%	HIV surveillance (as proxy)	The HIV transmission rate is calculated by dividing HIV incidence by HIV prevalence. Proxy for HIV incidence is new HIV diagnoses, and proxy for HIV prevalence is living reported cases of HIV infection. Surveillance data will not include those who are infected and undiagnosed, as well as those who are diagnosed but unreported. Therefore will need to adjust for undiagnosed and unreported cases using national estimates.

<b>NHAS Goal 1: Reduce the Number of People who become Infected with HIV</b>			
<b>Goal #</b>	<b>NHAS Strategic Goal</b>	<b>Local Data Source</b>	<b>Local Measurement Data</b>
2	By 2015: Increase from 79% to 90% the percentage of people living with HIV who know their serostatus	Data not currently available	Currently, there is no local estimate or means to measure this. However, various HIV surveillance and behavioral surveillance data suggest that fewer than 79% of people living with HIV in Maryland know their serostatus (based on high percentage of people with an AIDS diagnosis in the 12 months after their HIV diagnosis and low levels of seropositivity awareness among persons in the National HIV Behavioral Surveillance System. PHPA will work with the CDC to develop local estimate of percent of people living with HIV who know their serostatus.
3	By 2015: Increase percentage of people newly diagnosed with HIV who have a CD4 count of 200 cells/ul or higher by 25%	HIV surveillance/ laboratory reporting	Proportion of newly diagnosed patients who have a CD4 count within three months of their HIV diagnosis
4	By 2015: Reduce the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25%	Behavioral surveillance (Baltimore-Towson MSA)	Statewide data not available. Behavioral surveillance data for the Baltimore-Towson MSA will be used as an estimate.
5	By 2015: Reduce the proportion of IDU at risk for transmission/acquisition by 25%	Behavioral surveillance (Baltimore-Towson MSA)	Statewide data not available. Behavioral surveillance data for the Baltimore-Towson MSA will be used as an estimate.
6	By 2015: Decrease the number of perinatally acquired pediatric HIV cases by 25%	Perinatal surveillance	Number of perinatal exposures and acquired pediatric HIV cases

<b>NHAS Goal 2: Increase Access to Care and Optimize Health Outcomes for People Living with HIV</b>			
<b>Goal #</b>	<b>NHAS Strategic Goal</b>	<b>Local Data Source</b>	<b>Local Measurement Data</b>
7	By 2015: Reduce AIDS diagnoses by 25%	HIV surveillance	Number of new AIDS diagnoses
8	By 2015: Increase the proportion of newly diagnosed patients linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of their HIV diagnosis to 85%	HIV surveillance/ laboratory reporting	Proportion of newly diagnosed patients receiving clinical monitoring tests (CD4 and viral load) within three months of their HIV diagnosis
9	By 2015: Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable	HIV surveillance/ laboratory reporting	Provide number of HIV-diagnosed who had an undetectable viral load in the past 12 months
10	By 2015: Reduce the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%	Behavioral surveillance (Baltimore-Towson MSA)	Statewide data not available. Behavioral surveillance data for the Baltimore-Towson MSA will be used as an estimate.

<b>NHAS Goal 2: Increase Access to Care and Optimize Health Outcomes for People Living with HIV</b>			
<b>Goal #</b>	<b>NHAS Strategic Goal</b>	<b>Local Data Source</b>	<b>Local Measurement Data</b>
11	By 2015: Increase the proportion of RW clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%	Ryan White Clinical Quality Management chart reviews	Number of RW clients receiving primary medical services in Maryland who attend 2 visits for routine HIV medical care in 12 months at least 3 months apart
12	By 2015: Increase the percent of RW clients with permanent housing from 82% to 86%	Ryan White Annual Report	Number of RW clients reported having permanent housing

<b>NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities</b>			
<b>Goal #</b>	<b>NHAS Strategic Goal</b>	<b>Local Data Source</b>	<b>Local Measurement Data</b>
13	By 2015: Increase the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%.	HIV surveillance/ laboratory reporting	Proportions of HIV-diagnosed gay and bisexual men with undetectable viral load test results.
14	By 2015: Increase the percentage of HIV-diagnosed Blacks with undetectable viral load by 20%	HIV surveillance/ laboratory reporting	Proportions of HIV-diagnosed Blacks with undetectable viral load test results.
15	By 2015: Increase the percentage of HIV-diagnosed Hispanics with undetectable viral load by 20%	HIV surveillance/ laboratory reporting	Proportions of HIV-diagnosed Hispanics with undetectable viral load test results.
16a	By 2015: Reduce the disparity in HIV incidence for Blacks versus Whites (Black:White ratio of new infections) by 25%;	HIV surveillance (as proxy)	Number and ratio of new diagnoses among Blacks and Whites.
16b	By 2015, reduce the disparity in HIV incidence for Hispanics versus Whites (Hispanic:White ration of new infections) by 25%	HIV surveillance (as proxy)	Number and ratio of new diagnoses among Hispanics and Whites.
17	By 2015: Reduce the disparity in HIV incidence for MSM versus other adults by 25%.	HIV surveillance (as proxy)	Number and ratio of new diagnoses among MSM and other adults.
18	By 2015: Ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups.	HIV surveillance/ laboratory reporting	Proportion of newly diagnosed patients who have a CD4 count within three months of their HIV diagnosis.

**Major Data Sources**

PHPA will use these data sources to monitor our progress of addressing and measuring the strategic goals developed through the NHAS:

*HIV surveillance:* Information on HIV and AIDS diagnoses, including residence at diagnosis, age, race/ethnicity, sex at birth, country of birth, vital status, HIV exposure category, and CD4 and HIV viral load test results is maintained in the Maryland Department of Health and Mental Hygiene’s Enhanced HIV/AIDS Reporting System (eHARS). Physicians and Clinical and infection control practitioners in hospitals, nursing homes, hospice facilities, medical clinics in correctional facilities, inpatient psychiatric

facilities, and inpatient drug rehabilitation facilities are required to report patients in their care with diagnoses of HIV or AIDS by name to the Local Health Department.

*Laboratory reporting:* Laboratory directors are required to report patients with laboratory results indicating HIV infection (e.g., positive confirmatory HIV diagnostic tests, all CD4 immunological tests, all HIV viral load tests, and all HIV genotype and phenotype tests) to the Local Health Department. As described above, many laboratories in Maryland now report lab data electronically directly to the Maryland Department of Health and Mental Hygiene.

*Behavioral surveillance:* The Maryland Department of Health and Mental Hygiene receives funding from the CDC to participate in the National HIV Behavioral Surveillance (NHBS) System and to collect data for the Baltimore-Towson metropolitan area through interviews and laboratory testing, in collaboration with the Johns Hopkins Bloomberg School of Public Health. Data are used to assess prevalence of and trends in HIV risk behaviors, HIV testing behaviors, exposure to and use of prevention services among persons at high risk for infection, and HIV prevalence and incidence among persons at high-risk for HIV infection (men who have sex with men, injecting drug users, and high-risk heterosexuals).

*Perinatal surveillance:* Physicians are required to report infants born to HIV-positive mothers within 48 hours to the State Health Department. The State collects additional information on the HIV-positive mothers, including demographics, prenatal care usage, HIV test history, substance use, and initiation of HIV-related care, and on exposed infants, including birth history, infection status, referral to care, receipt of prophylaxis and treatment by the infant, and appropriate follow-up care of the child.

### **Data Quality and Linkages**

PHPA will primarily use HIV surveillance data to monitor progress toward achieving the NHAS strategic goals. NHAS includes several objectives that are or could be measured by HIV laboratory surveillance data. These measures, such as linkage to care, retention in care, viral suppression, and population levels of viral load depend on complete, accurate, and timely laboratory reporting. The Maryland Department of Health and Mental Hygiene has licensed 623 laboratories to perform tests on patients from Maryland. These include 58 hospital laboratories and 145 commercial laboratories in Maryland and 22 hospital laboratories and 398 commercial laboratories outside of Maryland. The HIV surveillance program has established electronic laboratory reporting with 20 of the largest providers of HIV-related tests.

Linkages of laboratory data to other public health data, such as testing data, partner services data, and care services data can be used to provide better quality surveillance data and improve our ability to measure program outcomes. These linkages will be facilitated by Maryland's implementation of the new CDC guidelines for data security across all HIV, STI, TB and viral hepatitis surveillance, prevention, and health services programs in the state.

## **Monitoring of PPHA-Supported HIV Prevention and Health Services**

In addition to monitoring local progress towards the NHAS strategic goals, PPHA conducts on-going monitoring and evaluation to ensure the effectiveness and quality of HIV prevention and health services programs. A description of the monitoring and evaluation, and quality assurance activities for HIV prevention services are included in Maryland's PS12-1012 Comprehensive Program Plan. Descriptions of the activities to monitor the quality of HIV health services are included in Appendix F.

### **Maryland HIV Report Card**

As part of the M&E plan over the next three years, PPHA will develop a "report card" for Maryland, assessing the state on its response to the HIV/AIDS epidemic, specifically in regards to progress meeting the NHAS goals. This will ensure accountability and interagency coordination for improving the health of Marylanders. In order to also ensure efficiency in prevention and care program monitoring, quality of service delivery, routine monitoring of health outcomes, and meeting NHAS goals, PPHA will assess and track progress to ensure data driven programming.

## **APPENDICES**

- A. Glossary of Terms and Abbreviations
- B. HRSA Definitions of Service Categories
- C. Resources Inventory
- D. STI Overview
- E. Evaluation of 2009 Comprehensive Plan: Successes and Challenges
- F. Monitoring the Quality of HIV Care



## **APPENDIX A: GLOSSARY OF TERMS AND ABBREVIATIONS**

<b>ACA</b>	Affordable Care Act
<b>ADAP</b>	AIDS Drug Assistance Program
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ASL</b>	American Sign Language
<b>BCHD</b>	Baltimore City Health Department
<b>CDC</b>	Centers for Disease Control and Prevention
<b>COMAR</b>	Code of Maryland Regulations
<b>COG</b>	(Metropolitan Washington) Council of Governments
<b>CPG</b>	Community Planning Group
<b>CSS</b>	Client Satisfaction Survey
<b>DIS</b>	Disease Intervention Specialists
<b>DHMH</b>	Maryland Department of Health and Mental Hygiene
<b>ECHPP</b>	Enhanced Comprehensive HIV Prevention Plan
<b>EFA</b>	Emergency Financial Assistance
<b>EIIHA</b>	Early Identification of Individuals with HIV/AIDS
<b>EMA</b>	Eligible Metropolitan Area
<b>HAB</b>	HIV/AIDS Bureau
<b>HetSex</b>	Heterosexual contact
<b>HERR</b>	Health Education and Risk-Reduction
<b>HEZ</b>	Health Enterprise Zone
<b>HIV</b>	Human Immunodeficiency Virus
<b>HOPWA</b>	Housing Opportunities for Persons Living with AIDS
<b>HPSA</b>	Health Professional Shortage Area
<b>HRSA</b>	Health Resources Services Administration
<b>HUD</b>	U.S. Department of Housing and Urban Development
<b>IDEHA</b>	Infectious Disease and Environmental Health Administration

<b>IDU</b>	Injection Drug Use
<b>IGS</b>	Intergroup Services
<b>LGBTQ</b>	Lesbian, Gay, Bisexual, Transgender, Queer
<b>MADAP</b>	Maryland AIDS Drug Assistance Program
<b>MAI</b>	Minority AIDS Initiative
<b>MCHIP</b>	Maryland Children’s Health Insurance Program
<b>MCO</b>	Managed Care Organization
<b>MSA</b>	Metropolitan Statistical Area
<b>MSM</b>	Men Who Have Sex With Men
<b>MOU</b>	Memorandum of Understanding
<b>MUA</b>	Medically Underserved Area
<b>NHAS</b>	National HIV/AIDS Strategy
<b>NHBS</b>	National HIV Behavioral Surveillance
<b>PAC</b>	Primary Adult Care Program
<b>Part A</b>	HRSA funding to eligible metropolitan areas for HIV medical and support services
<b>Part B</b>	HRSA funding to states for HIV medical and support services
<b>Part C</b>	HRSA funding directly to clinical providers of HIV early intervention medical services
<b>Part D</b>	HRSA funding for women, infants, children and youth Infected and affected by HIV/AIDS
<b>PLWHA</b>	People living with HIV/AIDS
<b>RAC</b>	Regional Advisory Committee
<b>SCSN</b>	Statewide Coordinated Statement of Need
<b>SHIP</b>	State Health Improvement Processes
<b>STD</b>	Sexually Transmitted Diseases
<b>TB</b>	Tuberculosis
<b>TBRA</b>	Tenant-based rental assistance
<b>TGA</b>	Transitional Geographic Area
<b>YMSM</b>	Young Men Who Have Sex with Men

## APPENDIX B: HRSA DEFINITIONS OF SERVICE CATEGORIES

### Services Funded by the Maryland Ryan White Part B

#### CORE SERVICES:

**Outpatient/ Ambulatory Health Services:** Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretrovirals therapies. NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/ Ambulatory medical care.

**Oral Health Care:** Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists, and auxiliaries, and other trained primary care providers.

**Mental Health Services:** Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

**Medical Nutrition Therapy:** Medical nutrition therapy is provided by a licensed dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

**Medical Case Management (including Treatment Adherence):** Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a 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 ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a Medical Transportation Services: Medical transportation services include

conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

**Substance Abuse Services – Outpatient:** Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and /or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

#### **SUPPORT SERVICES:**

**Case Management (Non-Medical):** Case management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

**Child Care Services:** Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. NOTE: This does not include child care while a client is at work.

**Emergency Financial Assistance:** Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. NOTE: Part A and Part B programs must be allocated, tracked, and report these funds under specific services categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

**Food Bank/ Home Delivered Meals:** Food bank/ home delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and housing cleaning supplies should be included in this item. Includes vouchers to purchase food.

**Housing Services:** Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or support services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

**Medical Transportation Services:** Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

**Outreach Services:** Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals.

Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

**Psychosocial Support Services:** Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

## APPENDIX C: References

- Alderman, E. (2012). *State of Maryland's Housing Opportunities for Persons with AIDS (HOPWA)* [PowerPoint slides]. Presentation to Eastern Regional Advisory Committee (RAC) Meeting. March 6.
- Anne Arundel County Commission on HIV/AIDS. (2012). HIV/AIDS Commission. Retrieved from <http://www.aacounty.org/HIV/>.
- AVERT. (2011). Introduction to HIV Prevention. Retrieved from <http://www.avert.org/prevent-hiv.htm>.
- AVERT. (2012). Injecting Drugs, Drug Users, HIV & AIDS. Retrieved from <http://www.avert.org/needle-exchange.htm>.
- Blattner, W. & Brown, T. (2005). Baltimore City Commission on HIV/AIDS Treatment and Prevention Interim Report. Retrieved from [http://www.baltimorecitycouncil.com/PDF\\_Files/2005\\_HIVCommission\\_Report.pdf](http://www.baltimorecitycouncil.com/PDF_Files/2005_HIVCommission_Report.pdf).
- Buchanan D., Kee R., Sadowski L.S., & Garcia D. (2009). The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial. *American Journal of Public Health*, 99(Suppl 3), S675–80.
- Center for AIDS Prevention Studies at the University of California at San Francisco. (1999). What are Deaf Person's HIV Prevention Needs. Retrieved from <http://caps.ucsf.edu/factsheets/deaf-persons/>.
- Centers for Disease Control and Prevention. (2003). Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, HRSA, NIH, and the HIV Medicine Association of the Infectious Diseases Society of America. *Morbidity and Mortality Weekly Report*, 52 (RR12), 1-24. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>.
- Centers for Disease Control and Prevention. (2008). Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection. *Morbidity and Mortality Weekly Report*, 57 (RR09), 1-63. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm>.
- Centers for Disease Control and Prevention. (2011). Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2012). Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2010. *HIV Surveillance Report*, Vol. 22. Retrieved from <http://www.cdc.gov/hiv/surveillance/resources/reports>.
- Centers for Disease Control and Prevention. (2011). HIV among Latinos. Retrieved from <http://www.cdc.gov/hiv/resources/factsheets/pdf/latino.pdf>.
- Community Dialogues (2009-2011). State of Maryland, Infectious Disease and Environmental Health Administration, Department of Health and Mental Hygiene, State of Maryland. Cycle: Annual .
- Currie, D. More Health Departments nationwide embracing social media: Use of tools rises. *The Nation's Health*, 43 (4). Retrieved from <http://thenationshealth.aphapublications.org/content/42/4/1.2.full>.
- Eldred L., Malitz F. Introduction [to the supplemental issue on the HRSA SPNS Outreach Initiative]. *AIDS Patient Care and STDs*, 21 (1), S1-S2.

HIV/AIDS Epidemiological Data. State of Maryland, Infectious Disease and Environmental Health Administration, Center for Surveillance and Epidemiology. Cycle: Quarterly. Method: Surveillance

Monaghan, L. (2012). HIV/AIDS Deafness and Disability. Retrieved from <http://hivdeaf.blogspot.com/>.

InterGroup Services, Inc. (IGS). (2011). *The Greater Baltimore HIV Health Services Planning Council Consumer Survey: Baltimore EMA, 2010*. Baltimore, MD: IGS.

InterGroup Services, Inc. (IGS) for the Baltimore Commission on HIV/AIDS Prevention and Treatment. (2011). *Moving Forward — Baltimore City HIV/AIDS Strategy 2011*. Baltimore, MD.: IGS.

InterGroup Services, Inc. (IGS). (2007). *Engaging PLWH/As in Care: Lessons Learned for the Baltimore EMA*. Baltimore, MD.: IGS.

MADAP Client Survey. State of Maryland, Infectious Disease and Environmental Health Administration, Center for Surveillance and Epidemiology. Cycle: Two years, Completed in September 2010.

Marks G., Burriss S., Peterman T.A. (1999). Reducing sexual transmission of HIV from those who know they are infected: The need for personal and collective responsibility. *AIDS*, 13 (3), 297-306.

Maryland AIDS Administration. (2009). Maryland Ryan White Part B 2009-2011 Comprehensive Plan.

Maryland Statewide Coordinated Statement of Need (2006). State of Maryland, Infectious Disease and Environmental Health Administration, Center for HIV Care and Health Services. Cycle: Every 3 years.

Maryland Statewide Coordinated Statement of Need (2009). State of Maryland, Infectious Disease and Environmental Health Administration, Center for HIV Care and Health Services. Cycle: Every 3 years.

Mascolini, M. HIV prevention with positives: Often ignored, yet often effective. *Research Initiative/Treatment Action*, 16 (1), 5-25. Retrieved from <http://www.centerforaids.org/pdfs/ritawinter2011.pdf>

Metropolitan Washington Council of Governments. (2012). Public Health Programs. Accessed from <http://www.mwcog.org/services/health/default.asp>

Monister M. (2008) The Nature of Risk: HIV/AIDS and the Deaf Community in the United States. *Disability Studies Quarterly*, 28 (4). Retrieved from <http://dsq-sds.org/article/view/144/144>.

Regional Advisory Committee (RAC) Meeting Minutes. State of Maryland, Infectious Disease and Environmental Health Administration, Center for HIV Care and Health Services. Cycle: Quarterly.

Ryan White Client Satisfaction Survey. State of Maryland, Infectious Disease and Environmental Health Administration, Center for Surveillance and Epidemiology. Cycle: Annual. Method: Survey

The Deaf AIDS Project. (2009). Retrieved from <http://www.deafnonprofit.net/dap/>.

Washington, DC Department of Health. (2012). The Ryan White Planning Council. Retrieved from <http://dchealth.dc.gov/doh/cwp/view,a,1371,q,602815.asp>.

The White House Office of National AIDS Policy. (2010). National HIV/AIDS Strategy for the United States. Washington D.C.: White House.

## APPENDIX D: STI OVERVIEW

### The HIV Epidemic is Linked to STIs

HIV and sexually transmitted infections (STIs) are interrelated on multiple levels: biological, behavioral, and population. On the biological level, the presence of an STI can increase susceptibility to acquiring HIV infection in someone who is seronegative. For example, an STI, especially one that causes lesions or sores such as syphilis or genital herpes, can provide a break in the surface of the mucosal membrane, thereby allowing HIV a convenient passageway into the body. Having an STI also recruits immune cells, including CD4 cells, to the site of infection in the mucosal membrane. Among seropositive persons, the presence of an STI also increases the communicability, or infectivity, of HIV, because HIV viral load increases when a person is co-infected with a STI.<sup>15</sup>

The HIV and STI epidemics are also linked because they are transmitted through sexual contact. Therefore, behavioral risk factors such as inconsistent condom use, and those behaviors which can affect condom use such as drug and alcohol use, are necessary considerations in preventing the spread of HIV and other STIs.

At the population level, many of the groups who are disproportionately affected by HIV, including young adults and racial and ethnic minorities, also have high rates of STIs. This is not coincidental. While social determinants such as poverty and access to care most likely play a role in the persistence of these disparities, the likelihood of exposure to infection within a sexual network or within a geographic area also plays a critical role in connecting STIs to HIV. For example, within Maryland, rates of STIs and HIV new diagnoses are highest in Baltimore City and low in Garrett County (in western Maryland). Therefore, a person in Baltimore City who is engaging in high risk behaviors is more likely to be exposed to STIs and/or HIV than a person engaging in the same behavior in Garrett County. Similarly, persons within a sexual network with a higher concentration of disease (e.g., networks including persons that exchange sex for money, housing, or drugs) will be more likely to become exposed to STIs and/or HIV than in persons within sexual networks with lower concentration of disease.

This increased likelihood of exposure and overlapping behavioral risk factors, along with the biologically-based increase in susceptibility to and communicability of HIV in the presence of a STI, leads to STIs contributing to the continued transmission of HIV.

### Overview of STI Epidemiology

STIs are widespread throughout Maryland, although the true burden of STIs is not known because many STIs go undiagnosed and unreported, and common viral STIs such as human papilloma virus and genital herpes are not reportable conditions in Maryland. Summarized below are the salient features of chlamydia, gonorrhea, and syphilis epidemiology in Maryland.

Similar to the U.S., chlamydia and gonorrhea are the two most frequently reported communicable diseases in Maryland with 26,192 and 7,413 cases reported in 2010 respectively. Youth and young adults are hardest hit by chlamydia and gonorrhea (see Figure 1). Persons ages 15-24 accounted for 74%

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<sup>15</sup> Centers for Disease Control and Prevention. 1998. HIV prevention through early detection and treatment of other sexually transmitted diseases - United States. MMWR 47(RR-12):1-24.



of reported chlamydia and 65% of reported gonorrhea cases in 2010. Chlamydia is more commonly reported in females, which reflects screening recommendations as well as biological factors that place females at greater risk than males. Rates of gonorrhea in females and males are nearly equal. Chlamydia is present in communities throughout Maryland (see Figure 2). Areas with the highest incidence rates are in Baltimore City and surrounding counties, suburban Washington, DC, and areas on the Eastern Shore.

The epidemiological profile of syphilis is different from chlamydia and gonorrhea. In 2010, there were 328 cases of primary and secondary syphilis reported in Maryland. The highest rates of syphilis are in Baltimore City, followed by Prince George’s County. The incidence rate of syphilis rate in males was 12 times higher than the incidence rate in females (10.8 and 0.9 cases per 100,000 in 2010). African American men who report having sex with other men are disproportionately affected by syphilis (see Figures 3 and 4).

**Figure 1**

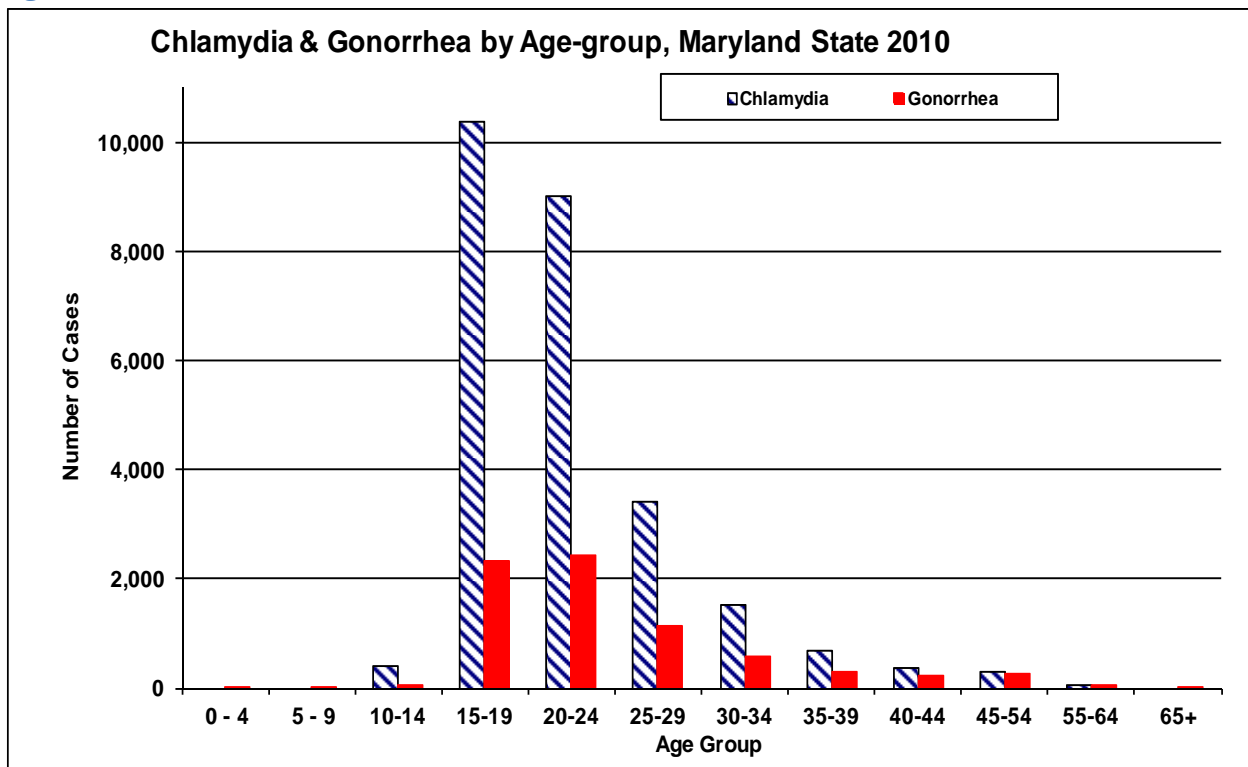


Figure 2

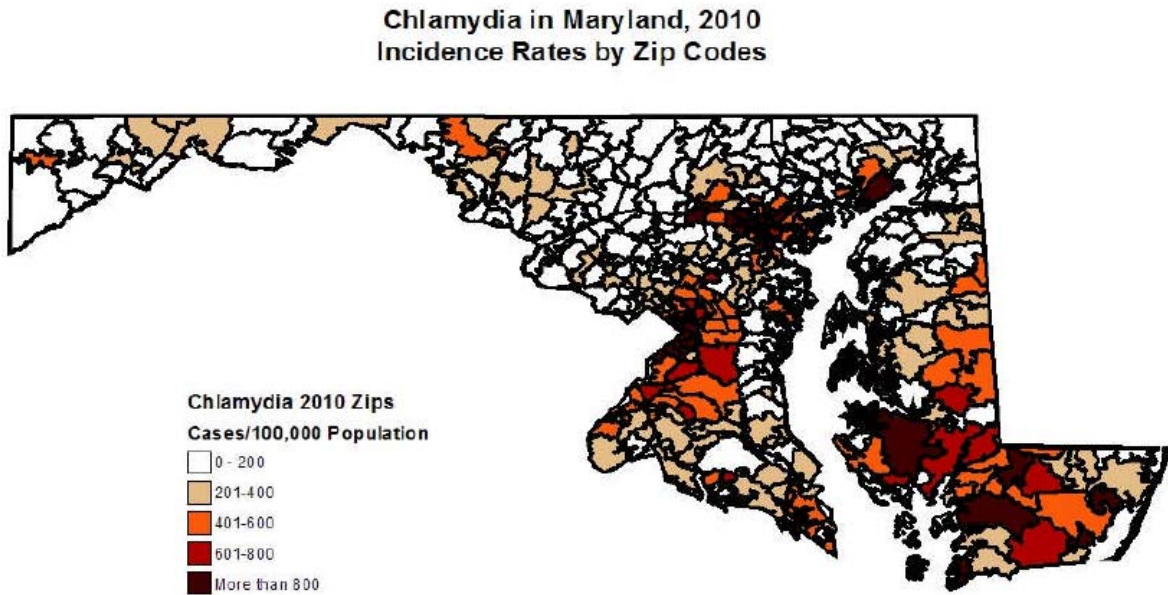


Figure 3

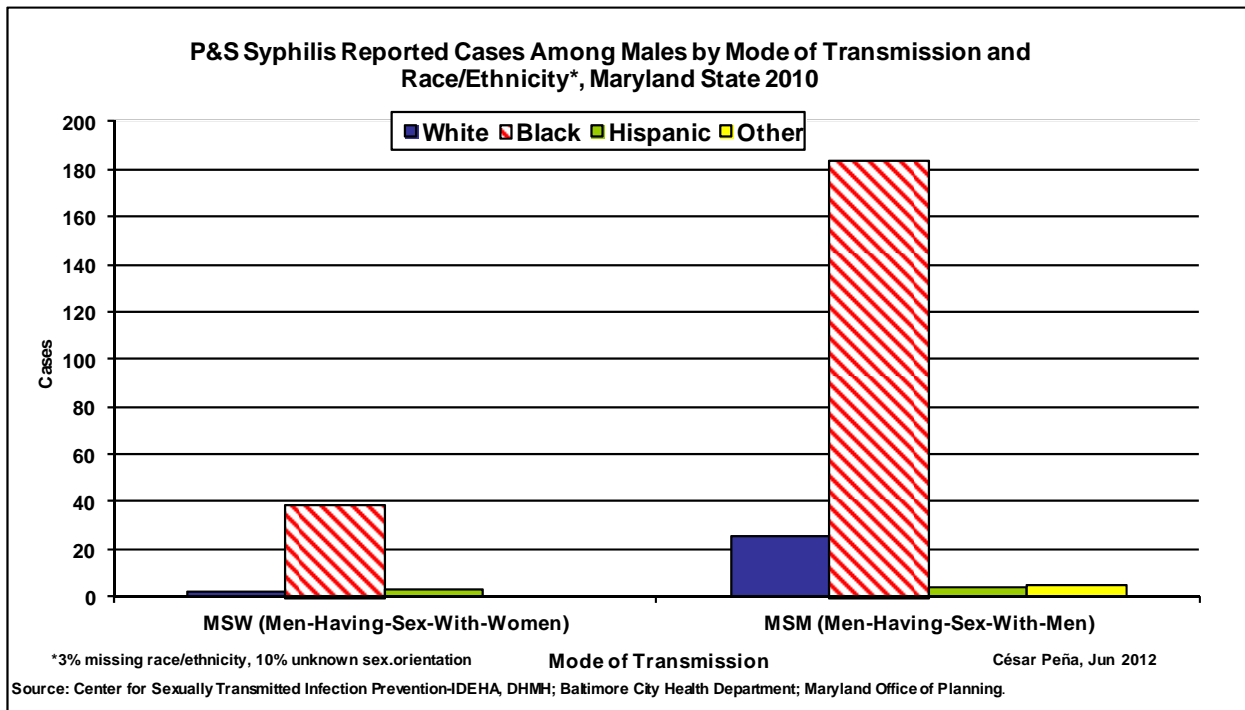
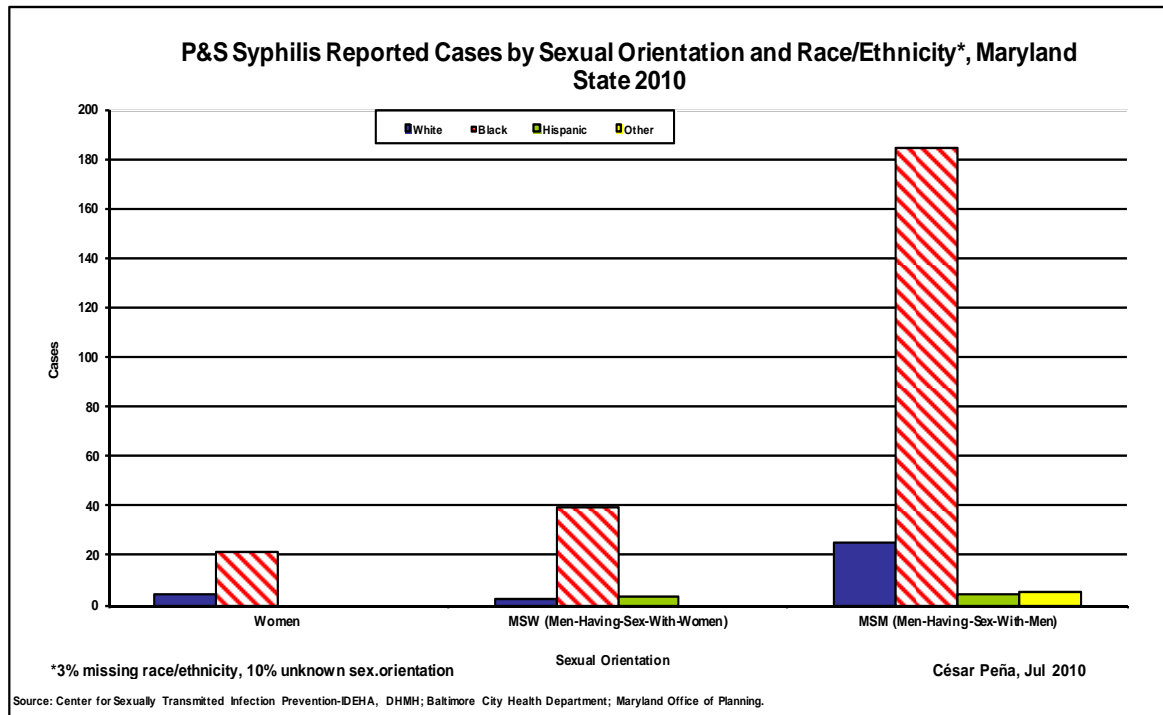


Figure 4



### Current Public Health System Responding to STIs

At the state level, the Center for STI Prevention (CSTIP), located within the Infectious Disease and Environmental Health Administration, promotes the control and prevention of the spread of STIs in Maryland by providing leadership, support, and technical assistance to local-level STI programs, and by monitoring STI case reports and trends. Local health departments offer free STD clinical services, including testing and treatment services for STIs, as well as partner notification services to help those persons who are infected with an STI make their sexual partners aware that they may have been exposed and should be tested. Local programs also engage in community and health provider awareness and outreach activities. CSTIP also designs, conducts or sponsors provider education including annual CME webinars, tailored provider training, and provides links to web-based provider training.

Federal, state, and local funding for STI programs has been declining over the last decade and eroded further at the state and local levels with the start of the economic downturn in 2008. Significant portions of the funds from the CDC Division of STD Prevention cannot be used for clinical services. Even prior to the economic recession, local STI clinics routinely could not meet the public's demand for clinical services, resulting in persons being turned away from STD clinics. This is particularly troublesome because STI clinics tend to serve uninsured or under-insured populations, high-risk populations such as youth, and individuals who are seeking confidentiality (i.e., do not want STI testing and treatment to appear on health insurance claims). Decreased funding has also led to limiting the capacity of the DHMH Laboratories Administration in providing chlamydia and gonorrhea nucleic acid amplification testing to local health department STD and family planning clinics.

## Opportunities for Integrating STIs into Routine HIV Prevention Roles

Given the extent of the interrelatedness of STIs and HIV, and the large case numbers of these infections, there are several situations where adding STI prevention messages to those for HIV are appropriate.

Some of these opportunities include:

1. Incorporate information on how STIs increase the risk of HIV acquisition and transmission during HIV counseling and testing sessions, HERR programming, and during HIV/STI partner services counseling.
2. Provide information on where clients can access STI screening ([www.findSTDtest.org](http://www.findSTDtest.org) or [www.HIVtest.org](http://www.HIVtest.org)) during HIV counseling and testing sessions and HERR programming.
3. Provide education on how STIs increase the risk of HIV acquisition and transmission, either as stand-alone training sessions or as components of existing trainings offered by IDEHA's Center for HIV Prevention and Health Services, such as "HIV 101" and refresher courses that are aimed at health care providers, educators, counselors, and outreach workers.
4. Include STI prevention messages where appropriate in mass communication campaigns or targeted community outreach campaigns.
5. Encourage HIV-at-risk individuals to request STI screening from their health care providers as part of routine health care and as part of on-going HIV care.
6. Encourage HIV-at-risk individuals to request STI tests of appropriate anatomic sites including oropharyngeal and rectal sites.

## APPENDIX E: Evaluation of 2009 Comprehensive Plan: Successes and Challenges

The 2009 Maryland HIV Services Plan included six long-term goals. Successes and challenges in working toward these goals are described below:

1. Coordinate a collaborative system of HIV care across all Ryan White Parts and with other service providers.
  - PPHA successfully continued active participation in Baltimore’s Ryan White Part A HIV Services Planning Council, attending monthly Council meetings and providing monthly updates of Part B and Part D to the Council. PPHA staff were active participants in the following committees: Comprehensive Planning, Continuum of Care, Services to Surrounding Counties, Executive, Nominating, and Standards of Care. Another success was the addition of a Planning Council Prevention seat to be occupied by a “community” member of the Maryland HIV Prevention Community Planning Group.
  - PPHA also maintained representation for Ryan White Part B on the Washington, D.C.s Ryan White Part A HIV Services Planning Council, with representation on several committees: Needs Assessment and Care Strategies. A challenge in maintaining this representation was that the process for appointing new members is time-consuming.
  - PPHA staff participated in the Baltimore City HIV/ AIDS Commission and the Anne Arundel County HIV/AIDS Commission.
  - PPHA successfully convened a Ryan White-Funded-All-Parts meeting in January 2011.
2. Ensure people who are newly diagnosed HIV-positive and those not in HIV care enter HIV health care by collaborating with Counseling, Testing and Referral (CTR) programs and facilitating connections to care and support services.
  - Successes include the establishment a forum for collaboration, the HIV Prevention and Care Collaboration Committee that includes HIV prevention, testing and care staff from Part A and Part B as well as HIV prevention staff. This group meets semi-monthly to improve coordination of services and program.
  - PPHA reorganization that has resulted in a merger of HIV Prevention with Health Services
  - Presentations about HIV Partner Services were provided for Part A HIV Services Planning Councils to facilitate increased referrals to HIV Partner Services
  - Funded linkage-to-care initiatives with Part B Minority AIDS Initiative (MAI) and State funding through Case Management Services Categories resulting in expansion of service capacity. In 2011, all newly funded MAI providers attended a mandatory orientation for MAI services
  - Efforts are underway to establish mechanisms to utilize existing data sources to enhance and ensure linkage to programs such as MADAP for newly identified PLWHA
  - PPHA implemented new Monitoring Standards that resulted in MAI sub-grantees receiving an annual comprehensive site visit with identified needs for technical assistance.

3. Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the importance of retention in care, treatment adherence support and prevention with HIV-positive individuals.
  - It has been challenging to revise statewide quality indicators for clinical services due to a number of staff vacancies, including the Quality Assurance Coordinator position.
  - PHPA worked with an information technology contractor to improve management of available programmatic data
  - PHPA implemented new HRSA Monitoring Standards, which increased the frequency of comprehensive site visits from every 3 years to every year. It has been challenging to implement the new monitoring standards, as annual site visits require significantly increased the staff work load.
  - PHPA staff continue to provide technical assistance and access to training programs for funded vendors.
  
4. Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Maryland.
  - PHPA has had success in ensuring that the MADAP Advisory Board membership is representative of Maryland's epidemic. The Board is composed of prescribing physicians, consumers, members of community-based organizations, and client advocates who advise PHPA on which medications should be on the MADAP formulary and assist with quality management by reviewing utilization and program data and making recommendations to PHPA leadership on program sustainability. The PHPA leadership is working to fill an opening on the Advisory Board for a representative from an administrative agent for Ryan White Part A EMAs.
  - A success has been implementing a process for MADAP formulary review to ensure optimal coverage of HIV and related medications. The MADAP Advisory Board members receive quarterly updates on the status of MADAP enrollment and drug utilization with the primary focus on HIV antiretroviral expenditures. The Board's consulting pharmacologist provides recommendations to inform the members of the treatment benefits, potential drug interactions and cost effectiveness of the drugs in question. The first round of the comprehensive review was completed in July 2010 and has been followed by ongoing review.
  - MADAP has successfully implemented a new custom built MADAP database system to track eligibility and claims data. This new system will enhance PHPA's ability to conduct quality assurance activities and manage the program. Various reports have been created to enable in-depth analysis of frequency and use of medications, insurance premium payment patterns, and work flow.
  - The MADAP Client Survey is used to assess client satisfaction with the MADAP program. The survey includes questions about satisfaction with interaction with MADAP staff, medication coverage, adherence to medication and health status. It is conducted every two years and was sent to all persons enrolled in MADAP in 2010. Results will be used to improve MADAP

services and presented at internal staff meetings and the MADAP Advisory Board Meeting. The 2012 survey effort is in process with results anticipated by mid-Summer 2012.

5. Improve access to mental health services and substance/alcohol abuse counseling and treatment for persons living with HIV/AIDS and co-morbidities.
  - PHPA applied for and received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE). Among other activities, this grant will fund activities to ensure that PLWHA receive culturally competent and integrated behavioral health and primary care services, including appropriate screening, assessment, testing, referrals, care, and treatment for mental health and substance abuse. This grant has fostered increased collaboration with the mental health and substance abuse treatment systems both statewide and regionally.
6. Provide appropriate case management and access to essential supportive services that enable persons living with HIV/AIDS to seek treatment, remain in care and adhere to medication regimens. Such services include but are not limited to: non-medical case management, medical nutritional counseling, housing assistance, transportation, and emergency financial assistance.
  - PHPA has continued to utilize the Regional Advisory Committees to prioritize the Ryan White Part B service categories for each region. The regional priorities guide the use of funding for HIV health services, and has ensured promoted access to essential services to PLWHA

## **APPENDIX F: Monitoring Quality of HIV Care**

The Center for HIV Prevention and Health Services is responsible for oversight of the HIV care funded through Ryan White Part B and Part D. PHPA has designated staff in the Center for HIV Surveillance and Epidemiology for on-going monitoring and evaluation of HIV services and prevention programs to ensure that funds are being effectively used to meet the needs of people living with HIV/AIDS in Maryland. Health Services and Prevention evaluators examine performance and outcome goals and data collected towards measuring attainment of program objectives. The Health Services evaluators coordinate the development and implementation of the client satisfaction surveys, medical record reviews, and other evaluation activities that assess and gauge quality of care. Quarterly reports are required for Part B and D funded agencies and include a programmatic narrative, performance measures per service category, and expenditure documents. The narrative section provides a summary of how the program functions, what services are provided, and indicates any barriers to providing services and/or program successes. It also presents the program's progress, efforts at increasing adherence to treatment services, and services targeting women and children. Program staff utilizes this information to enhance their program monitoring activities and assess utilization of services by service category.

### **Ambulatory Outpatient Medical Record Reviews**

As a routine part of the monitoring of health services programs, site visits and record reviews are conducted among providers who receive Part B, D, and State funds for Adult Ambulatory Outpatient Care. A Quality of Care Evaluation Tool, based on the Adult Ambulatory Outpatient Standards of Care, is utilized to review a sample of medical records to determine the quality of the medical care that is being provided. At each site on an annual basis, active medical records of HIV/AIDS patients who have received care at the site for at least one year are reviewed. The information abstracted from the records includes: demographics; treatment for HIV (including antiretroviral medications), co-morbid conditions, and STIs; preventive therapy and prophylaxis; gynecology; mental health; substance abuse; and documentation quality. The results of these reviews are tabulated and presented to staff at the Administration and at each of the sites. The results are used to assess quality of care, identify notable practices, and recommend areas that need improvement.

### **Client Satisfaction Surveys**

Client satisfaction surveys are administered to provide critical feedback on the success of Ryan White funded programs in meeting the needs of clients with HIV. A Client Satisfaction Survey for Part A, B, and D-funded services is administered annually. Reports are stratified by region and agency. Agency reports are filed in each individual provider's record and staff review results to ascertain if any corrective action is needed. A MADAP Client Satisfaction Survey is administered bi-annually and provides feedback on access, process, and customer service issues related to the pharmacy and insurance premium assistance programs. Over the next three years, feedback will also be collected from HOPWA-assisted households regarding their satisfaction with the housing and support services they receive.

### **Client Level Health Services Data**

A primary goal of Maryland's HIV monitoring and evaluation system is to collect, manage, evaluate, and report accurate, standardized, client-level data on Ryan White Part B and D services. This is necessary in



order to increase accountability, program improvement, and advocacy to improve health outcomes for HIV infected persons in Maryland. Since January 2004, all Part B and state-funded HIV service providers have been required to submit electronic, unduplicated client level data to HRSA on an annual basis. Beginning in 2009, Ryan White Program grantees and service providers started using a new data reporting system to report information on their programs and the clients they serve to the HIV/AIDS Bureau (HAB) called the Ryan White HIV/AIDS Program Services Report, or the RSR. Each service provider submits this report online as an electronic file upload using a standard format. Providers submit data directly to HRSA in various formats using an assortment of data systems (e.g., CAREWare - Free software that can be used to manage HIV/AIDS care service data and submit the RSR). HRSA's data systems primarily track service delivery by HRSA funding category. Required by the federal funder, all grantees and providers that deliver Ryan White HIV/AIDS Program funded services must complete an RSR for each annual reporting period. An aggregate report is developed and then distributed to PHPA. The reports are reviewed to assess service utilization patterns within geographical areas and by demographic trends. PHPA will strategize ways to directly access client level data from providers or HRSA in order to have access to service information necessary to improve our understanding of the population utilizing Ryan White services and address unmet need.