

September 2011

Moving Forward — Baltimore City HIV/AIDS Strategy Summary, 2011

Report to Mayor Stephanie Rawlings-Blake

Submitted by:

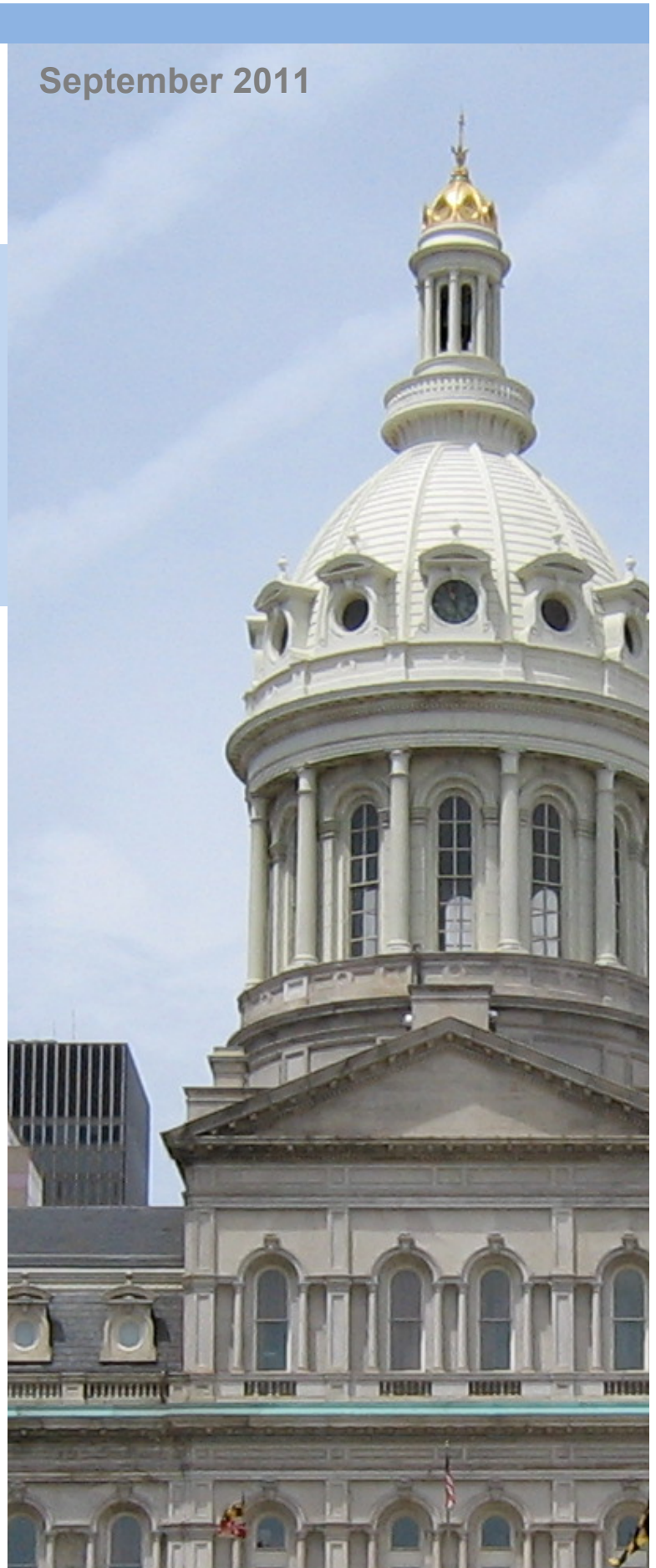
*Baltimore City Commission of HIV/AIDS
Prevention and Treatment*

and

Baltimore City Health Department

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1. Background

The Baltimore City Commission on HIV/AIDS Prevention and Treatment (BCCHIV or “the Commission”)¹ was chartered by the offices of the mayor and the Baltimore City Council president to address the HIV/AIDS² state of emergency declared by the mayor in the spring of 2002. As it enters its tenth year of advocacy on behalf of city residents, the Commission continues its mission: to provide policy guidance, recommendations and consultation to the city’s leadership and health community to improve services, with a view toward effective prevention and treatment programs to protect the citizens of Baltimore.

In 2005, the BCCHIV called upon city officials to coordinate HIV/AIDS-related activities and create a strategic plan (BCCHIV 2005). In 2008, the Commission presented an interim report to city officials reflecting the concerns and promoting the development of a city-driven strategic plan to decrease new HIV cases in the city (BCCHIV 2008). Since then, the BCCHIV has played an integral role in coordinating multi-disciplinary organizations in the prevention and treatment of HIV/AIDS. The synergy of academic, government and community leaders has informed local stakeholders of the most recent research, policy and changing community needs. As a result of the collaboration and hard work of the BCCHIV, the Baltimore City Health Department (BCHD), the Maryland Department of Health and Mental Hygiene (DHMH) and other partners, a Baltimore City HIV/AIDS strategy has been created. This stand-alone summary document describes in outline the simultaneously released full *Moving Forward* strategic plan (IGS 2011), which provides Baltimore City and the Commission with a framework to collaboratively prevent and treat HIV/AIDS in local neighborhoods.

Setting The Tone: Healthy Baltimore 2015

In May 2011, under the leadership of Baltimore City Health Commissioner Oxiris Barbot and Mayor Stephanie Rawlings-Blake, the Baltimore City Health Department and the Office of the Mayor released a comprehensive health-policy agenda and accompanying report, both called *Healthy Baltimore 2015* (Spencer *et al.* 2011). The plan sets ambitious yet reachable goals for reducing high rates of disease, infections and addictions among city residents. *Healthy Baltimore 2015* highlights 10 issue areas with 36 specific measures. BCHD will partner with nearly every community in Baltimore, including hospitals, neighborhood associations, businesses, non-profits and faith organizations, to reduce morbidity and mortality, address health inequities and improve the local quality of life (Cohn 2011).

One of the goals of *Healthy Baltimore 2015* is to stop the spread of HIV and other sexually transmitted diseases. The target is to decrease the number of new HIV infections from current levels by 25 percent by 2015. This coincides with the *National HIV/AIDS Strategy for the United States* (NHAS), released in June 2010. *Healthy Baltimore 2015* addresses the “role that social factors such as poverty, educational attainment, substance abuse, and health literacy” play in shaping health opportunities (Spencer *et al.* 2011:10). The full document can be downloaded from this website: <http://bit.ly/rfqUtM> or http://baltimorehealth.org/info/Healthy_Baltimore_2015/HealthyBaltimore2015_Final_Web.pdf.

Baltimore City’s goal for Healthy Baltimore 2015: to decrease the number of new HIV infections by 25 percent.

¹ Referred to as “the Commission” or “HIV Commission” in the full report: *Moving Forward — Baltimore City HIV/AIDS Strategy 2011* (IGS 2011).

² Human immunodeficiency virus/acquired immune deficiency syndrome.

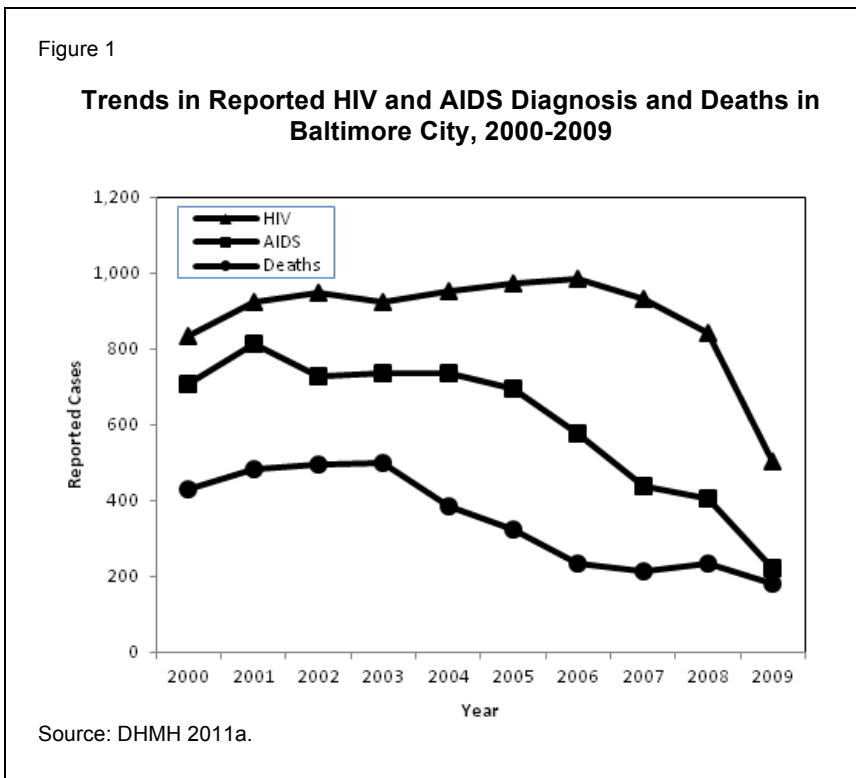
HIV in Baltimore City

Despite remarkable national advances in countering the effects of HIV/AIDS over the last 30 years, the Baltimore metropolitan area continues to be among the top 10 urban areas in the country with regard to HIV incidence rates (Flynn 2011). At the end of 2009, there were 13,048 individuals living with HIV/AIDS who were residents of Baltimore City at diagnosis (DHMH 2011a). Of those, 12,809 were adult/adolescent cases (age 13+ at HIV diagnosis), of whom 5,620 were living with HIV and 7,189 were living with AIDS (DHMH 2011a). In 2009, HIV infections were being diagnosed at a rate of almost one and a half per day (DHMH 2011a). Additionally, treatment for HIV/AIDS is costly. A 2006 study found the lifetime expense of treating each new case of HIV to be approximately \$355,000 (Schackman *et al.* 2006). This cost will impose a significant strain on evolving health-care systems, especially in a city like Baltimore with a high poverty rate.

HIV/AIDS disproportionately affects men in Baltimore City. Of the adult/adolescent HIV diagnoses in 2009, 63.2 percent were among men (DHMH 2011a). When age at HIV diagnosis is

considered, 40-to-49-year-olds comprised 27.1 percent of the 2009 diagnoses; 20-to-29-year-olds comprised 24.0 percent; 30-to-39-year-olds comprised 22.4 percent; 50-to-59-year-olds comprised 18.4 percent, and those 60 and older comprised 5.0 percent of those diagnosed with HIV. Those 20 years old and below encompassed 3.2 percent of the diagnoses in 2009 (DHMH 2011a).

Baltimore's most at-risk populations include men who



have sex with men (MSM); high-risk heterosexuals; African-Americans; Latinos; and substance abusers. Although African-Americans constitute only about 64 percent of Baltimore's population, more than 85 percent of adult/adolescent HIV cases diagnosed in 2009 occurred among them (DHMH 2011a). That same year, the proportion of new cases among Latinos was similar to the relative size of that population: 1.8 percent of adult/adolescent 2009 diagnoses were among Latinos, who constitute about 1.7 percent of the city's population (DHMH 2011a). However, the rate of reported HIV/AIDS diagnoses for Latinos was nonetheless twice as that of Caucasians (DHMH 2011a).

Throughout 2009, there were 505 reported HIV diagnoses, 221 reported AIDS diagnoses and 180 AIDS deaths (DHMH 2011a). Figure 1 illustrates the trend in HIV diagnoses, AIDS diagnoses

and AIDS deaths from 2000 through 2009. HIV diagnoses peaked in 2006. AIDS diagnoses peaked in 2001 and have since shown a decreasing trend which accelerated between 2005 and 2009. AIDS deaths peaked in 2003 with 499 reported deaths (DHMH 2011a). Baltimore's accomplishments as reflected by the decreasing number of HIV and AIDS diagnoses and deaths are encouraging, yet the BCCHIV recognizes there is more progress to be made, particularly given that access and adherence to anti-retroviral drugs can prevent AIDS and death.

At the end of 2009, there were 13,048 individuals living with HIV/AIDS who were residents of Baltimore City.

In 2009, Baltimore had an overall HIV-incidence rate of 94.6 cases per 100,000 people (age 13+). That same year, the following 9 city ZIP codes had HIV-incidence rates that exceeded this citywide rate: 21201 (218.4 per 100,000), 21223 (204.4 per 100,000), 21202 (196.9 per 100,000), 21217 (181.6 per 100,000), 21205 (156.0 per 100,000), 21213 (139.2 per 100,000), 21216 (126.9 per 100,000), 21225 (126.7 per 100,000), 21218 (124.0 per 100,000). Although only about 42 percent of the city's population resides in these ZIP codes, they were in aggregate, the location of about 71 percent of new HIV cases in 2009 (DHMH 2011a). As neighborhoods are so obviously disproportionately affected by this epidemic, geographic location *must* factor into the Baltimore City HIV/AIDS Strategy.

2. Policy Environment

The last two years have been a revolutionary time in health policy, especially for HIV/AIDS prevention and treatment. Plans and legislation have been enacted that address the health-care needs of those uninsured and with pre-existing conditions such as HIV. The following plans and guiding documents have informed Baltimore in the development of its local strategy.

Affordable Care Act

The 2009 Patient Protection and Affordable Care Act (P.L. 111-148, also known as the Affordable Care Act) will make it somewhat easier for all Americans, regardless of income, to obtain and keep health insurance coverage (ONAP 2010:ix). This will be important in the engagement, stabilization and maintenance of health care for low-income people living with HIV/AIDS (PLWHA) who might not otherwise be able to afford care. Starting in 2014, insurance companies may no longer deny coverage or charge higher premiums based on disabilities, including HIV infection, and lower-income people with HIV but not AIDS will no longer have to wait until an AIDS diagnosis before becoming eligible for Medicaid. In the meantime, Baltimore PLWHA will be able to access coverage through state-run high-risk insurance pools. The new law also ends lifetime limits on coverage, phases out annual limits on coverage, and will require increased coverage for preventive care, including HIV screening (Soriano 2010). These regulations will allow additional Baltimore residents to access insurance and/or Medicaid, obtain additional preventative care, and potentially pay less for their lifetime coverage. The full version of the act can be found at this website: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.

National HIV/AIDS Strategy

On July 13, 2010, the White House released the *National HIV/AIDS Strategy for the United States*, a document summarizing the president's top HIV/AIDS policy priorities for the nation (ONAP 2010:1). The NHAS set four overarching goals that are now driving HIV/AIDS-related policies and government programs throughout the country:

1. Reducing the number of people who become infected with HIV.

2. Increasing access to care and optimizing health outcomes for people living with HIV.
3. Reducing HIV-related health disparities.
4. Achieving a more coordinated national response to the HIV epidemic.

Baltimore City has based its own HIV/AIDS prevention strategy on the four pillars outlined by the NHAS. A full version of the National Strategy can be found on this website: <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.

Enhanced Comprehensive HIV Prevention Plan

In September 2010, the Infectious Disease and Environmental Health Administration (IDEHA) of the Maryland Department of Health and Mental Hygiene received funding to develop an Enhanced Comprehensive HIV Prevention Plan (ECHPP) for the Baltimore/Towson metropolitan statistical area (MSA). This plan is designed to align HIV-prevention activities with the NHAS through 24 required and recommended interventions specified by the U.S. Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention, which provides the funding for the ECHPP project. The primary goals of the local ECHPP are:

“To identify the optimal combination of coordinated HIV prevention, care, and treatment services that can maximize the impact on reducing new HIV infections in the Baltimore-Towson MSA, Maryland. The ECHPP addresses gaps in current HIV prevention strategies and coordination of HIV prevention, care and treatment services, and recommends activities to strengthen and refocus current efforts” (DHMH 2011b).

The Baltimore/Towson MSA includes Baltimore City and the surrounding counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne’s. ECHPP was developed with contributions from the health departments of these jurisdictions, five HIV/AIDS community-planning bodies, community-based organizations, and other stakeholders. The implementation phase of ECHPP will use resource-optimization strategies to increase coordination across the HIV prevention, care, and treatment continuum. As part of the MSA, Baltimore City benefits not only from this funding, but also from the focused planning of resources and strategies that this plan uses. These strategies have been incorporated into *Moving Forward — Baltimore City HIV/AIDS Strategy 2011*.

Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA

In 2008, the Greater Baltimore Health Services Planning Council produced its *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA: 2009-2011* (IGS 2008). This group is the metro area’s Ryan White Part A planning body, whose members are appointed by the mayor of Baltimore City. The plan detailed the current state of HIV/AIDS in the area, the ideal continuum of care, several strategies and partnerships to achieve the goals, and how to measure progress to the goals. The planning council and other planning bodies have used this document to steer planning and collaboration. In 2011, the planning council began drawing up a new comprehensive plan for 2012-2015, to include four overarching goals for HIV health service delivery in the Baltimore metropolitan area: 1) prevent new infections; 2) engage people who are HIV-positive but not in care; 3) stabilize HIV-positive individuals in medical care; and 4) maintain HIV-positive individuals in medical care.³ The comprehensive plan provides guidance

³ Despite their similar sounding names, care stabilization and care maintenance are not the same. Maintenance is for those who are already in consistent HIV care; it is about keeping them in that care. Stabilization is about working with clients who may have obtained some HIV care at some point, but who are not yet consistently in care. The probability of success is greater for patients’ adherence to highly active antiretroviral treatment (HAART) when co-morbid

and benchmarks to the Baltimore planning council and other interested parties on how to best prevent and treat HIV/AIDS within the Baltimore Ryan White eligible metropolitan area (EMA), given the local epidemic and political landscape.⁴ The comprehensive plan provides the blueprint for the allocation of approximately \$20 million a year in service funding under Ryan White Part A. The complete 2009-2011 comprehensive plan can be found on this website: <http://www.intergroupservices.com/pdf/CompPlan0911.pdf>.

3. Baltimore City HIV/AIDS Strategy

The Baltimore City HIV/AIDS Strategy, of which this document is a summary, aligns with the 2005 BCCHIV report recommendations and all of the planning documents described in section 2. As Baltimore City is continually ranked one of the most HIV-affected urban areas in the country, a “Baltimore City-centric” plan is essential for prevention and treatment within the city. Over the last 30 years, the Baltimore metropolitan area has continued to be among the top 10 most HIV-impacted urban areas in America. Researchers, policy makers and the community continue to strive for effective and innovative planning, prevention, care and treatment solutions. With this in mind, the Commission, in the strategy report, focused on Baltimore’s own experiences and proven strategies to provide extensive recommendations for strengthening HIV-prevention efforts in Baltimore. As part of the data-collection process, a variety of community-planning mechanisms were used to collect consumer and stakeholder input. An on-line survey and town-hall meeting were utilized to gather stakeholder feedback. These stakeholders included city officials, health-care providers, HIV service consumers and the general public. The strategy report considers what existing and new programs and interventions might help achieve national goals at the local level. What has resulted is a local adaptation of the NHAS that reflects Baltimore’s specific needs, strengths and challenges. The strategy document provides a menu of possible approaches for achieving overall goals. It does not provide an estimate of either the costs or exact consequences of doing so. Therefore, the result may be viewed as a critically important array of possible actions that can be taken with the knowledge that not all will be possible with current resource limitations.⁵

A variety of community-planning mechanisms were used to collect consumer and stakeholder input. The result is a local adaptation of the NHAS that reflects Baltimore’s needs.

Treatment is Prevention

An emerging body of scientific data demonstrates that the impacts of HIV prevention are magnified when contextualized with comprehensive treatment interventions. The “treatment is prevention” paradigm is being adopted as a national policy, impacting both prevention and the treatment of HIV infection. The approach that combines testing, linkage to care and stabilization of clients in treatment regimens has been nationally developed for local implementation. Based on these evolving prevention and treatment policies, the Commission recommends:

1. That HIV counseling and testing be expanded, such that all adults and adolescents in Baltimore City be provided at least one HIV test, given that there are many undiagnosed HIV infections that are contributing to the epidemic. Annual HIV testing is recommended for those persons and communities at highest risk of infection.

conditions have been stabilized.

⁴ The Baltimore EMA covers the same geographic area as the Baltimore/Towson MSA.

⁵ The ECHPP process noted above provides a mathematical model that attempts to identify the optimal group of interventions and scale given the currently available resources

2. That all persons living with HIV in the city be given access to immediate treatment with anti-retroviral medications with proper monitoring and continuity of care, including those incarcerated, and in transition from or to incarceration, as well as those who are homeless.
3. That all HIV-positive persons, whether opting for therapy or not, be linked to care and social services, including drug treatment linked to HIV services for substance-abusing populations with or at risk of HIV infection, and that drug treatment services be universally available.
4. That BCHD, in collaboration with the Ryan White Part A HIV planning council and with input from the Commission, evaluate the affordability and the potential benefits based on emerging science of making pre-exposure prophylaxis readily available to most at risk in Baltimore.
5. That condoms and educational materials be widely distributed with a single message through and in local organizations, churches, venues that cater to gay and bisexual men, venues frequented by substance abusers, and age-appropriate school settings.

Discussed below are the Commission’s goals, based on the National Strategy’s goals. They are summarized in table 1, a more detailed version of which appears in chapter E of the full strategy report. Table 1 summarizes the Commission’s first three policy goals; a fourth, administrative goal is omitted for brevity’s sake.

Goal 1 — Reducing New HIV Infections

As Baltimore City continues to refine its prevention methods, it is important to gather sufficient data to identify and target the most at-risk populations and communities. The first step under goal one of the *Baltimore City HIV/AIDS Strategy* is to intensify HIV-prevention efforts in specific geographic areas and among particularly high-risk populations that, in aggregate, account for 60 percent of all infections. Using epidemiologic data and available resources, funding can be targeted to individuals in the most heavily affected ZIP codes and to specific high-risk groups whose HIV incidence is highest. This includes African-American homosexual men, bisexual men, transgendered individuals and substance users. Possible actions include using effective and proven intervention services, developing and implementing social marketing campaigns, creating and funding community-level interventions, and implementing outreach programs. ECHPP recommends 24 interventions, including the “provision of post-exposure prophylaxis to populations at greatest risk,” the “implement[ation of] ongoing partner services for HIV-positive persons” and “condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection” (Hauck 2011).

The second step of this goal is to expand targeted efforts to prevent HIV infection. Some tactics that have been identified are the designing and evaluation of innovative prevention services, the support and strengthening of HIV screening and surveillance activities, the expanding of access to effective prevention services, and the expanding of prevention services among HIV-positive individuals. Approaches such as needle exchanges and other risk-reduction programs, partner services, condom distribution and treatment-adherence programs are defined.

The third step of the first goal is to educate Baltimore City residents about the threat of HIV and how to prevent it. Identified approaches include the utilization of social marketing and education campaigns and the promotion of age-appropriate HIV and STI⁶ prevention education for Baltimore City residents. Potential strategies include developing and implementing a standardized

⁶ I.e., sexually transmitted infections.

curriculum for comprehensive sexual health education for school-age children, as well as city residents over 50; and implementing social marketing campaigns targeted towards youth and young adults. Specifically, the “HIV Stops with Me” campaign could be effective for reaching African-American MSM.

Table 1

Summary of Baltimore HIV/AIDS Strategy Targets for 2015⁷

Goal 1 — Reducing New HIV Infections

By 2015:

- Lower the annual number of new infections by 25 percent. We would measure this with new diagnosis data, lowering the number of new diagnoses from 505 in 2009 to 379 (DHMH 2011a).
- Reduce the HIV transmission rate (i.e., ratio of annual transmissions to number of people living with HIV), by 30 percent (from 3.87 persons new diagnoses per 100 people⁸ with HIV to 2.71 persons newly identified per 100 people with HIV)⁹ (DHMH 2011a).
- Increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus. The number of living cases in 2008 was 13,048. Assuming progress towards reducing new infections by 25 percent and no change in deaths, then the number of people knowing their status in 2015 will be 14,557 (DHMH 2011a).

Goal 2 — Increasing Access to Care and Improving Health Outcomes

By 2015:

- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 to 85 percent.
- Increase the proportion of Ryan White HIV/AIDS Program 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 percent to 80 percent.
- Increase the number of Ryan White clients with permanent housing from 82 percent to 86 percent. (This serves as a measurable proxy of our efforts to expand access to HUD¹⁰ and other housing supports to all needy people living with HIV.)

Goal 3 — Reducing HIV-related Health Disparities

By 2015:

- Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20 percent from an estimated 2009 baseline of 14 percent, up to 16.8 percent (DHMH 2011a).
- Increase the proportion of HIV-diagnosed African-Americans with undetectable viral load by 20 percent from an estimated 2009 baseline of 13 percent, up to 15.6 percent (DHMH 2011a).
- Increase the proportion of HIV-diagnosed Hispanics with undetectable viral load by 20 percent from an estimated 2009 baseline of 14 percent, up to 16.8 percent (DHMH 2011a).

Goal 2 — Increasing Access to Care and Improving Health Outcomes

The improved treatments that are now available for people living with HIV/AIDS can only benefit people who enter and remain in HIV-related primary care. Because of the high cost of many HIV treatments, expense has been, and will continue to be, a barrier to care for some HIV-

⁷ Table 1 shows Baltimore’s concrete targets for improvements related to the first three of these goals. Please note that for areas that have measurable data, we have included these. In areas where we do not have local measurable data, the national goals apply to Baltimore.

⁸ In 2009, there were 505 new HIV diagnoses in Baltimore residents and 13,048 individuals living with HIV who were residents of Baltimore at diagnosis (DHMH 2011a).

⁹ This estimate was made using new diagnoses (not new infections) divided by people living with HIV who know their status, not all people living with HIV. If we use an estimate of all people living with HIV as the denominator, then the 2009 rate is 3.06 per 100. Reducing it by 30 percent would be 2.14 per 100 (DHMH 2011a).

¹⁰ U.S. Department of Housing and Urban Development.

positive people. Ensuring access, linking PLWHA to care, and supporting treatment adherence are key steps to lowering the viral load in Baltimore and preventing new infections.

A seamless system may be achieved by increasing access to care and improving health outcomes. To do this, the Commission suggests a plan to facilitate linkages to care, to promote collaboration among providers and to maintain PLWHA in care. To achieve this, approaches such as increasing collaboration and implementing protocols that require immediate linkage based on rapid test results are proposed. Further, strengthening of the links between HIV-prevention providers, housing- services providers, faith-based organizations and other support services is vital to creating a seamless system.

To increase the number and diversity of providers is the second step of goal two. By increasing the number of available providers and strengthening the current providers of HIV care, access to care and health outcomes may improve. Strategies for doing so include the involvement of faith leaders in HIV prevention activities. Specific approaches include continuing the training of clinicians and other service providers, promoting continuous quality management practices, and providing technical assistance and capacity building to providers.

The third step of goal two is to support PLWHA with their co-occurring health conditions. To do so, the plan proposes to enhance client-assessment tools and measurement of health outcomes, in addition to addressing policies to promote access to housing and supportive services. Approaches to meeting these targets will be the reviewing and updating of standards of care and the continued advocacy for support services that stabilize clients in care.

Goal 3 — Reducing HIV-related Disparities and Health Inequities

In Baltimore, the first step under goal three is to reduce HIV-related mortality in communities at high risk for HIV infection. Approaches for ensuring that high-risk groups have access to testing include working with corrections agencies and homeless-outreach efforts to maintain or increase current levels of testing.

The second step is to adopt community-level approaches to reduce HIV infection. Strategies include the establishment of pilot programs that utilize community models and the promotion of a more holistic approach to health. Tactics for adopting community-level approaches include collecting and releasing data; advocating for resources; reviewing the feasibility of programs and community models; and supporting linkages to and collaboration between providers of HIV prevention, housing, mental-health, substance-abuse and general health-care services.

The third step of goal three is to reduce stigma and discrimination against PLWHA. Strategies for bringing about this aim are to encourage communities to affirm support of people living with HIV, to promote public leadership among people living with HIV, to promote public health approaches to HIV prevention and care, and to strengthen enforcement of civil rights laws. Specific actions, such as supporting community forums and awareness days, offering training to providers and peer advocates, encouraging voluntary testing, and expanding health and sex education in schools, can help reduce stigma and discrimination.

Goal 4 — Achieving a More Coordinated City Response

Achieving a more coordinated city response to HIV is the fourth goal of the strategy (omitted from table 1). Although federal, state and local governments have devoted considerable time and money to the fight HIV, these efforts have not always been well coordinated or focused on common needs. Improving coordination across all public and private entities engaged in

combating HIV is important, especially given the difficult economic times that may likely continue into the foreseeable future.

In Baltimore, the first step is to increase the coordination of HIV programs. Methods such as ensuring coordinated program administration, promoting equitable resource allocation, and streamlining and standardizing data collection can be implemented. Specific actions include increasing coordination between grantees funding HIV prevention, treatment, surveillance and quality management, as well as developing integrated systems.

The second aim is to develop improved mechanisms to monitor progress. Strategies include providing rigorous evaluation and encouraging organizations to provide regular progress reports. Tactics involve developing tools and programs to strengthen city collaboration within city and state agencies, perform program effectiveness evaluations and revising forms and protocols to facilitate the collection of more complete HIV/AIDS data.

Next Steps

The full-length Baltimore City HIV/AIDS Strategy (IGS 2011) is available from the HIV Commission. This larger document provides a detailed guide for planners to review previous progress and the actions that much still be taken.

Although the implementation plan has been started, there is much work to be done. Measures need to be created and/or agreed upon to evaluate the progress of the community. As seen in table 1, some baseline data are available for large-scale targets. Additional short-term goals targets must be operationalized based on the implementation plan.

This report is but one step in the continuing relationship BCCHIV and BCHD have established to prevent and treat HIV in Baltimore. The Commission and the health department look forward to aggressively addressing HIV in the city.

Disclaimer

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4. Sources Cited

BCCHIV 2005: Baltimore City Commission of HIV/AIDS Prevention and Treatment (BCCHIV). 2005. *HIV/AIDS in Baltimore City: An Ongoing Emergency, Interim Report, 2005*. Baltimore, Md.: BCCHIV. Internet site (http://www.baltimorecitycouncil.com/PDF_Files/2005_HIVCommission_Report.pdf), downloaded August 3, 2011.

BCCHIV 2008: _____. 2008. *Interim Report 2007, HIV/AIDS in Baltimore City: An Ongoing Emergency*. Baltimore, Md.: BCCHIV.

Cohn 2011: Meredith Cohn. 2011. "Baltimore Launches Effort to Improve Worst Health Problems." *Baltimore Sun*, May 10. Internet site (http://articles.baltimoresun.com/2011-05-10/health/bs-hs-healthy-baltimore-20110510_1_oxiris-barbot-health-department-health-issues), downloaded September 15, 2011.

DHMH 2011a: State of Maryland, Department of Health and Mental Hygiene (DHMH), Infectious Disease and Environmental Health Administration, Center for HIV Surveillance and Epidemiology. 2011. "Unpublished data provided by IDEHA." Baltimore, Md.: DHMH, September.

DHMH 2011b: _____. 2011. "Enhanced Comprehensive HIV Prevention Planning (ECHPP) for the Baltimore-Towson Metropolitan Statistical Area, Maryland."

Flynn 2011: _____. 2011. "HIV in the Baltimore-Towson Metropolitan Area: An Epidemiological Profile." Presentation given before the Greater Baltimore HIV Health Services Planning Council, June 21.

Hauck 2011: Heather Hauck, Director, Infectious Disease and Environmental Health Administration, Department of Health and Mental Hygiene, State of Maryland. 2011. E-mail correspondence to IGS staff member Natalie Slaughter, dated May 13.

IGS 2008: InterGroup Services, Inc. (IGS). 2008. *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA: 2009-2011*. Baltimore, Md.: IGS, December. Internet site (<http://www.intergroupservices.com/pdf/CompPlan0911.pdf>), downloaded July 1, 2011.

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, September.

ONAP 2010: The White House, Office of National AIDS Policy (ONAP). 2010. *National HIV/AIDS Strategy for the United States, July 2010*. Washington, D.C.: ONAP, July. Internet site (<http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>), downloaded on September 10, 2010.

Schackman *et al.* 2006: Bruce Schackman, Kelly Gebo, Rochelle Walensky, Elena Losina, Tammy Muccio, Paul Sax, Milton Weinstein, George Seage, Richard Moore and Kenneth Freedberg. 2006. "The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States." *Medical Care* 44(11).

Sorian 2010: Richard Sorian. 2010. "The Affordable Care Act and People Living with HIV or AIDS." U.S. Department of Health and Human Services *HealthCare Notes* series. Internet site (http://www.healthcare.gov/news/blog/aca_aids_hiv.html), downloaded on November 12, 2010.

Spencer *et al.* 2011: Michelle Spencer, Ryan Petteway, LaVeda Bacetti and Oxiris Barbot. 2011. *Healthy Baltimore 2015: A City where all Residents Realize their Full Health Potential*. Baltimore, Md.: BCHD, May. Internet site (http://www.baltimorehealth.org/info/Healthy_Baltimore_2015/HealthyBaltimore2015_Final_Web.pdf), downloaded June 16, 2011.