Unduplicated Client-Level Data Report 2013

Ryan White Office
Baltimore City Health Department
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Yohannes Abaineh
1001 E Fayette Street
Baltimore, MD 21202
Phone : 410-396-1408
Fax : 410-396-8457

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Section I - Introduction

Background

The Baltimore City Health Department Ryan White Office (BCHD Ryan White Office) is the grantee for 37 Ryan White Part A and MAI direct service and support providers. The Office began collecting client level data from its contracted service providers in the Baltimore-Towson EMA (Eligible Metropolitan Area) in fiscal year 2001 to meet the Health Resources and Services Administration, Bureau of HIV/AIDS (HRSA/HAB) data requirements.

In the subsequent years, the Ryan White office strived to overcome several challenges encountered in the areas of data collection, data analysis, and data reporting and in providing technical assistance to providers submitting client-level data. As a condition of grant award, BCHD Ryan White Office is required to report demographic and eligibility data on clients served, and the services provided.

HRSA/HAB released a new data reporting system in 2007 called RDR (Ryan White Data Report) focusing on a group of core clinical performance measures for Ryan White eligible clients in the management of HIV, namely; ARV therapy for pregnant women, CD4 T-cell counts, HAART, Medical visits, and PCP. In 2009, HRSA released another reporting system called Ryan White Service Report (RSR) that requires client-level data reports to include dates of services/visits on all clients served by Ryan White funds.

To address the challenges in data collection and reporting, BCHD Ryan White office applied for a grant in September of 2008 and was awarded a Special Programs of National Significant (SPNS) grant to implement electronic client-level data system. BCHD, in partnership with Social Solutions Inc., the vendor for Efforts to Outcomes (ETO) web-based software application, the Planning Council, and our Part A funded programs all contributed to the development and implementation of a web-based unduplicated client-level data system (ETO-CLDS) for Ryan White Part A Programs. ETO-CLDS was completed in the summer of 2009 and is currently being utilized in a limited capacity to meet data management and reporting needs.

This report is prepared based on the 2013 client-level data reported by the Baltimore EMA Part A providers. The Greater Baltimore HIV Health Services Planning Council (PC) requires timely, accurate, and meaningful unduplicated client demographics and service indicator data to appropriately evaluate the success of funded programs. To that effect, the Ryan White office developed and implemented a client-level data collection system to monitor programmatic activities related to the Ryan White Care Act funds. Descriptive analysis of the 2013 client-level data that is divided into three sections, namely; 1) Demographics, 2) Service Utilization, and 3) Clinical indicators is provided in this report. Methodology and list of the 2013 required data elements as well as the list of provider agencies are presented in this final report. This is the fourth year providers are asked to report client-level data by funding streams, as a result a better picture of the funding stream distributions might emerge from the final data analysis.

Client-Level-Data System Overview

ETO-CLDS was designed to meet the following main objectives: 1) Provide centralized eligibility processing of Part A consumers; 2) Collect and store client-level demographics and service utilization data received from providers; 3) Un-duplicate and analyze client-level data to determine service utilization trends, identify special populations served, and establish a demographic profile of the Baltimore EMA; and 4) Measure health outcomes, such as CD4 and viral load counts, to determine the wellness of consumers served and the potential need for increased medical services.

In addition to the above goals, ETO-CLDS has two primary functions; 1) to provide Part A and MAI client-level data to the Ryan White funding agency (HRSA/HAB) for providers who chose to use ETO-CLDS as a tool for generating the RSR report, and 2) to provide BCHD-Ryan White with data that can be analyzed for local planning and resource allocation decisions.

The software has the following limitations:

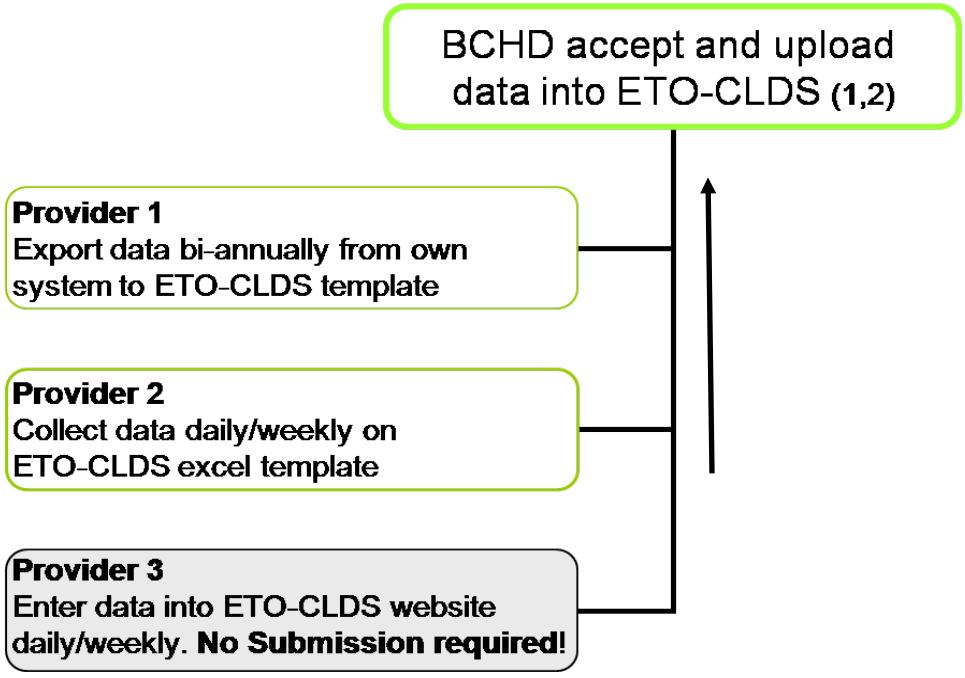
A) Lack of data flow between the Form8 site and the CLDS site
B) Inability to capture units of services for each category
C) Lack of standard reports for aggregated service and clinical data
D) Inability to generate standard reports to show the statistics of service utilization
E) Reports by funding streams are not available in the ETO-CLDS software
F) Although the software was intended to capture only Part A data, a number of Part A providers who also receive Part B and/or other program parts have mentioned the inability of the software to capture data from other program parts as the main reason why they are reluctant to use the software. Understandably, using more than one record system can be costly and inefficient for a Ryan White provider that is striving to provide quality care with limited resources. Moreover, a number of providers in the EMA have their own Electronic Medical Record (EMR) systems and do not want to allocate additional resource towards adopting ETO-CLDS.

In 2013, the Ryan Office decided to replace the aggregate Form 8 data collection system by a client level data system. The CLD system was expanded to incorporate all the Form 8 measures and providers were instructed to submit monthly service report on a preformatted excel template. Due to high volume of data requirement and reporting burden, BCHD streamlined the data collection processes that resulted in a significant reduction in the volume of reported measures and frequency of reporting. In 2014, providers will be collecting fewer client-level data and will be reporting only four times in the fiscal year.

Section II - Methodology

Ryan White service providers were instructed to submit client-level data monthly on a preformatted excel template in one of the three methods as shown in the diagram below. Description of each data element and detailed instructions on how to complete the report is included in the template – see Table-1 for a list of required data elements and Table-2 for a list of providers who have submitted their monthly data. BCHD assumed monthly data from all funded programs which covered from March 1, 2013 to February 28, 2013 and cleaned and validated data for analysis. Providers submitted their data in accordance to data elements that are applicable to their respective contracts – refer to Appendix A for type and number of Part A contracts for each provider agency (type and number of contracts may change over time due to new funding and defunding). Information was collected for a total of 113 possible data elements including the 64 data elements required by HRSA for the RSR.

Diagram-2: Three Ways to Submit Data to BCHD



Data files were reviewed for content and format to certify uniformity, integrity, and validity across all data files. Each provider submitted an excel workbook containing four sheets for Demographics, Eligibility, Clinical (for PMC providers only), and Service data reports. To ensure that the initial data submitted remained intact, original data files are copied and saved before data-cleaning process. After the data has been reviewed for content and amended to meet coding and formatting standards, the files from 37 providers were combined based on data types. Demographics reports from each provider were combined and the master data set was unduplicated using both *SPSS Statistics 18 and Microsoft Excel 2007*. Finally, the un-duplication process yielded a total of 10,079 clients out of the total of 12,562 duplicated clients submitted by 37 providers. This unduplicated client number is the basis for this data analysis.

Some data are not included due to the volume of unreported or unknown data in the total dataset. Therefore, the valid percents may differ among the presented data element. A valid percent refers to a category's proportion of a set of values (for a data element) that includes only reported or known data. A note section is included for each measure to indicate the number of clients missing required data or with unknown data. All percentages in this report are valid percents.

The Unique Client Identifier (UCI), approved and used in HRSA's CAREWare application, is an alpha-numeric combination of eleven characters representing the client's first and last name, date of birth, and gender. The UCI is used to distinguish one client from all others and is essential for un-duplicating client records across programs.

Table-1: List of the 2013 Unduplicated Client-Level Data Elements

	Demographic and Eligibility Data Elements		
1	Unique Client ID (UCI)	58	Hepatitis B Screen Date
2	Date of Birth	59	Hepatitis B Screen Result
3	Gender Stated by Client	60	Has Client Ever Completed Hepatitis B Vaccine Series
4	Last 4 Digits of Social Security Number	61	During Reporting Period, Was Client Screened for Hepatitis C
5	Residence Zip Code	62	Hepatitis C Screen Date This Period
6	Is Client Member of Affected Community	63	Hepatitis C Screen Result This Period
7	Relationship with Person Living with HIV/AIDS	64	Since HIV Diagnosis, Was Client Screened for Hepatitis C
8	Residence Zip Code Documentation Type	65	Hepatitis C Screen Date
9	Date of Residence Zip Code Verification	66	Hepatitis C Screen Result
10	Date of Residence Zip Code Verification Request	67	During Reporting Period, Was Client Screened for Syphilis
11	Annual Household Income	68	Syphilis Screen Date This Period
12	Income Documentation Type	69	Syphilis Screen Result This Period
13	Date of Income Verification	70	Was Syphilis Treatment Completed
14	Date of Income Verification Request	71	During the Reporting Period, Did Client Receive a PAP Screen
15	Household Size	72	PAP Screen Date This Period
16	Percent of Federal Poverty Level (FPL)	73	PAP Screen Result This Period
17	Ethnicity	74	Was Client Referred for Colposcopy
18	Race	75	During the Reporting Period, Was Client Pregnant
19	Housing Status	76	Was the Pregnancy Terminated
20	Was Client Incarcerated at Anytime in Past Year	77	Was the Client Referred to Another Program
21	Date of First Visit to Agency for Any Ryan White Service	78	When was Prenatal Care Started
22	Vital Enrollment Status	79	Were Antiretrovirals Prescribed to the Client
23	Date of Death	80	When During the Pregnancy were Antiretrovirals First Prescribed
24	Risk Factors for HIV Infection		**Service Data Elements**
		81	Health Insurance Premiums and Cost-Sharing Assistance
25	Source of Primary Medical Insurance	82	Hospice Services
26	Primary Insurance Coverage Start Date	83	Medical Case Management
27	Source of Secondary Medical Insurance	84	Treatment Adherence Counseling
28	Secondary Insurance Coverage Start Date	85	Risk Education
29	Type of Insurance Application Submitted	86	Referral for Health Care/Supportive Services
30	Date Insurance Application Submitted	87	Medical Nutrition Therapy
31	HIV/AIDS Status	88	Mental Health Services
32	Year of HIV Diagnosis	89	Oral Health Care
33	Year of AIDS Diagnosis	90	Outpatient Ambulatory Health Services (OAHS)
34	Date of First HIV-Related Primary Medical Care Visit at Agency	91	OAHS Visit with a Clinical Care Provider with Prescribing Privileges
35	**Clinical Data Elements**		
	CD4 Result	92	OAHS Emergency Financial Assistance
36	Was PCP Prophylaxis Prescribed	93	OAHS Co-Morbidity Primary Medical Care (PMC) Visit
37	Was MAC Prophylaxis Prescribed	94	OAHS Co-Morbidity Mental Health Visit
38	Viral Load Result	95	OAHS Co-Morbidity Substance Abuse Visit
49	Was Client Prescribed HAART	96	OAHS Viral Load Testing
40	For Clients on HAART, Was a Fasting Lipid Panel Done	97	Rehabilitation Service
41	Was Adherence Counseling Done	98	Substance Abuse Treatment, Outpatient
42	Was Risk Reduction Screening/Counseling Done	99	Non-Medical Case Management
43	Was a Mental Health Screen Done	100	Child Care Services
44	Was a Substance Use (Alcohol/Drugs) Screen Done	101	Food Bank and Home-Delivered Meals
45	During the Reporting Period, Was Client Screened for TB	102	Food Bank or Home Delivered Meal
46	TB Screen Date This Period	103	Emergency Food Assistance
47	TB Screen Result This Period	104	Housing Services
48	Since HIV Diagnosis, Was Client Screened for TB	105	Bed Night
49	TB Screen Date	106	Voucher
50	TB Screen Result	107	Emergency Utility Assistance
51	Was TB Treatment Ever Completed	108	Legal Services
52	During Reporting Period, Was Client Screened for Hepatitis B	109	Medical Transportation
53	Hepatitis B Screen Date This Period	110	Outreach Services
54	Hepatitis B Screen Result This Period	111	Psychosocial Support Services
55	Since HIV Diagnosis, Was Client Screened for Hepatitis B	112	Respite Services
56		113	Substance Abuse Treatment, Residential

Table-2: 2013 Ryan White Part A Provider List and Data Submission Status

	PROVIDER NAME	Status
1	AIDS Interfaith Residential Services	✓
2	Anne Arundel County Health Department	✓
3	Independent Living Foundation	✓
4	Sinai Hospital (PMC)	✓
5	Baltimore City Health Department - Prevention	✓
6	Baltimore City Health Department - STD Clinics (PMC)	✓
7	Baltimore City Health Department Dental	✓
8	Baltimore County Health Department	✓
9	Baltimore Substance Abuse Systems	✓
10	Carroll County Health Department	✓
11	Chase Brexton Health Services (PMC)	✓
12	Family Health Centers of Baltimore	✓
13	Harford County Health Department	✓
14	Health Care for the Homeless (PMC)	✓
15	JHU Moore Clinic (PMC)	✓
16	JHU OB/GYN (PMC)	✓
17	JHU Pediatrics (PMC)	✓
18	JHU Psychiatry	✓
19	JHU Comprehensive Care Practice (PMC)	✓
20	Joseph Richey Hospice	✓
21	Legal Aid Bureau	✓
22	Light Health & Wellness Comprehensive Service	✓
23	Moveable Feast	✓
24	New Vision House of Hope	✓
25	Park West Medical Center (PMC)	✓
26	People's Community Health Center (PMC)	✓
27	Project PLASE	✓
28	Queen Anne's County Health Department	✓
29	Sisters Together and Reaching	✓
30	Total Health Care	✓
31	UMB - Psychiatric	✓
32	University of Maryland - Dental PLUS	✓
33	University of MD / Institute Human Virology (PMC)	✓
34	University of MD / Maryland General Hospital (PMC)	✓
35	University of MD / Pediatrics (PMC)	✓
36	University of MD Adolescent STARTRACK (PMC)	✓
37	University of MD Evelyn Jordan Center (PMC)	✓

✓= submitted 2013 client-level data report; De-f = de-funded in FY13; --- = did not submit data report; PMC = Primary Medical Care provider.

Client-Level Data Requirements and Challenges

Ryan White Part A-funded agencies are required to report client-level data quarterly to BCHD for inclusion in HRSA's annual performance report and for maintaining a profile of the HIV/AIDS epidemic in the Baltimore EMA – refer to Appendix B for HRSA/HAB required data types. In 2009, BCHD transitioned to the new web-based client-level data reporting. The new reporting system was implemented in time to meet the RSR client-level data requirement. Since 2009, Ryan White funded agencies have been submitting their bi-annual client-level-data report to BCHD on the preformatted Excel template and BCHD has uploaded submitted data files into the ETO-CLDS web system. Close to 15 agencies are able to generate XML files for their annual RSR report to HRSA via the ETO-CLDS software in addition to submitting client-level data report to BCHD bi-annually.

Getting accurate data reports remains challenging. Accurate and complete data reporting involves active data collection processes where the reporting agency fields its own trained personnel to fetch the data from its primary sources such as patient charts, Lab records, etc. In our case, we utilize a passive data collection method where providers submit data to us bi-annually on a preformatted excel template; as a result, data accuracy and completeness depends on the professional integrity of the data submitting staff at each provider agency.

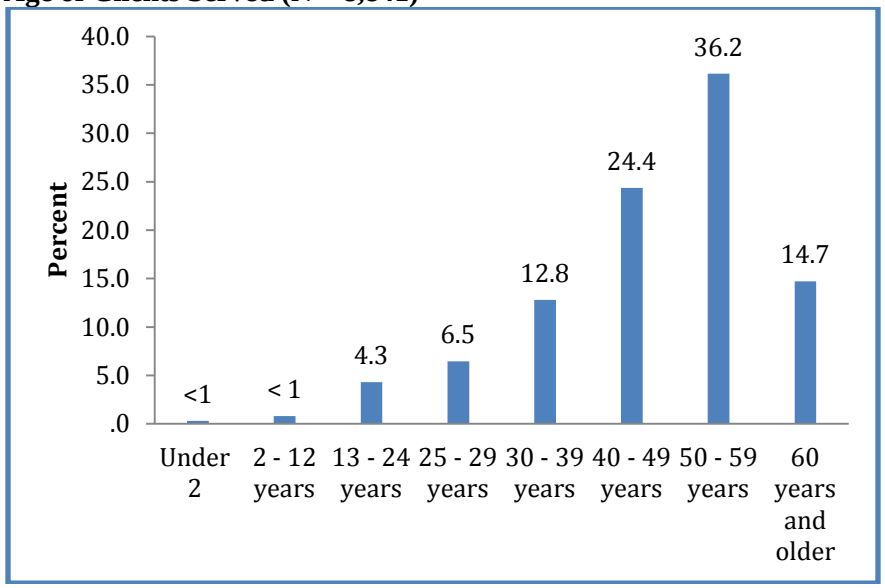
A second challenge is attributed to the ETO-CLDS software design. In compliance to patient record confidentiality and security, the software was designed in such a way that certain data elements are restricted from being shared across programs. As a result, the software is rendered incapable to generate critically needed site wide aggregate reports. BCHD circumvent this problem by exporting data for each individual program into SPSS for analysis and generating the desired type of reports. This is a tedious, redundant, and time consuming process that should have been handled by the software.

Lastly, the *duplicate check* feature of the software is not effectively preventing duplications. This feature was originally set to match clients on three data elements, namely: 'Last Name' (UCI), Date of Birth, and 'First Name' (last 4 of SSN). However, since different providers can submit the same client with different 'First Names' (such as 9999 when they did not know the SSN), relatively large number of clients have ended up as duplicates in the system. The *duplicate check* setting is now reset to match only on 'Last Name' and Date of Birth to prevent such client duplication in the system.

Client Age

In 2013, nearly 36 percent of the consumers in the Baltimore-Towson EMA were 50 to 59 years old. Nearly one quarter (24.4%) were 40 to 49 years old. The mean and median age was 47 and 50 respectively. The most frequent age (mode) was 52. In 2007 and 2011, the mean age was 42 and 45 respectively, indicating that the majority of consumers are living longer and getting older.

Age of Clients Served (N = 8,841)



Age of Clients Served , 2013

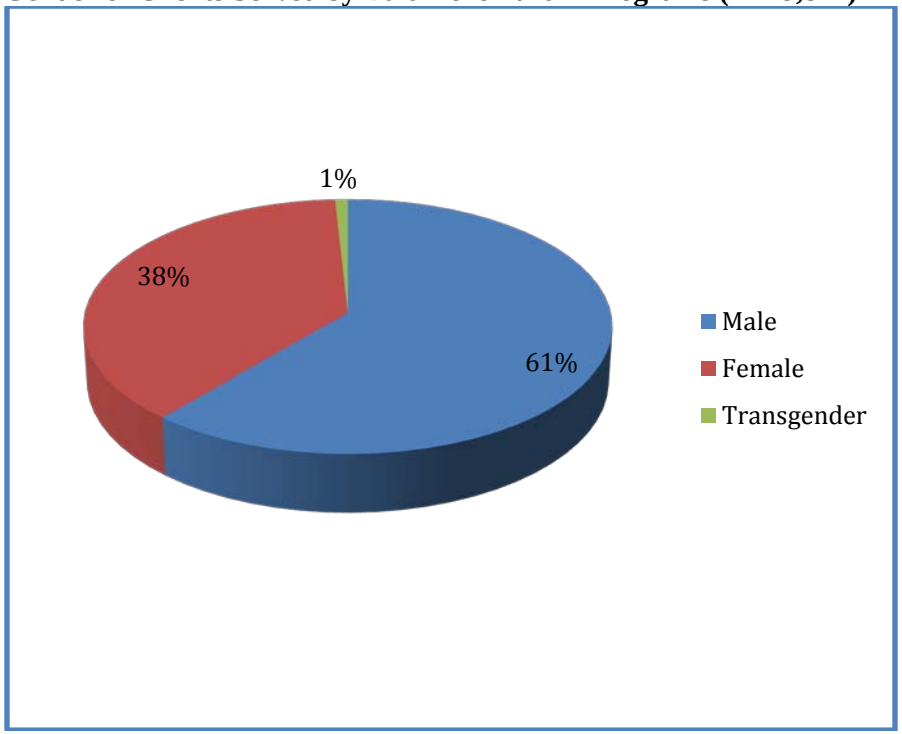
Age	Number	Percent
Under 2	30	< 1
2 - 12 years	72	< 1
13 - 24 years	381	4.3
25 - 29 years	571	6.5
30 - 39 years	1132	12.8
40 - 49 years	2155	24.4
50 - 59 years	3198	36.2
60 years and older	1302	14.7
Total	8841	100.0

Note: Age was unknown or unreported for 1,238 clients.

Client Gender

In 2013, 61 percent of the total consumers were male and 38 percent were female. Gender percent distribution is consistent when compared to data in previous years. The 2011 Maryland Ryan White State Profile reported 60 percent males and 39 percent females that were nearly the same as the figures below [1]. Trans-genders make up one percent of the EMA consumers; with Male to Female transgender sub-type making up the larger proportion of trans-genders.

Gender of Clients Served by Baltimore Part A Programs (N = 9,841)



Gender of Clients Served, 2013

Gender	Number	Percent
Male	6024	61%
Female	3733	38%
Transgender	84	1%
Total	9841	100%

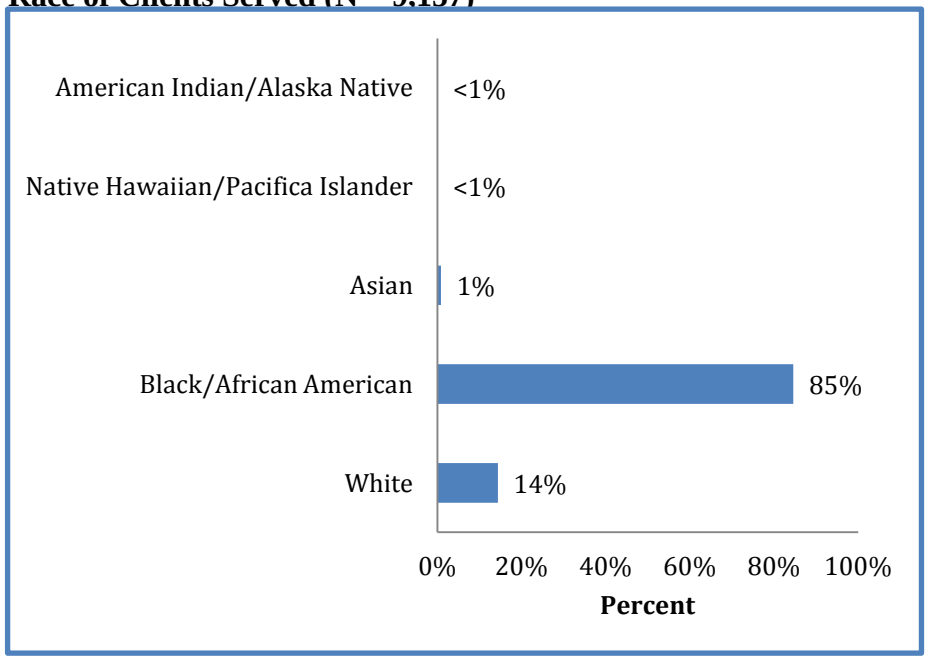
Note: Gender was unknown or unreported for 238 clients.

1. http://hab.hrsa.gov/stateprofiles

Client Race

In 2013, African Americans make up 85 percent of the EMA consumers while Whites consisted of 14 percent. Baltimore EMA race percentages vary slightly but generally were consistent over the past years; however, comparison to the oldest data in 1985 shows a 20 percent decrease in the number of infected whites and a 20 percent increase in the number of infected blacks. The most recent HRSA/HAB Maryland Ryan White Profile indicated that 80.2 percent were Black and 15.4 percent were White.

Race of Clients Served (N = 9,157)



Race of Clients Served, 2013

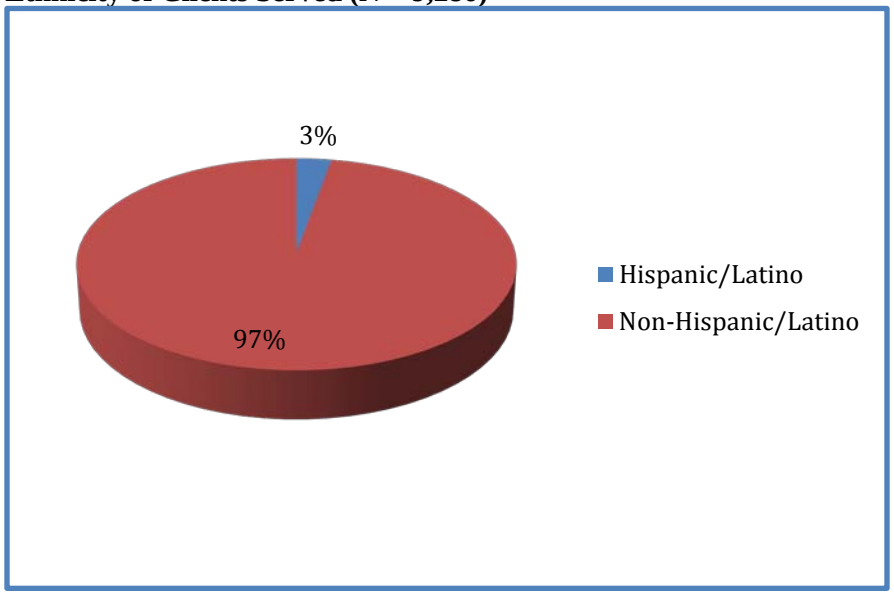
Race	Number	Percent
White	1,315	14%
Black/African American	7,747	85%
Asian	80	1%
Native Hawaiian/Pacifica Islander	3	<1%
American Indian/Alaska Native	12	<1%
Total	9,157	100.00%

Note: Race data was unknown or unreported for 922 clients.

Client Ethnicity

Three percent of the total clients served during the report period were Hispanic while 97 percent were Non-Hispanic. About 12 percent of the Hispanic consumers in the EMA have self reported as Black. Eighty three percent (83%) reported White. Zip code areas 21224, 21218, 21225, 21245, 21231, 21215, and 21203 have an average of 10 Hispanic clients making up 40% of the total Hispanic population in the EMA. In 2013, the percentage of Latinos has declined by 3% from 6% in 2012 and by 1% from 4% in 2011. The transient nature and migration status of this group of consumers might have contributed to the sudden drop in the number of Latino consumers. A recent study conducted in Baltimore city showed that of the 247 Latinos (46% male) accessing BCHD's outreach services, 96% were foreign-born and transient.[2]

Ethnicity of Clients Served (N = 9,286)



Ethnicity of Clients Served, 2013

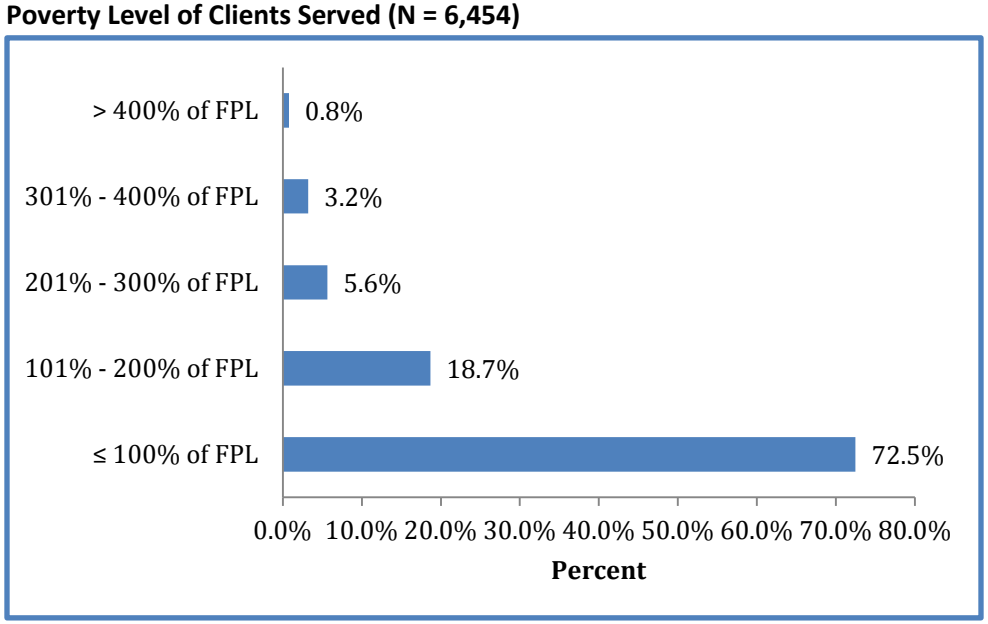
Ethnicity	Number	Percent
Hispanic/Latino	265	3%
Non-Hispanic/Latino	9021	97%
Total	9286	100%

Note: Ethnicity was unknown or unreported for 793 clients.

2. Chen, N.E. & *etal* (2012). HIV testing behaviors among Latinos in Baltimore City. Journal of immigrant and minority health, 14(4), 540-541

Income Level

The 2011 HRSA's Ryan White State Profile shows 6,515 (66%) of the clients served in 2011 had household incomes equal to or below the Federal Poverty Level (FPL). An additional 2,006 (20.3%) were between 101% and 200% of the FPL.[3] The chart below shows the Baltimore-Towson EMA with a higher poverty status compared to the State data above. In 2013, 72% of the consumers in the Baltimore-Towson EMA had household incomes equal or below the FPL compared to 66% for the State. 18.7%% of the EMA consumers had incomes between 100% and 200% of the FPL. Further analysis of the income data shows 61% of the EMA's county HIV population with incomes equal or below the FPL and another 24% with incomes between 100% and 200% of the FPL. Nearly 7% have incomes between 200% and 300% of the FPL.



Income Level of Clients Served

Federal Poverty Level	Number	Percent
≤ 100% of FPL	4676	72.5%
101% - 200% of FPL	1206	18.7%
201% - 300% of FPL	364	5.6%
301% - 400% of FPL	208	3.2%
> 400% of FPL	50	0.8%
Total	6454	100%

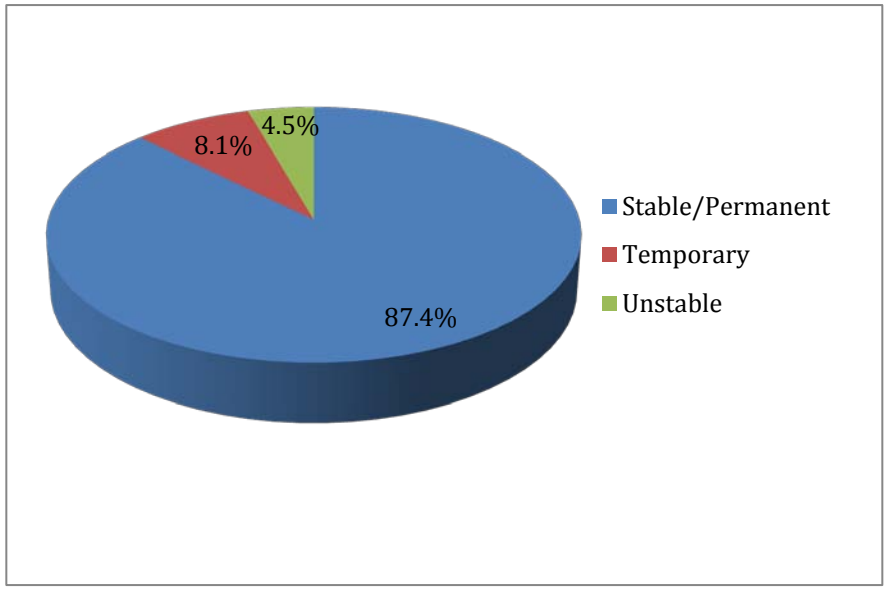
Note: Income data was unknown or unreported for 3,625 clients.

3. http://hab.hrsa.gov/stateprofiles

Housing Status

In 2013, most (87.4%) of the EMA consumers lived in stable housing conditions. 8.1% were living in temporary housing arrangements. 4.5% were living in an unstable or homeless status. The percentage of Baltimore EMA consumers living in stable housing is slightly higher than the 86% NHAS target set for 2015.[4]

Housing Status of Clients Served (N = 6,886)



Housing Status of Clients, 2013

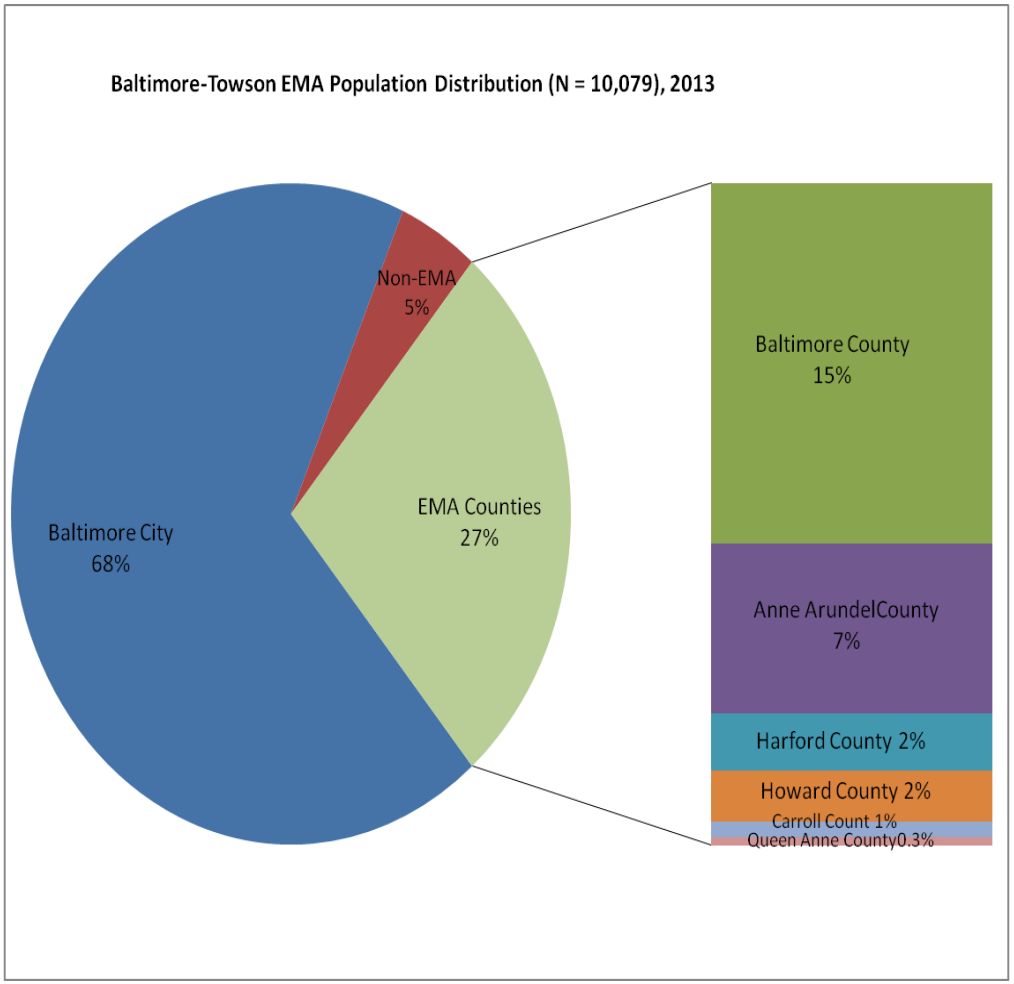
Housing Status	Number	Percent
Stable/Permanent	6021	87.4%
Temporary	557	8.1%
Unstable	308	4.5%
Total	6886	100%

Note: Housing Status was unknown or unreported for 3,190 clients

4. http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-fact-sheet.pdf

Geography of Client Residence

Geographic distribution of Ryan White consumers in the Baltimore EMA remains nearly the same compared to recent years. The majority of clients (68%) still reside in Baltimore city. Additional 27% are living in the six surrounding counties, with the majority in Baltimore and Anne Arundel Counties. Client zip code analysis shows similar distribution patter as data from recent past years, with the top 5 zip code areas (21217,21215,21218,21213, and 21223) accommodating nearly a third (33.3%) of the total EMA client population.



Geographic Distribution of Clients Served, 2013

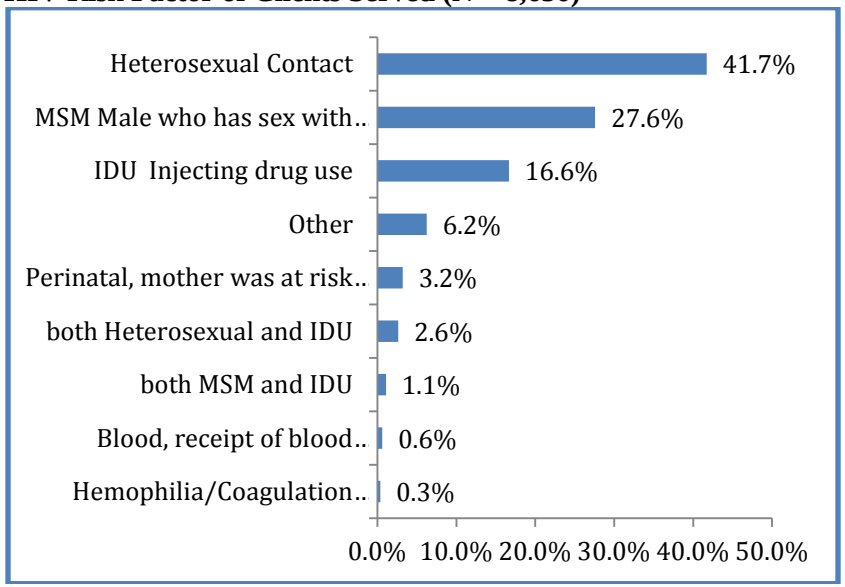
Client Residence	Number	Percent
Baltimore City	6,847	67.9%
Non-EMA	498	4.9%
Baltimore County	1,501	14.9%
Anne Arundel County	697	6.9%
Harford County	203	2.0%
Howard County	202	2.0%
Carroll County	101	1.0%
Queen Anne County	30	0.3%
Total	10,079	100%

Note: Non-EMA includes consumers outside of the EMA, unknown, or invalid addresses. Since some zip codes crisscross one or more counties, percent distributions are only best approximations. GIS analysis reveals that non-EMA clients came from surrounding counties, mainly Montgomery and Prince George's county.

HIV Risk Factor

Heterosexual contact is the number one risk factor for HIV infection in the Baltimore EMA at 41.7%, followed by MSM at 27.6%. Injection Drug Use (IDU) was the third leading mode of HIV transmission at 16.6%. When calculated for men only, MSM is the highest risk in the EMA at 42%, heterosexual contact is second risk at 29%, and IDU is third at 17%. MSM is the leading risk factor for 83% of the transgender population. A recent CDC report indicated MSM as the leading risk factor nationally at 70% for men only.[5]

HIV Risk Factor of Clients Served (N = 8,656)



HIV Risk Factor of Clients Served, 2013

Hiv Risk Factor	Number	Percent
Hemophilia/Coagulation Disorder	30	0.3%
Blood, receipt of blood transfusion, blood components, or tissue	52	0.6%
both MSM and IDU	93	1.1%
both Heterosexual and IDU	227	2.6%
Perinatal, mother was at risk for HIV infection	277	3.2%
Other	540	6.2%
IDU Injecting drug use	1441	16.6%
MSM Male who has sex with male(s)	2386	27.6%
Heterosexual Contact	3610	41.7%
Total	8656	100%

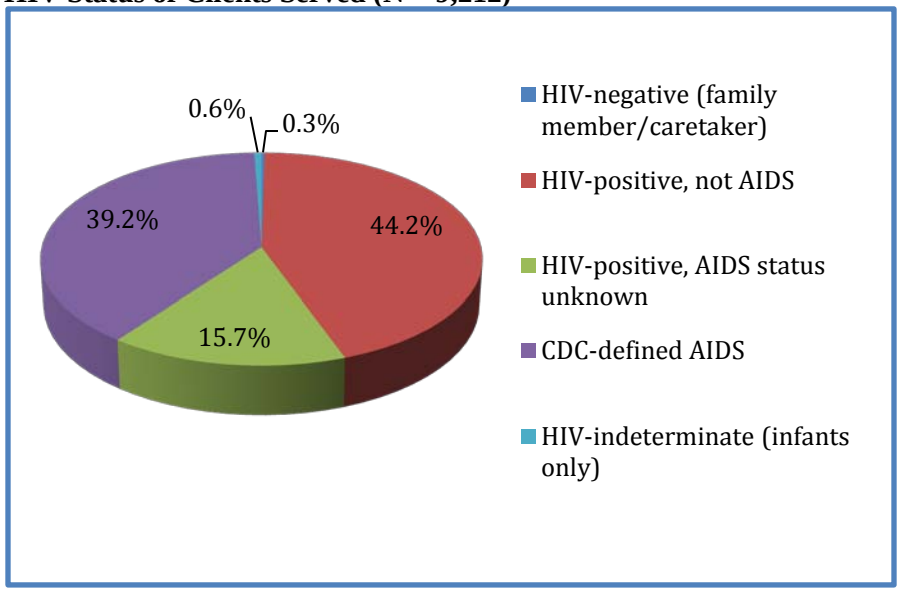
Note: Risk factor was unknown or unreported for 1,423 clients.

5. http://www.cdc.gov/hiv/topics/msm/index.htm

HIV/AIDS Status

44.2 percent of the clients in the EMA are HIV-positive without AIDS. 39.3 percent are CDC-defined AIDS clients.

HIV Status of Clients Served (N = 9,212)



HIV Status of Clients Served, 2013

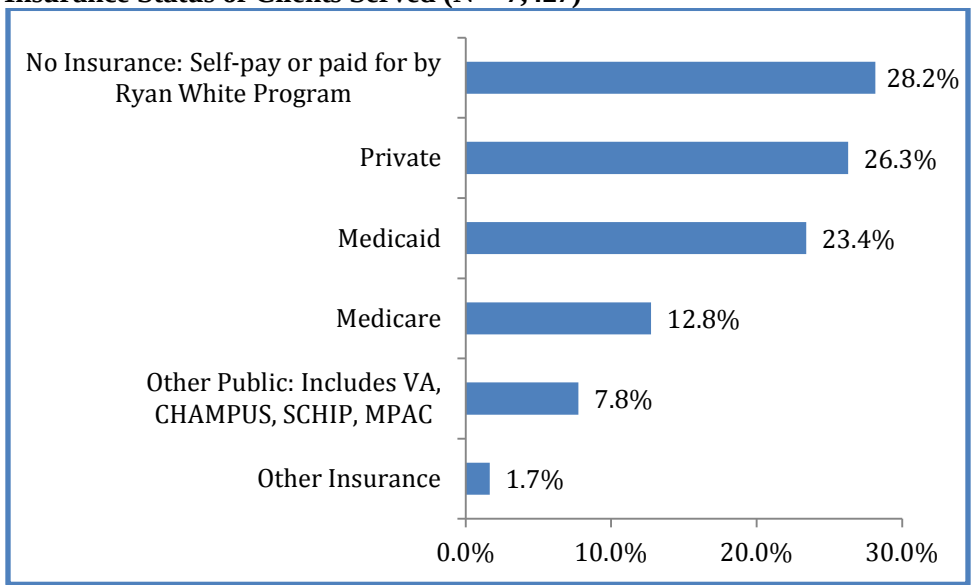
HIV Status	Number	Percent
HIV-negative (family member/caretaker)	24	0.3%
HIV-positive, not AIDS	4072	44.2%
HIV-positive, AIDS status unknown	1448	15.7%
CDC-defined AIDS	3614	39.2%
HIV-indeterminate (infants only)	54	0.6%
Total	9212	100.0%

Note: HIV Status was unknown or unreported for 867 clients.

Medical Insurance

The 2013 client-level data analysis shows the majority of Part A consumers (28.2%) have no insurance. 26.3% have private insurance. Medicaid and Medicare provided coverage for 23.4% and 12.8% of the total consumers respectively. Since clients can be covered by more than one type of insurance during the year, this data represents a snap shot of consumers' insurance status during the time data was reported. The 2011 U.S. Census data shows 72 percent of Maryland's population is privately insured while 13.8 percent were uninsured. Medicare and Medicaid covers for 13.4% and 12.2% of Maryland population respectively.[6]

Insurance Status of Clients Served (N = 7,427)



Note: Insurance was unknown or unreported for 2,652 clients.

HIV Status of Clients Served, 2013

HIV Status	Number	Percent
Other Insurance	123	1.7%
Other Public: Includes VA, CHAMPUS, SCHIP, MPAC	576	7.8%
Medicare	947	12.8%
Medicaid	1738	23.4%
Private	1952	26.3%
No Insurance: Self-pay or paid for by Ryan White Program	2091	28.2%
Total	7427	100.0%

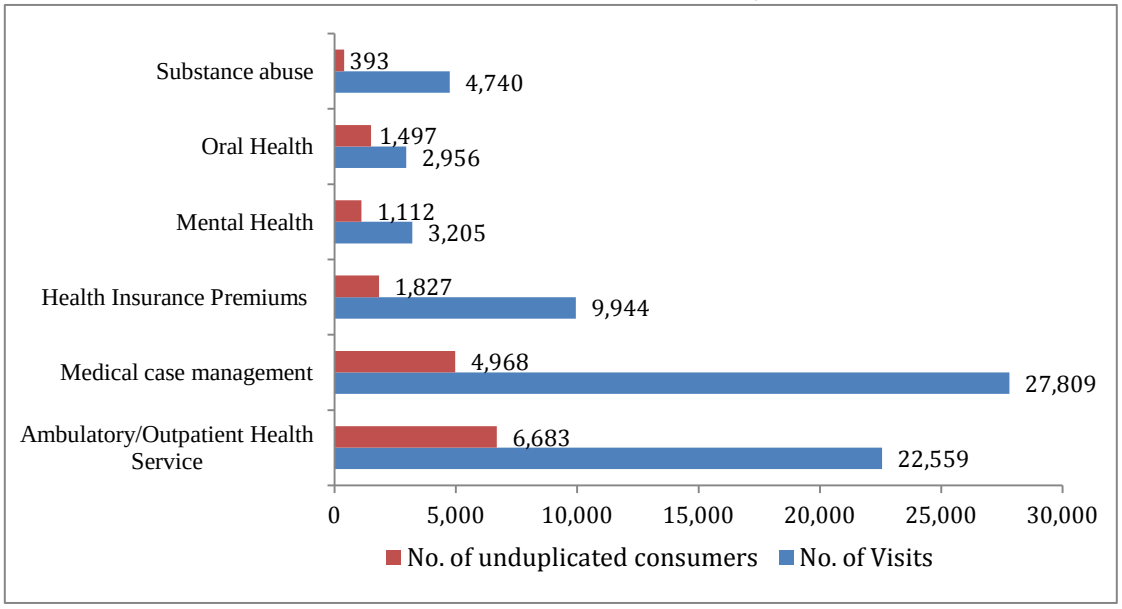
6. U.S. Census Bureau. Health Insurance Coverage Status and Type of Coverage by State All People: 2011. In: Current Population Survey, Annual Social and Economic Supplement. Washington, DC: U.S. Census Bureau; 2012 Table HlB-4. Data subject to change

Section IV - Service Utilization

Core Medical Services:

Among the core service categories, OAHS and MCM were the most utilized services with 66% (6,683 clients) and 49% (4,969 clients) of the total 10,079 Part A consumers served respectively. Health Insurance Premiums was the third most utilized core service at 18% (1,827 clients). Hospice was the least utilized service with only 34 clients. Some of the client numbers in the chart below may be higher than the actual since providers may have reported clients whose services were paid by funding sources other than Ryan White Part A. Reporting data accurately by funding sources remains challenging for most providers who are multiply funded by different funding sources.

Number of Clients Served and Visits for Core Medical Services, 2013



Number of Clients Served and Visits for Core Medical Services, 2013

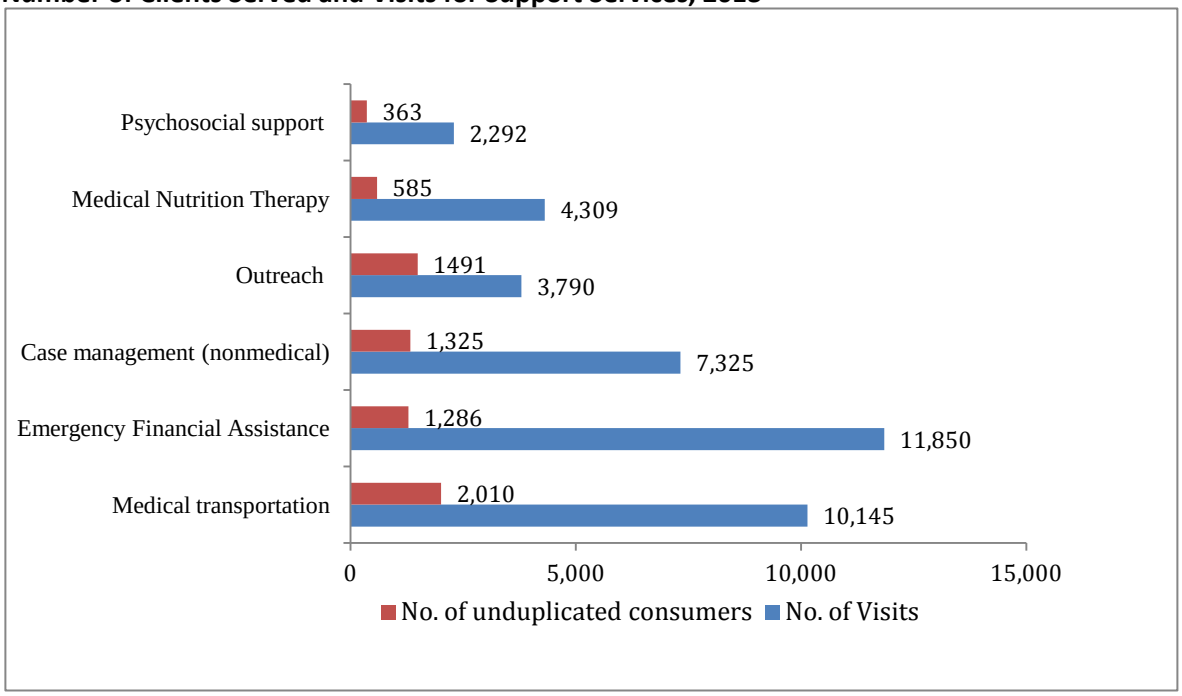
Core Medical Services	No. of Visits	No. of unduplicated consumers
Ambulatory/Outpatient Health Service	22,559	6,683
Medical case management	27,809	4,968
Health Insurance Premiums	9,944	1,827
Mental Health	3,205	1,112
Oral Health	2,956	1,497
Substance abuse	4,740	393
Hospice	792	34

Note: People can be served by more than one service category during the year.

Support Services:

Medical Transportation was the most utilized support service at 20% (2,010 clients) followed by Outreach services at 15% (1,491 clients). 65% of the trips were made to primary care visits while 35% were made to other support services. The majority of consumers (80%) outreached were clients who were lost to care. New clients consisted approximately 20 %. There were a total of 170 clients reported as newly diagnosed at the outreach funded sites. The 2013 data from BCHD's office of HIV/STD indicate that of the total of 48,435 people tested for HIV 483 were positive. This is equivalent to a 1% HIV Positivity rate in the EMA. EFA was the third most utilized support service at 13% (1,286). Child care was the least utilized support service with only 9 clients served. It is important to note that the number of clients and services below may be higher than the actual since some providers may have inadvertently included in their data reports services that were not funded by Ryan White Part A.

Number of Clients Served and Visits for Support Services, 2013



Number of Clients Served and Visits for Support Services, 2013

Support Services	No. of Visits	No. of unduplicated consumers
Medical transportation	10,145	2,010
Emergency Financial Assistance	11,850	1,286
Case Management (non-medical)	7,325	1,325
Outreach	3,790	1491
Medical Nutrition Therapy	4,309	585
Psychosocial support	2,292	363

Note: People can be served by more than one service category during the year.

Table-3: Part A and MAI Core and Support Service Utilization in Baltimore EMA (2013)

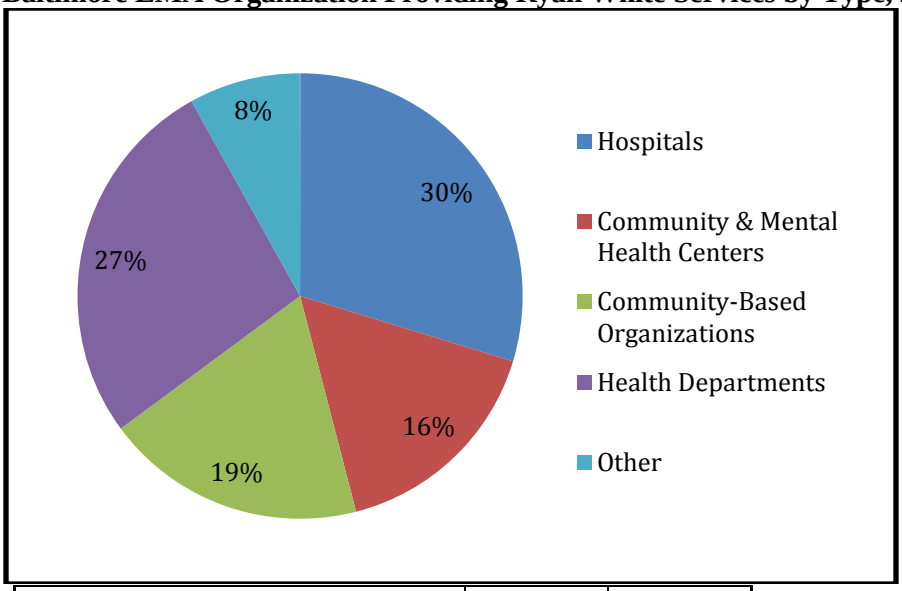
Core and Support Service Categories	Clients served	Total Number of visits	Number of Visits by Funding Streams							
			EMA Part A	%	EMA MAI	%	STSC Part A	%	STSC MAI	%
Health Insurance Premiums & Cost-Sharing	1,827	9,944	9,918	100%			26	0%		
Hospice Services	34	34	34	100%						
Days Of Hospice Services	Avg=23	792								
Medical Case Management	4,968	27,809	18,946	68%	3,904	14%	4,959	18%		
Medical Nutrition Therapy	585	4,309	2,786	65%	652	15%	871	20%		
Mental Health Services	1,112	3,205	2,067	64%	635	20%	503	16%		
Oral Health Care	1,240	2,956	2,063	70%			722	24%	171	6%
OAHS PMC Visit	3,460	13,646	13,373	98%			273	2%		
OAHS CoMorbidity PMC Visit	545	3,773	3,352	89%	282	7%			139	4%
OAHS CoMorbidity Mental Health Visit	445	2,308								
OAHS CoMorbidity Substance Abuse Visit	294	2,832								
Emergency Financial Assistance*	1,286	11,850	10,310	87%			1540	13%		
Substance Abuse Treatment (Outpatient)	393	4,740	4,125	87%	615	13%				
Treatment sessions - all venues		4,740								
Counseling sessions - all venues		1,723								
Non-Medical Case Management	1,315	7,325	7,325	100%						
Child Care Services	9	690	690	100%						
Food Bank Or Home Delivered Meal	689	2,294	1,637	71%	242	11%	415	18%		
Number of Meals Delivered	Avg=132	90,947								
Liquid Supplements	Avg=39	27,126								
Emergency Food Vouchers	415	785	702	89%			83	11%		
Housing Services	586	1,118								
Bed Nights	216	14,394	14,113	98%			281	2%		
Rental Voucher	200	251	239	95%			12	5%		
Number Of Months Of Rent Paid	Avg=1.25	251								
Emergency Utility Assistance	233	262	230	88%			32	12%		
Legal Services	261	389	389	100%						
Medical Transportation	2,010	10,145	7,882	78%	859	8%	1,190	12%	214	2%
Tokens		25,693								
Van		3,803								
Taxi		2,632								
Outreach Services	1,491	3,790	3,053	81%	737	19%				
Psychosocial Support Services	363	2,292	2,073	90%	219	10%				
Substance Abuse Treatment (Residential)	52	52	52	100%						
Treatment sessions - all venues		1,048								
Counseling sessions - all venues		319								

Note: Grey areas indicate data not applicable or not reported. Percent distributions by funding streams are based on known funding sources; unknown or unreported funding streams are excluded from calculation. * EFA funding could be used for either OAHS, housing, or food services.

Table-4 Ryan White Part A and MAI Contracts by Category and Number

	Name of Funded Service Category	# of Contracts 2013
1	Outpatient & Ambulatory Health Services (PMC/Lab, Co-Morbidity, EFA)	36
2	Medical Case Management	20
3	Outreach Services	11
4	Housing Services, bed nights	11
5	Medical Transportation	11
6	Food Bank/Home Delivered Meals	8
7	Mental Health Services	7
8	Substance Abuse Treatment Outpatient	7
9	Psychosocial Services	7
10	Oral Health	6
11	Case Management (non-medical)	5
12	Legal Services	3
13	Health Insurance Premiums & Cost Sharing	4
14	Medical Nutritional Therapy	4
15	Substance Abuse Residential	1
16	Child Care Services	1
17	Hospice Care	1
	Total number of contracts	**143**

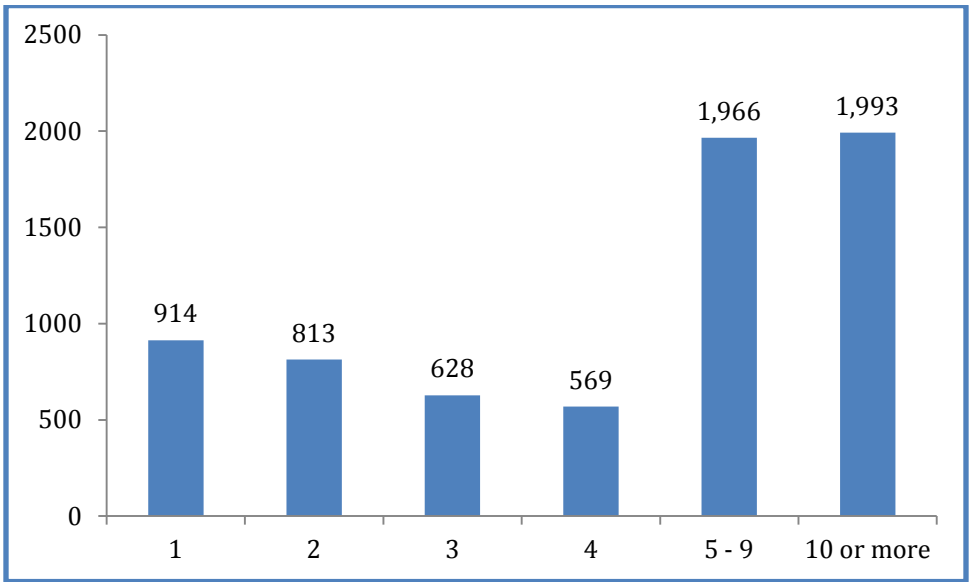
Baltimore EMA Organization Providing Ryan White Services by Type, 2013



Types of Organizations	Number	Percent
Hospitals	11	30%
Community & Mental Health Centers	6	16%
Community-Based Organizations	7	19%
Health Departments	10	27%
Other	3	8%
Total Number	37	100%

Section V - Clinical Data

Number of Medical Visits Per Client in Baltimore EMA, 2013 (N = 6,883)



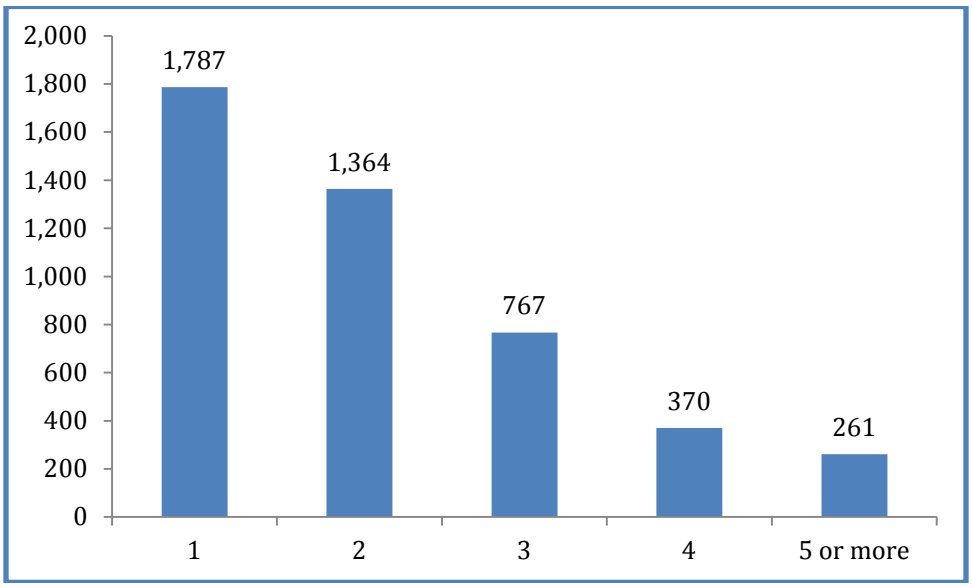
Number of Medical Visits per Client, 2013

Visits	Number	Percent
1	914	13%
2	813	12%
3	628	9%
4	569	8%
5 - 9	1,966	29%
10 or more	1,993	29%
Total	6,883	100%

CD4 Result

Of the 6,883 unduplicated clients linked to primary care, 4,549 (66%) have their CD4 tested at least once during the reporting period. 39% were tested for CD4 just once. 30% were tested twice. CD4 results data analysis shows 183 clients (4%) of the clients had a CD4 test result that is less than 50 copies/mL. 14% or 655 clients had a CD4 result that is less than 200 copies/mL. 22% or 1,003 clients had results between 200 and 350 copies/mL. Nearly 76 % had a result above 350 copies/mL. The average number of CD4 tests performed for a client was 2.2.

Number of CD4 Lab Tests Per Client in Baltimore EMA, 2013 (N = 4,549)



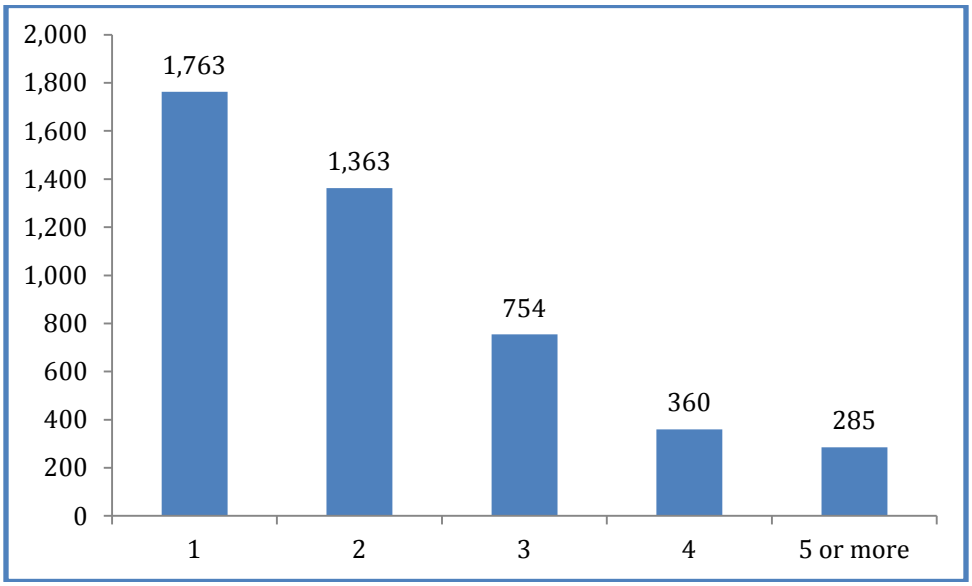
Number of CD4 Lab Tests Per Client, 2013

CD4 Lab Tests	Number	Percent
1	1,787	39%
2	1,364	30%
3	767	17%
4	370	8%
5 or more	261	6%
Total	4,549	100%

Viral Load Result

Of the 6,883 unduplicated clients linked (i.e. at least one visit) to primary medical care, 4,525 (or 67%) have their viral loads tested at least once during the reporting period. For the clients retained in primary care (i.e. two or more visits), this percentage goes up to 75%. Nearly one half (3,482 of the 6,883 clients) of the consumers have a viral load result that was undetectable (less than or equal to 50 copies/ml). 54% of those clients linked to care and 63% of those retained in care have a suppressed viral load test result that is less than or equal to 200 copies/mL. The viral load suppression rate of those clients with at least one OAHC visit and one viral load test is 82.5% (3,735 out of 4,525). The average number of viral load tests performed for a client this reporting period was 2.2.

Number of Viral Load Lab Tests Per Client in Baltimore EMA, 2013 (N = 4,525)



Number of Viral Load Lab Tests Per Client, 2013

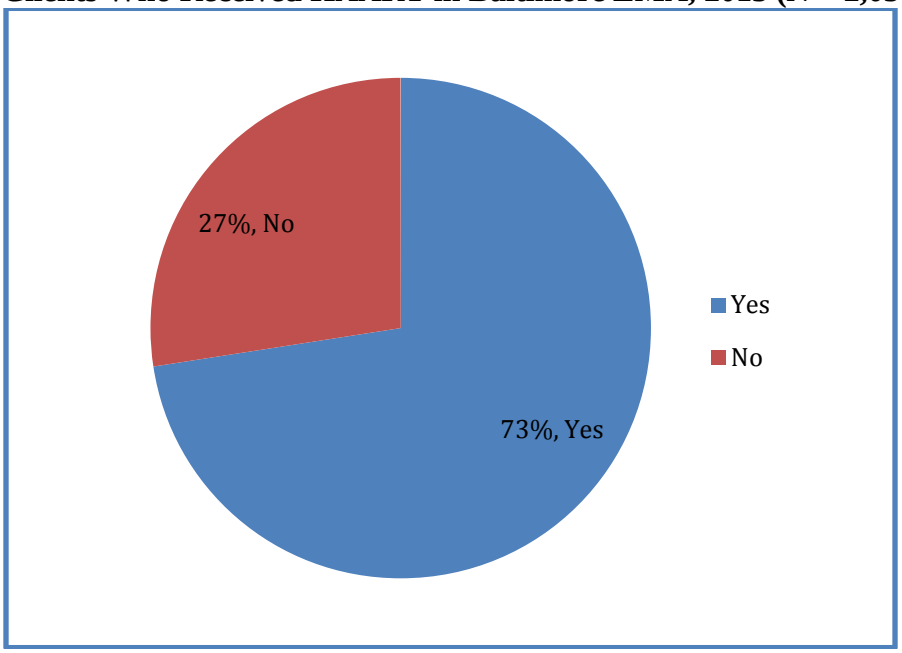
Viral Load Lab Tests	Number	Percent
1	1,763	39%
2	1,363	30%
3	754	17%
4	360	8%
5 or more	285	6%
Total	4,525	100%

Note: Viral load was unknown or unreported for 2,358 clients.

Anti-Retroviral (HAART) Prescription

Seventy three percent (73%) of the consumers who responded to the HAART status question reported that they were on HAART medications this period. The remaining 27% were not on HAART for various reasons such as client refusal, drug toxicity/intolerance, or other reasons; however, the majority of clients (22%) indicated that they were not on HAART because they were 'not ready for medication' as determined by their clinicians.

Clients Who Received HAART in Baltimore EMA, 2013 (N = 2,057)

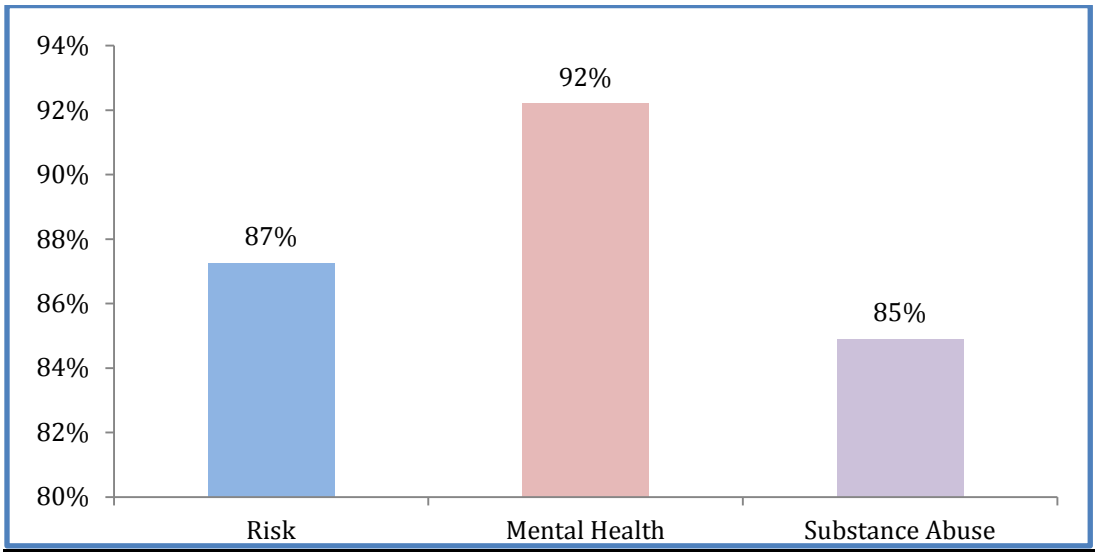


Clients Who Received HAART, 2013

Received HAART	Number	Percent
Yes	1,492	73%
No	565	27%
Total	2,057	100%

Note: HAART and some other clinical data were incomplete because some providers were under implementation of a new EMR system (EPIC) and complete data was not available during data analysis.

Risk Reduction, Mental Health, and Substance Abuse Screenings in Baltimore EMA, 2013

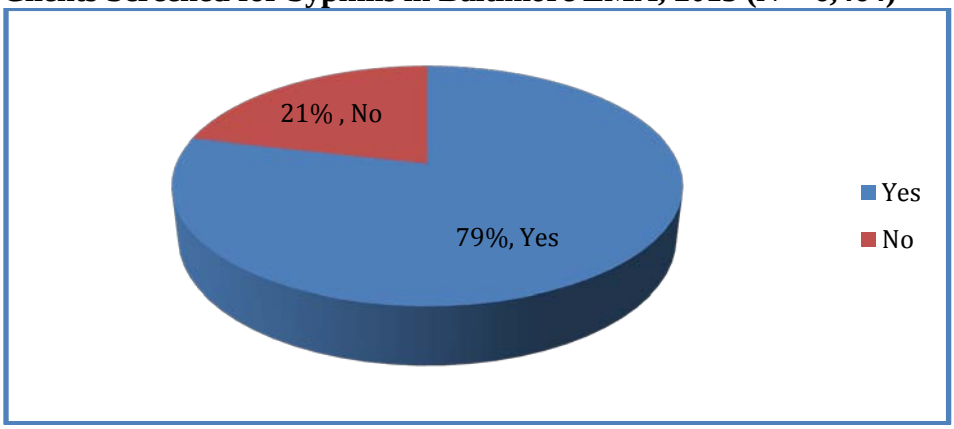


Risk, Mental Health, and Substance Abuse Screenings, 2013

Screening	Yes	No	Total	Percent
Risk	1,720	251	1,971	87%
Mental Health	4,577	387	4,964	92%
Substance Abuse	2,270	404	2,674	85%

Note: 'Not medically indicated' was reported for 25 clients for risk reduction, 39 clients for mental health, and 48 clients for substance abuse screenings.

Clients Screened for Syphilis in Baltimore EMA, 2013 (N = 6,464)

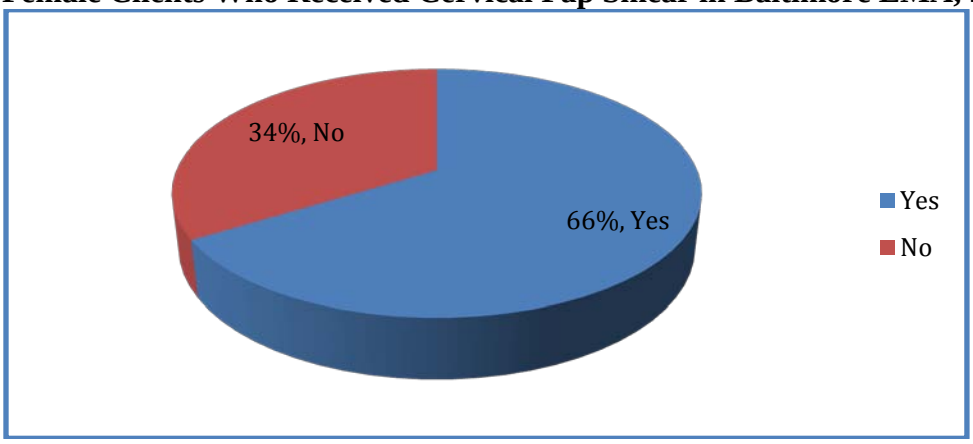


Clients Who Received Syphilis Screening, 2013

Received Syphilis	Number	Percent
Yes	5,079	79%
No	1,385	21%
Total	6,464	100%

Note: Not medically indicated was reported for 115 clients. Syphilis screening result was positive for 376 clients.

Female Clients Who Received Cervical Pap Smear in Baltimore EMA, 2013 (N = 1,286)



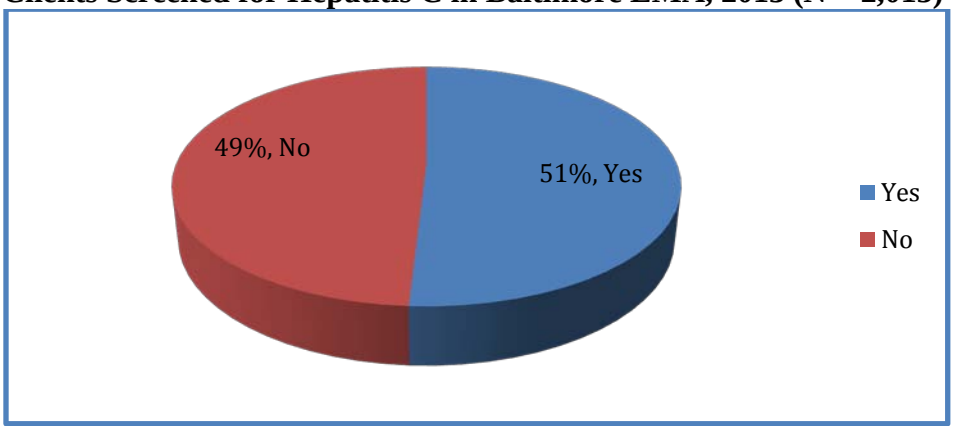
Female Clients Who Received Cervical Pap Smear, 2013

Received Cervical Pap Smear	Number	Percent
Yes	851	66%
No	435	34%
Total	1,286	100%

Note: Not medically indicated was reported for 76 clients. Pap smear screening result was positive for 89 clients.

In 2013, 51% of the 2,013 total respondents were screened for Hepatitis C. This sample size is large enough for this outcome to be extrapolated for the total OAHS population. Hepatitis C screening is one of several clinical measures that were deprecated from the 2014 RSR as part of the HRSA/HAB data streamlining process. Providers will not be required to collect and report this data element in 2014.

Clients Screened for Hepatitis C in Baltimore EMA, 2013 (N = 2,013)

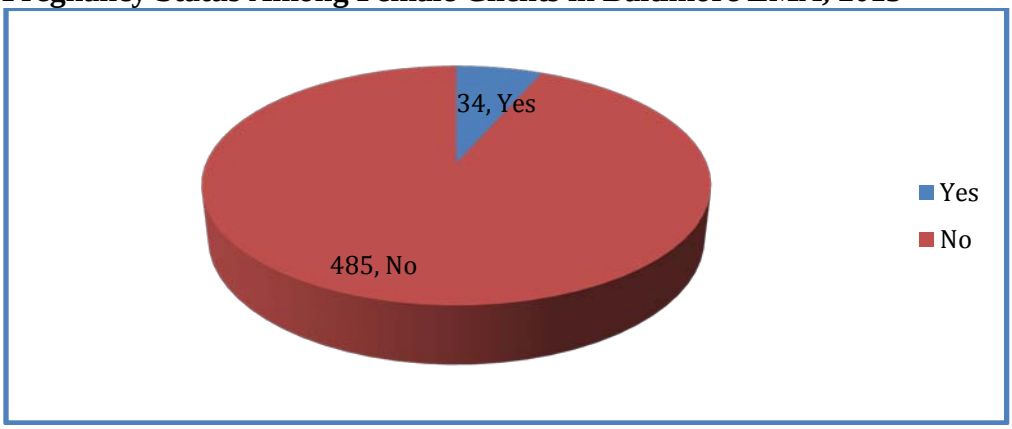


Clients Screened for Hepatitis C, 2013

Received Hepatitis C Screening	Number	Percent
Yes	1,025	51%
No	988	49%
Total	2,013	100%

Note: Not medically indicated was reported for 191 clients. Hepatitis C data was unknown or unreported for 4,870 clients. Hepatitis C screening result was positive for 270 clients.

Pregnancy Status Among Female Clients in Baltimore EMA, 2013

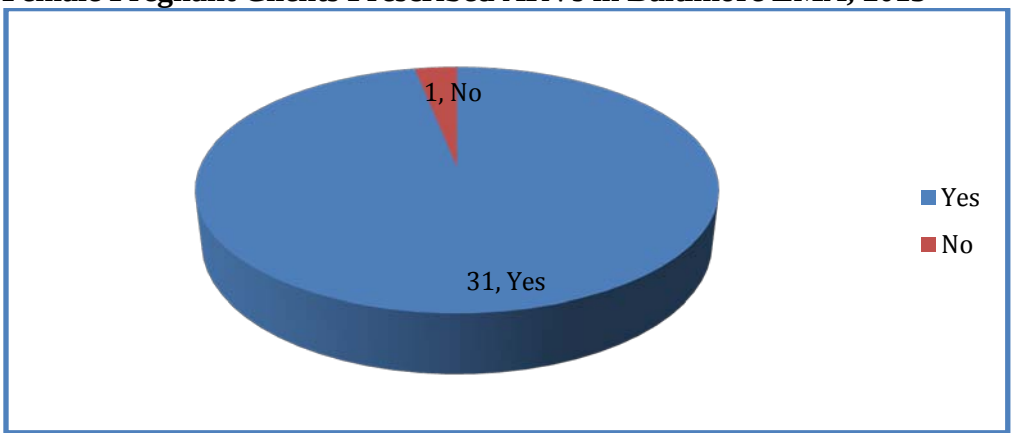


Pregnancy Status, 2013

Pregnancy Status	Number	Percent
Yes	34	7%
No	485	93%
Total	519	100%

Note: Pregnancy Status was missing for most of the 3,733 female clients.

Female Pregnant Clients Prescribed ARVs in Baltimore EMA, 2013



Pregnant Clients Prescribed ARVs, 2013

Prescribed ARVs	Number	Percent
Yes	31	97%
No	1	3%
Total	32	100%

Note: Pregnancy ARV prescription status is missing for 2 clients.

Baltimore EMA, 2013 HHS Indicators				
HHS INDICATORS		**HAB MEASURE**	**HAB RESULT**	**EMA RESULT**
HIV Positivity	Percentage of HIV tests that were HIV positive.	Percentage of tests	1.6%	1.0%
Late HIV Diagnosis	Percentage of clients diagnosed with AIDS within 3 months of a diagnosis of HIV.	Data not available at this time.	--	--
Linkage to HIV Medical Care	Percentage of clients who attended a routine HIV medical care visit within 3 months of HIV diagnosis.*	Data not available at this time.	--	--
Retention in HIV Medical Care	Percentage of clients with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the period 6 month period and the last medical visit in the subsequent 6 month period.	Data not available at this time.	--	--
Antiretroviral Therapy (ART) Among Persons in HIV Medical Care	Percentage of clients with an HIV diagnosis who were prescribed ART.	Percentage of HIV positive clients who had at least one OAMC visit and were prescribed ART	63.2%	73.0%
Viral Load Suppression Among Persons in HIV Medical Care	Percentage of clients with an HIV diagnosis with a viral load <200 copies/mL at last test.	Percentage of HIV positive clients who had at least one OAMC visit, had at least one viral load reported and the most recent viral load was <200 copies.	69.8%	82.5%
Housing Status	Percentage of clients with an HIV diagnosis and receiving HIV services who were homeless or unstably housed.	Percentage of clients with a known status whose status was HIV positive non-AIDS, AIDS status unknown or AIDS who were unstably housed. Please note that we cannot account for homeless clients.	3.8%	4.5%

ART prescription data was missing/unknown for 4,826clients.
Viral load was missing/unknown for 2,358 clients.
Housing data was missing/unknown for 3,193 clients.
*Initial HIV diagnosis dates are not collected.

Baltimore EMA, 2013 NHAS Targets				
	NATIONAL TARGET*	**HAB MEASURE**	**HAB RESULT**	**EMA RESULT**
Increasing Access to Care and Improving Health Outcomes for People Living with HIV/AIDS	By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85%	Data not available at this time.	--	--
	By 2015, increase the proportion of 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%	Percentage of HIV positive clients who had at least one funded visit and one visit date reported.	66.0%	59.20%
	Increase the percentage of Ryan White recipients with permanent housing from 82% to 86%	Percentage of Ryan White clients who were stably housed.	85.0%	87.4%
Reducing HIV-Related Health Disparities	By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%	Data not available at this time.	--	--
	By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%	Percentage of HIV positive clients who had at least one funded OAMC visit, had at least one viral load reported and the most recent viral load was <200 copies.	69.0%	82.5%
	By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%	Percentage of HIV positive clients who had at least one funded OAMC visit, had at least one viral load reported and the most recent viral load was <200 copies.	79.0%	74.00%

Retention data was missing/unknown for 4,110 clients.
Housing data was missing/unknown for 3,193clients.
Viral load data was missing/unknown for 1,897Black clients and 118 Latino clients.
* Note that the NHAS goals are National targets and a compilation for work across The Federal government. The result shown applies only to Ryan White Programs and Baltimore EMA in support of these goals.

APPENDIX A: Service Category Type and Number of Part A Contracts by Provider and Funding Stream

Agency Name	ETO Prog CODE	OAMC (OAHS)	MCM	Oral	Hospice	Mental	MNT	SAT Outpt.	HIP	EFA	NMCM	Child Care	Food Bank	Housing	Legal	mTransportn	Outreach	Psychosocial	SAT Residential	Legends	EMA	STSC
		Core								Support												
AIDS Interfaith Residential Services	693									1				O				●		O = EFA	2	0
Anne Arundel County Health Dept.	694	cO	c●							1						c●	c●	c●		c = County	0	5
Baltimore City Health Dept. - Prevention	698																●			● = nonEFA	1	0
Baltimore City Health Dept. - STD Clinics	699	O●∞								1	●					●	●			co = Co-morb.	6	0
Baltimore City Health Dept. Dental	700			●																	1	0
Baltimore County Health Dept.	701	cO	c●						c●	3			cO	cO		c●					0	6
Baltimore Substance Abuse Systems	702																		●		1	0
Carroll County Health Dept.	704		c●																		0	1
Chase Brexton Health Services	705	cOO●∞	c●●	●		●	●	●	●	3				O	●	●	●				13	2
Family Health Centers of Baltimore	706		●					●												Yellow = PMC	2	0
Harford County Health Dept.	707	cO	c●							2			c●	cO		c●					0	5
Health Care for the Homeless	708	●∞	●					●													4	0
Independent Living Foundation	696			●																	1	0
JHU Comprehensive Care Practice	714	●	●																		2	0
JHU Moore Clinic	710	c●∞O	●						●	2				O		●	●				8	1
JHU OB/GYN	711	●																			1	0
JHU Pediatrics	712	●	●			●															3	0
JHU Psychiatry	713					c●●															1	1
Joseph Richey Hospice	715				●													●			2	0
Legal Aid Bureau	716													●							1	0
Light Health & Wellness Comp. Service	717											●					●	●			3	0
Moveable Feast	718						c●●						c●●			●					3	2
New Vision House of Hope	719													●							1	0
Park West Medical Center	720	O●∞	●						●	3	●		O	O			●				9	0
People's Community Health Center	721	●O	●			●		●		3			O	O			●				8	0
Project PLASE	722													●			●	●			3	0
Queen Anne's County Health Dept	723	cO	c●							1						c●					0	3
Sinai Hospital	697	●	●								●										3	0
Sisters Together and Reaching	724		●														●				2	0
Total Health Care	725	●O		●		●		●		2				O			●				7	0
UMB - Psychiatric	726					●		●													2	0
University of Maryland - Dental PLUS	727			c●●																	1	1
U of MD / Institute of Human Virology	728	●	●													●	●				4	0
U of MD / Maryland General Hosp.	729	●								1			O			●					2	0
University of MD / Pediatrics	730	●	●								●							●			4	0
U of MD Adolescent STARTRACK	731	●	●																		2	0
University of MD Evelyn Jordan Center	732	O●∞	●				●		●	2	●		O		●	●					10	0
EMA		29	14	5	1	6	3	6	4	**16**	5	1	5	8	3	7	11	5	1	**113**	**113**	**27**
STSC		6	6	1		1	1	0	1	**8**	0		3	2		4	1	1	0	**27**		

APPENDIX B: Required Client-Level Data Elements for RWAP Services

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral health care	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Mental health services	Medical nutrition therapy	Substance abuse services–outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop assess/early interv serv	Emergency financial assistance	Food bank/home-delivered meals	Health education/risk reduction	Housing services	Legal services	Linguistics services	Medical transportation services	Outreach services	Permanency planning	Psychosocial support services	Referral hlth care/support services	Rehabilitation services	Respite care	Substance abuse services-residential	Treatment adherence counseling	Rationale
Client Demographics																															
Year of birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,7
Ethnicity	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,4,7
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Gender	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Transgender subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Health insurance	•	•	•	•	•	•	•	•	•	•	•	•																			2,7
Housing status	•	•										•					•														2,7
3 Digit ZIP code	•	•										•																			8,9
Federal poverty level	•	•										•																			2,7
Date of first service visit	•	•										•																			2,3,4,7
HIV/AIDS status	•	•										•																			2,4
Year of AIDS diagnosis	•	•										•																			2,4
Client risk factor	•	•										•																			7
Vital enrollment status	•	•										•																			5,6
Date of death	•	•										•																			5,6

RATIONAL CODES

1. Necessary for identifying new clients
2. 2009 Ryan White Legislation requirement
3. Necessary to assess RWHAP performance as required for GPRA
4. Necessary to assess RWHAP performance as required for PART
5. Necessary to track enrollment or vital status over the course of the reporting period
6. Informs the denominator of other items
7. Used to identify important population subgroups
8. Used to measure and assess the extent of out-of-service area utilization.
9. Used to determine areas of eligibility.
10. Accountability, use of funds