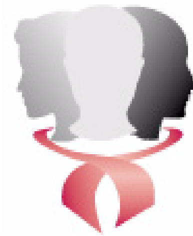
GREATER BALTIMORE HIV HEALTH SERVICES
PLANNING COUNCIL

CONSUMER SURVEY

BALTIMORE EMA ❖ 2007



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1. EXECUTIVE SUMMARY

This report presents the results of a 2007 HIV services consumer survey conducted in and around Baltimore, Maryland. The survey targeted area clients (or "consumers") of the federal government's Ryan White program, which provides HIV/AIDS-related services for people with no other means of paying for them. The survey was conducted on behalf of the Greater Baltimore HIV Health Services Planning Council (referred to as the "planning council") by InterGroup Services, Inc. (IGS), a Baltimore-based consulting and project-management firm that serves as the planning council support office (PCSO).

The Greater Baltimore HIV Health Services Planning Council is a 40-member blue-ribbon panel appointed by the mayor of Baltimore City to prioritize the expenditure of funds received under Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, which reauthorized what was formerly called the Ryan White CARE Act. The planning council's area of jurisdiction is known as the Baltimore eligible metropolitan area (EMA) and consists of seven local jurisdictions: Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties. (Baltimore City and Baltimore County are each independent jurisdictions from one another.)

This report describes the survey's purpose, methodology and findings, in addition to presenting the planning implications of the survey results. It should be noted that, while the report was administered early in the 2007 calendar year — and so after passage of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415) — respondents were asked about services received before that version of the act took effect. Therefore, some service-category names and definitions used in the survey and presented in this report are "pre-reauthorization" and vary somewhat from those specified in the new act. The next consumer survey, scheduled for 2010, will use service-category names and definitions from the 2006 act, assuming it has not been superseded.

1.1 Assessing the Needs of PLWH/As in the Baltimore EMA.

As mandated by the Health Resources and Services Administration (HRSA), the federal body that administers the Ryan White program nationwide, planning councils are required to base their funding-allocation decisions on various specific data, including research into the actual medical- and support-service needs of the population they serve, i.e., people living with HIV/AIDS (PLWH/As) who have no other way to pay for medical and support services.

HRSA uses two related terms to discuss such needs and shortfalls in meeting them. "Unmet need" describes the circumstance of an HIV-positive person, aware of his or her HIV status, who is not receiving primary medical care (often referred to as "not in care"). "Service gaps" refer to a person who is "in care" (i.e., receiving primary medical care) but not receiving some other needed HIV-related service (e.g., medical transportation, case management, etc.). To avoid confusion, and to emphasize the self-reported nature of the information collected by this survey, this report instead uses the terms "service demand" and "unmet demand" to refer to reported need and shortfalls in meeting that need across all HIV-related service categories studied.[1] As used in this

[1] "Service categories" are broad categories of service type — such as "oral health" or "case management" — to which the planning council may allocate funds each year. (Not all possible categories are funded in a given year, depending on the nature of local needs.) Service providers then apply to the appropriate parties within the EMA to provide services, and receive funding, under these headings. The council does not

report, “service demand” describes the circumstance of a respondent reporting needing any given HIV-related service, including primary medical care, while “unmet demand” describes any such respondent who is not receiving the service in question (the latter essentially enfolding the meanings of both “unmet need” and “service gap”).

Since 1998, the planning council has administered triennial consumer surveys, of which the one described in this report is the fourth. These surveys are one of several tools the planning council uses in its annual task of allocating Ryan White funds, and the most important for estimating consumers’ unmet service demands.

1.2 The 2007 Consumer Survey

The 1998 and 2001 surveys were relatively modest in scope and design. Intended to be filled out either by respondents themselves or with the assistance of volunteers from the community and/or service-provider staff, the two surveys also varied enough from each other in terms of wording that they did not support particularly extensive comparisons and trend analysis between the two survey years.

The 2004 survey represented a complete redesign. The number of questions was vastly expanded, and the decision was taken to hire trained interviewers to administer each survey in order to ensure a higher rate of survey completion, help respondents understand unfamiliar terms and correct for varying literacy levels in the largely impoverished community eligible for Ryan White services. In order to minimize the need for significant changes to the survey instrument’s design in subsequent years, a panel of independent experts was recruited to provide peer review of the survey’s wording and methodology. Since the 2004 changes significantly increased the time needed to complete the survey, interviewers offered incentives (gift cards to area grocery stores) to encourage participation.

> *“Respondents to the 2007 survey were predominantly middle aged, over 54 percent being aged between 45 and 64. This in itself is a testament to the success of HIV medical and support services in the EMA over the past several years.”*

The 2007 survey instrument was nearly identical to that used in 2004, with minor changes to the wording of a few questions. Also, because the 2006 version of the federal Ryan White legislation reorganized service categories into two groups (“core medical” and “support” services), the order of the questions on the survey instrument was altered to match.

IGS hired and trained 14 interviewers to administer the survey. During the mandatory training, interviewers were provided background information on the planning council and HIV/AIDS in the Baltimore EMA, shown how to administer the survey instrument in a professional and neutral manner, and instructed in research ethics, including the importance of client confidentiality and informed consent.

The survey contained three sections: (a) questions on core medical services, which collected information about respondents’ demand for and use of services such as HIV primary medical care, case management and substance-abuse treatment, (b) 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 (c) questions on demographics, which

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allocate funds directly to service providers but, rather, simply to the broad categories of service under which the providers operate.

collected information about consumers' income, race/ethnicity, jurisdiction of residency, mode of HIV transmission, and much more.

1.3 Results and Planning Implications of the 2007 Consumer Survey

A total of 745 interviews were conducted over six weeks, making this, IGS believes, the largest interviewer-administered survey yet conducted of Ryan White Part A service consumers in the United States. Of those 745 respondents, 730 reported having lived in the Baltimore EMA for most of the past year. There were 603 respondents from Baltimore City and 127 residing in one of the six EMA counties. Primary medical care, case management and local/consortium drug reimbursement were the services identified as having the highest demand (100.0, 91.2 and 84.1 percent, respectively), similar to results from the 2004 consumer survey, which found primary medical care, oral-health services and case management to be the services with the highest demand (91.8, 82.6 and 81.6 percent, respectively) (IGS 2005a).

"Heterosexual sex was the principal means of virus transmission, a first for an EMA long accustomed to intravenous drug use as the primary culprit. Nearly 40 percent of respondents gave heterosexual sex as their transmission mode."

Respondents to the 2007 survey were predominantly middle aged, over 54 percent being aged between 45 and 64 (this in itself is a testament to the success of HIV medical and support services in the EMA over the past several years). Almost 60 percent of respondents were male and well over 80 percent were African-American. Most respondents — above 82 percent — were Baltimore City residents. More than two thirds of survey takers reported living below the federal poverty line. Heterosexual sex was the principal means of virus transmission, a first for an EMA long accustomed to intravenous drug use as the primary culprit. Nearly 40 percent of respondents gave heterosexual sex as their transmission mode.

Legal services, hospice care and home health care ranked among the top three services with unmet demand in both 2004 and 2007. However, in these as in many other categories, there was a significant decrease in the proportion of unmet demand between the two surveys. In 2007, legal services had the highest unmet demand, at 69.3 percent, whereas in 2004 — when it ranked third in unmet demand — the unmet demand for this service was 75.1 percent. Unmet demand for hospice care in 2007 was 69.2 percent, down considerably from 84.6 percent in 2004. Lastly, home health care ranked third in unmet demand in 2007, at 64.2 percent, compared to a 2004 unmet-demand level in this category of 75.5 percent (IGS 2005a). And true unmet demand may be even lower than survey responses suggest. Several consumers indicated having a *current* demand for various services in the past year, but they said they had not received those services because they had not needed them *at the time*. Responses like this inaccurately inflate the survey's findings of unmet demand, since unmet demand only results when a service is needed but not provided.

When interpreting the survey's findings, one important question is whether services with high demand also have high unmet demand, since this would suggest an inefficient use of resources. Though unmet demand in any service category is regrettable (not to mention frustrating for the affected consumers), it is simply the case that the planning council must sometimes make hard choices and, due to a federally imposed planning schedule that allows for the bulk of funding decisions to be made only once a year, cannot always anticipate where new need will arise.

One way of answering the question about efficient use of resources alluded to above would be to consider, out of the 24 types of services that the survey asked about, how many of the 12 most

demanded services also ranked in the top 12 in terms of unmet need.[2] Reassuringly, this turned out to be the case for only three service categories: legal services (demand: 49.6 percent; unmet: 69.3 percent) ranked twelfth in demand and first in unmet demand; emergency financial assistance (demand: 61.2 percent; unmet: 57.9 percent) ranked sixth in demand and seventh in unmet demand; and oral-health care (demand: 83.4 percent; unmet: 44.2 percent) ranked fourth in demand and twelfth in unmet demand. And even more reassuringly, the top three most demanded services (primary medical services, case management and local/consortium drug reimbursement) were in the bottom four in terms of unmet demand.

The most commonly cited barrier to care among EMA-wide consumers was insufficient knowledge of how to access services. This barrier signifies either (1) communication problems between providers and consumers, either because the provider has not provided sufficient information or because the client has not been clear enough about his or her needs, or (2) client difficulty with correctly assimilating and retaining information about available services. Either way, as consumer needs evolve, there must be ongoing dialogue that supports (1) consumers' communicating their evolving needs and (2) providers' sharing information about available services efficiently and effectively. Possible solutions include producing a simple one-page document that lists available services (and eligibility requirements) in plain language and instituting a centralized on-line database that would help providers communicate with one another about client needs, de-duplicate services and otherwise address consumers' changing needs even more effectively than at present.

[2] The survey asked questions about 23 service categories, breaking one of these (treatment adherence) into two subcategories for a total of 24.

2. BACKGROUND

This report presents and analyzes data captured in a survey of consumers of federally funded HIV services in and around Baltimore, Maryland in early 2007. The survey was conducted by InterGroup Services, Inc. (IGS), a Baltimore-based consulting and project-management firm, for the Greater Baltimore HIV Health Services Planning Council. The planning council is a volunteer, 40-member panel appointed by the mayor of Baltimore City to allocate HIV-service-delivery funds received under Part A (formerly Title I) of the federal Ryan White program, some $20 million annually. Ryan White Part A funds are intended to pay for HIV-related medical and supportive services for clients with no other source of payment. The Ryan White program, which is authorized under the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006 (formerly the Ryan White CARE Act),[3] is managed by the Health Resources and Services Administration in the U.S. Department of Health and Human Services (HHS).

Per the Ryan White program's authorizing legislation, planning councils are required to conduct a variety of research activities to inform their funding-allocation deliberations, including needs-assessment research among their clienteles. To this end, Baltimore's planning council has conducted a needs-assessment survey every three years since 1998 in order to learn the service gaps and unmet needs of PLWH/As in the Baltimore EMA.[4] The consumer survey is a critical planning tool and a key source of information for the council as it sets goals and allocates resources.

2.1 The Baltimore EMA

Ryan White Part A funds are disbursed to geographical entities known as EMAs, typically consisting of an urban center and its surrounding jurisdictions. To first qualify as a Part A-eligible EMA, such a region must have a population of 50,000 or more and a cumulative total of more than 2,000 cases of AIDS during the most recent five-year period (HRSA 2003:2). Baltimore more than qualifies in this regard: the EMA's population is over 2.6 million and, as of December 2005, the city alone had close to 8,000 living AIDS cases (Flynn 2006). This section describes various characteristics of the Baltimore EMA that affect HIV-related service delivery and influence the planning council's decisions and resource allocations.

The Baltimore EMA consists of Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties. (Baltimore City is a separate jurisdiction equivalent to a county.) Although these jurisdictions are, with the exception of one (Queen Anne's County), contiguous, they are quite diverse in terms of their racial and ethnic compositions, their population sizes and their socio-economic characteristics. The strongest differences are between Baltimore City and the other EMA jurisdictions. With a population of a little under 636,000, Baltimore City is the most densely populated of these jurisdictions, home to about a quarter of the EMA's total population and 54.6 percent of its African-American residents. Nearly two thirds black, the city is the EMA's sole "majority minority" jurisdiction. In addition, 19.5 percent of Baltimore City residents live in poverty, as federally defined (DHR 2005:53; CB 2006a).

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[3] The "CARE" in CARE Act stood for "Comprehensive AIDS Resources Emergecy."

[4] "Unmet need" is HRSA's term for PLWH/As who know they are HIV positive but are not receiving primary medical care. "Service gaps" are any *other* unmet service needs of PLWH/As who *are* receiving primary medical care (HRSA 2003:2).

For their part, the counties of Anne Arundel, Baltimore, Harford and Howard are heavily suburban, particularly the two former, which surround Baltimore City. Together, these "suburban" EMA counties hold just over 1.8 million residents, or almost 70 percent of the EMA's population. Of these residents, around 18 percent are African-American. Poverty rates here range from 3.1 percent in Carroll County to 8.4 percent in Baltimore County (DHR 2005; CB 2006a).

Carroll and Queen Anne's counties — respectively situated at the western and eastern extremities of the EMA — are the most rural in the EMA, although they are not particularly like each other. Carroll County sits to the west of Baltimore County. Though bedroom communities are an undoubted fact of life in Carroll, the county is still in many respects like the pastoral area of Pennsylvania that borders it to the north. Queen Anne's, on the other hand, is on the Eastern Shore, on the far side of the Chesapeake Bay, with a local economy that rests on fishing, agriculture and, increasingly, tourism. Together, these two counties speak for only about eight percent of the EMA's population. Residents are 4.0 percent African-American. In Carroll County, the poverty rate is 3.1 percent; in Queen Anne's County, 7.8 percent.

Table 1

Racial Composition of the Baltimore EMA, 2005

	Balt. EMA	***Anne Arundel County***	***Balt. City***	***Balt. County***	***Carroll County***	***Harford County***	***Howard County***	***Queen Anne's County***
Total Pop.	2,655,675	510,878	635,815	786,113	168,541	239,259	269,457	45,612
Af.-Am.	28.5%	14.7%	64.9%	24.0%	3.0%	11.5%	16.1%	7.9%
White	66.3%	80.5%	31.7%	70.5%	94.7%	84.8%	70.6%	90.3%
Other	5.2%	4.8%	3.4%	5.5%	2.3%	3.7%	13.3%	1.8%

Source: DHR 2005:55.

Over 25 percent of Maryland's population resides in Baltimore County and Baltimore City combined (DHR 2005:53); these two jurisdictions, home to the bulk of the EMA's service providers, receive the greater share of the EMA's resources. In terms of race — an important topic, given that HIV is vastly more prevalent and deadly among African-Americans than among other minorities and whites — Baltimore City and Baltimore County are each home to more African-American residents than any other jurisdiction within the EMA. As shown in table 1, Baltimore County's population is 24.0 percent African-American, and Baltimore City's is 64.9 percent (DHR 2005:53). These figures compare to an overall EMA population that is 28.5 percent African-American and 66.3 percent white. Exclusive of Baltimore city and county, the EMA is only 12.5 percent black and fully 81.5 percent white. Throughout the EMA, the population that is neither black nor white is quite small, ranging from 1.8 percent in Queen Anne's County to 13.3 percent in Howard County (the only EMA jurisdiction in which it exceeds 6 percent). White residents make up over 80 percent of Ann Arundel and Harford counties' populations, and over 90 percent of Carroll and Queen Anne's counties' populations (DHR 2005:55).

Table 2

Baltimore EMA Income and Poverty Levels, 2006

	State of Maryland	***Anne Arundel County***	***Balt. City***	***Balt. County***	***Carroll County***	***Harford County***	***Howard County***	***Queen Anne's County***
Median Household Income ($)	65,144	79,160	36,031	59,995	74,106	69,549	94,260	65,144
Poverty Level (% of individuals)	7.8%	4.6%	19.5%	8.4%	3.1%	3.3%	4.2%	7.8%

Source: CB 2006a.

Poverty is another socioeconomic factor associated with disproportionate HIV risk. As shown in table 2, which presents poverty rates and median household incomes in the EMA jurisdictions, poverty is most prevalent in Baltimore City, affecting almost one out of five residents (19.5 percent). Not surprisingly, the city's median household income, $36,031, is by far the lowest in the EMA. Baltimore County has the next highest poverty rate (8.4 percent) and the next lowest median household income ($59,995), though it is worth emphasizing how vastly these differ from the city's: the county's poverty rate is less than half that of Baltimore City's, while its median household income is more than two thirds higher. Baltimore County, the "poorest," then, of the EMA's non-city jurisdictions, is followed in descending order of poverty rates and ascending order of median household incomes by Queen Anne's County (7.8 percent; $65,144), Harford County (3.3 percent; $69,549), Carroll County (3.1 percent; $74,106), Anne Arundel County (4.6 percent; $79,160) and Howard County (4.2 percent; $94,260). As these data show, and as was also the case where race was concerned, the six counties have much more in common with one another than with the city in terms of poverty and income levels (CB 2006b).

2.2 HIV/AIDS in the Baltimore EMA

The Baltimore EMA, home to just under half of Maryland's residents, is home as well to nearly two thirds of the state's prevalent, or living, HIV/AIDS cases, based on reporting through December 31, 2005 (table 3). Perhaps not surprisingly, given the racial and economic picture sketched above, the vast majority of the EMA's PLWH/As — nearly 80 percent — reside in Baltimore City, despite the fact that the city contains only about a quarter of the EMA's overall population. Next hardest hit are the city's two neighboring jurisdictions, Baltimore County (with 11.6 percent of the EMA's PLWH/As) and Anne Arundel County (with 4.8 percent), followed by Harford County (1.8 percent), Howard County (1.6 percent), Carroll County (0.7 percent) and Queen Anne's County (0.2 percent) (Flynn 2006:15).

Table 3

HIV/AIDS Prevalent Cases of Baltimore EMA Jurisdictions, 2005

	Balt. EMA	***Anne Arundel County***	***Balt. City***	***Balt. County***	***Carroll County***	***Harford County***	***Howard County***	***Queen Anne's County***
Pop.	2,552,994	489,656	651,154	754,292	150,897	218,590	247,842	40,563
Prevalent Cases	18,810	902	14,910	2,182	138	340	302	36
Proportion of Cases	61.6%*	4.8%**	79.3%**	11.6%**	0.7%**	1.8%**	1.6%**	0.2%**

* Figure expresses proportion of statewide caseload.

** Figure expresses proportion of EMA caseload.

Source: Flynn 2006:15, CB 2006a.

Injection drug use (IDU) and sex are, respectively, the two most common known modes of HIV/AIDS exposure in the Baltimore EMA, as they are nationwide. But there is a distinction to be made between men having sex with men (MSM), once the clear leader in transmission modes, and heterosexual intercourse, a transmission mode that has recently gained ground.

Table 4

Mode of HIV/AIDS Exposure among Prevalent Cases within the EMA by Jurisdiction as of Dec. 31, 2004

	EMA	***Anne Arundel County***	***Balt. City***	***Balt. County***	***Carroll County***	***Harford County***	***Howard County***	***Queen Anne's County***
Prevalent Cases	*18,001*	*851*	*14,346*	*2,039*	*132*	*316*	*281*	*36*
MSM	10.4	18.6	9.0	14.4	15.2	16.5	19.9	25.0
IDU	27.6	17.0	30.4	17.9	25.0	16.1	7.8	11.1
MSM/IDU	2.0	1.3	1.9	2.6	2.3	1.9	1.1	2.8
Pediatric	0.9	0.5	0.9	1.0	0.8	0.6	0.7	2.8
Hetero. Sex	17.3	22.6	16.8	16.7	10.6	26.3	21.0	30.6
Transfusion	0.2	0.7	0.1	0.4	1.5	3.2	0.4	0.0
Other, Missing or Risk Not Reported*	41.6	39.4	40.9	47.0	44.7	35.4	49.1	27.8

* Maryland AIDS Administration categories.

Source: DHMH 2005.

As can be seen in table 4, which displays data as reported through December 31, 2004 (the most recent exposure-mode data published on-line by the Maryland AIDS Administration),

heterosexual intercourse was the leader among cases with known transmission modes in Anne Arundel, Harford, Howard and Queen Anne's counties, where it was implicated in 22.6, 26.3, 21.0 and 30.6 percent of prevalent cases, respectively. IDU, on the other hand, was the leading known mode in Baltimore City, Baltimore County and Carroll County (30.4, 17.9 and 25.0 percent of prevalent cases, respectively). MSM did not lead in any EMA jurisdiction, so far as is known, but came in second among known modes in Anne Arundel, Carroll, Harford, Howard and Queen Anne's counties, where it was associated with 18.6, 15.2, 16.5, 19.9 and 25.0 percent of prevalent cases, respectively. Pediatric, MSM/IDU and transfusion transmission modes were reported in relatively small proportions, no more than three percent of cases in any jurisdiction. But of course, as can be seen in the bottom row of table 4, this type of analysis is hampered by the extremely high rate of cases for which exposure modes are what the Maryland AIDS Administration calls "other," "missing" or "risk not specified," ranging from 27.8 percent at the low end (in Queen Anne's County) to 49.1 percent in Howard County, and 41.6 percent EMA wide (DHMH 2005).

2.3 Needs Assessment Through Consumer Surveys

HRSA requires planning councils to incorporate needs-assessment research into their decision-making processes. In particular, planning councils must investigate what health-care and other needs of PLWH/As are not being met. As well, HRSA wants PLWH/As to have a voice in shaping the continuum of care that serves them. As one means of accomplishing these goals, the Baltimore planning council has conducted surveys of the EMA's PLWH/As every three years since 1998, relying heavily on the results for a variety of planning decisions. In addition to influencing the prioritization of funding categories, survey data have also led the council to develop new service categories, such as case management, treatment adherence and client advocacy.

One caveat regarding this type of survey is that it can only collect information on what PLWH/As *say* their needs are. In some cases, individual respondents may have opinions about their needs with which providers or planners might disagree, perhaps as a result of misunderstandings about the nature of particular services. Another caveat is that this survey utilizes a convenience sampling method, as opposed to random sampling: while the population that responded to this survey is similar to the EMA's PLWH/A population as a whole in many regards, the results of this survey cannot be said to be strictly representative of all PLWH/As in the EMA.

3. METHODOLOGY

Since its inception in 1998, the purpose of the Baltimore planning council's triennial consumer survey has been to gain a greater understanding of the service needs of PLWH/As and to assist the planning council in its priority-setting and other planning duties. This section describes the development of the 2007 survey and its administration.

3.1 Survey Development

The consumer survey is conducted every three years under the direction of the planning council's Needs Assessment Committee (NAC).[5] The first survey (1998) consisted of 75 questions and was self-administered (i.e., the respondents read and completed the survey on their own). Once completed, each respondent was responsible for returning the survey, either by mail or by hand delivery, to a specified council location (IGS 2005b:28).

Similar to its predecessor, the 2001 consumer survey consisted of 75 questions. However, only half of the surveys were self-administered while the rest were interviewer-administered surveys. In 2001, the survey's purpose had been refined, from a broad goal of gathering data for the council's priority setting, to a narrower one of identifying unmet service needs and barriers to care in the EMA (IGS 2005b:26). Interviewers were unpaid volunteers from the community and from provider staff. Again, respondents and interviewers were responsible for returning the completed surveys.

The 2004 survey was considerably more ambitious and sophisticated than its predecessors, in terms not only of its design but also its method of administration. Preparations for the 2004 consumer survey began about a year before its scheduled launch date. Building upon the previous surveys, the NAC enlisted the assistance of a peer-review panel of experts to expand the survey, develop more detailed and focused questions and otherwise increase the accuracy and utility of the data collected. And for the first time, trained interviewers were hired to administer the surveys.

The 2007 survey instrument and methodology were almost identical to those in 2004; the only changes made were to the order and wording of some questions in response to suggestions from the NAC and the grantee.[6] Unlike the 1998 and 2001 surveys, which varied in methodology and format, the similarities that exist between the 2004 and 2007 consumer surveys — and which will continue, the planning council intends, in subsequent surveys — will support detailed comparative and trend analyses of the evolving needs of the EMA's PLWH/As.

3.2 Survey Administration

Trained interviewers administered the 2007 consumer survey to interviewees in private locations. Unlike self-administered surveys, an interview-administered survey corrects for varying literacy levels, increases accuracy of responses (by avoiding misunderstandings about technical terms and service categories) and reduces the number of partially completed surveys. Additionally, an interview-administered survey can be more conducive to respondents' sharing personal

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[5] The NAC was dissolved in spring of 2007; its duties were transferred to the council's Comprehensive Planning Committee.

[6] In the Baltimore EMA, the Ryan White grantee is the Baltimore City Health Department, which receives, and overseas the expenditure of, the funds on behalf of the mayor of Baltimore City.

information and opinions, since interviewers can answer respondents' questions about the purpose of the survey, the meaning of any unfamiliar terms and how exactly respondent confidentiality will be protected.

3.3 Survey Instrument

The survey instrument was divided into three parts, sections on: (1) core medical services, (2) support services and (3) demographics. The demographics section was placed last to ensure that as much information as possible about service needs — the HRSA-mandated purpose of needs-assessment activities like this one — was captured in the event that a respondent elected to terminate the interview early. As it turned out, very few surveys were terminated early, and almost all of the 745 surveys conducted obtained complete demographic information.

But the meat of the survey was the questions on service categories contained in the survey's first two sections. For each support- and core-medical-service category eligible for funding, the survey sought answers to the following:

- Are you in need of this service?
- Are you receiving this service?
- If yes, in what jurisdiction do you receive this service?
- If no, why aren't you receiving this service?

For some selected services, the survey also asked certain additional questions — such as which provider offered the service, how it was paid for, etc. — as warranted by specific aspects of the service offered, funding streams available and other details.

3.4 Interviewers

Recruitment for interviewers began in November 2006. The goal was to hire individuals who had an interest in the HIV/AIDS pandemic, health care in the urban environment, or other related topics. Recruitment efforts focused on several area colleges and universities (particularly in the health and social work departments) as well as local newspapers with high gay, lesbian, bisexual and transgender (GLBT) readerships. Recruitment fliers were also posted in various locations throughout the city and counties.

Fourteen interviewers were hired in January 2007, five of whom had worked as interviewers for the 2004 survey. Interviewers received training that included background information on HIV, the Baltimore EMA, the planning council and the survey process. The survey instrument and informed-consent script were covered extensively during the training, as were various ethical issues related to public-health research, such as consent and confidentiality.

In the course of their duties, the interviewers were responsible for:

- Signing out incentive cards (discussed below in section 3.6) and stocking up on various supplies (surveys, consent forms, HIV-services information, record-keeping materials, etc.) from the planning council support office (PCSO).
- Confirming interview appointments with site contact persons one day prior to scheduled visits.
- Gaining informed consent from each respondent before administering the survey.

- Administering the survey by reading it to all respondents and marking their answers for them (to avoid having to ask and/or make assumptions about literacy levels).
- Distributing incentive cards to respondents.
- Recording the number of surveys completed or abandoned and the number of incentives distributed at each provider location.
- Completing time sheets for each location, including signatures from site contact persons for verification of hours worked.
- Maintaining secure custody of completed consent forms and surveys.
- Returning completed consent forms, surveys, unused incentive cards and other forms to the IGS office within 48 hours of survey administration.

3.5 Interview Sites

Interview-site coordination began about seven weeks prior to the survey launch. Initial contact was made via a letter from planning council Chairman Lennwood Green to all area Ryan White Part A service providers. The letter requested providers' cooperation in recruiting respondents, scheduling and providing space in which to conduct the interviews. Another letter from Baltimore City Health Commissioner Joshua M. Sharfstein also encouraged participation from providers. Planning council support office (PCSO) staff at InterGroup Services made follow-up calls shortly after the letters were sent and continued to do so for the duration of the survey. The purpose of the calls was to identify a contact person at each location and to schedule specific dates/times and private spaces for survey administration. PCSO staff also contacted non-Part A providers for assistance recruiting HIV-positive individuals who were either not currently in the Ryan White system or not in care at all.

Over the course of the survey-administration period, a total of 38 community-based organizations, health departments, hospitals, substance-abuse treatment facilities and support-group providers hosted interviewers. Conference rooms, examination rooms and offices were among the private locations in which surveys were administered. Interviews were also conducted at IGS headquarters when this was more convenient or appealing for respondents.

Coordinating all of this was a complex task that required frequent communication and careful attention to providers' and respondents' concerns and conflicting demands. Providers' flexibility and patience concerning scheduling and other changes were critical to the success of this survey. All participating host sites rose to the occasion and provided a remarkable level of assistance and support. (Many additional sites expressed willingness to host interviews but, due to funding and scheduling limitations, the need did not arise.)

3.6 Respondent Recruitment

A large number of survey respondents were recruited by providers who either contacted their eligible clients directly or posted fliers throughout their facilities. Some interviews were by appointment, but most were "walk-ups," so interview periods were scheduled so far as possible for each site's busiest days and times, when the greatest number of qualified respondents would be receiving services. Many locations that could not host interviewers worked to recruit respondents by posting fliers and encouraging their clients to call IGS and schedule a time to take the survey. Press releases sent to and ads placed in local newspapers further promoted the survey, while planning council members spread the word among their colleagues and within the community.

The common thread in all participant-recruitment efforts was a PCSO-created flier that gave a brief explanation of the purpose/importance of the survey and indicated that respondents would receive a $15 gift card for participating.[7] These fliers were circulated at local colleges, universities, hospitals, support groups, clinics, health departments and community-based organizations throughout the EMA. Once a date and time had been scheduled at a site, a site-specific flier was created and posted in that particular facility, advertising the dates and times interviews would be conducted there.

3.7 Data Collection and Storage

The 2007 consumer survey commenced on January 16, 2007 and concluded on February 28, 2007. During this period, 745 interviews were conducted. Each interview followed the same pattern.

The interviewer first welcomed the participant and took steps to ensure privacy, such as by closing a door.

The interviewer next read the introductory script, which gave an overview of the project and its purpose.

A consent form was then given to each participant and read aloud by the interviewer. The form included another description of the project's purpose and procedures and made the participant aware that, while some questions in the survey were of a sensitive nature, participation was completely voluntary, and no negative actions would result from their terminating the survey at any time. Confidentiality protection and a participant's right to withdraw were also outlined in the consent form.

If the participant declined to participate in the survey, the interviewer signed and dated the consent form, filed it in an envelope and concluded the session. If the participant decided to proceed with the survey, the participant and the interviewer signed and dated both copies of the consent form, one of which was issued to the respondent while the other was stored in an envelope labeled "Completed Consent Forms."

Once the consent forms were signed, the interviewer recorded his or her name on the script as well as the name of the site where the interview was taking place. Interviewers also recorded whether or not respondents were completing the survey for themselves or for someone else and then proceeded with the survey, reading each question and possible response aloud and recording respondents' answers.[8]

On average, the survey took approximately 30-45 minutes to complete. Afterward, the interviewer stored the survey in an envelope marked "Completed Surveys," separate from the "Completed Consent Forms" envelope.

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[7] The rationale behind offering a financial incentive was that many respondents — in poor health and often reliant on public transportation — might need to travel out of their way to participate in a survey of 30-45 minutes' duration. The incentive was considered compensation for assisting the planning council in this important research activity.

[8] Due to the high poverty rate among Ryan White recipients, survey designers were concerned about the possibility of low literacy levels among respondents. As mentioned earlier, then, interviewers were instructed to read all materials aloud to respondents and to mark respondents' answers for them, in order to avoid having to ask and/or make assumptions about literacy levels.

The interviewer recorded disbursement of any incentives in a log book and initialed the sheet. The participant also initialed the log to verify receiving an incentive.

All completed surveys and consent forms were returned to the IGS office within 48 hours of completion. There, the surveys were counted and stored in a locked office awaiting data entry.

3.8 Survey Data Entry and Analysis

Survey responses were entered by IGS staff using a Filemaker Pro 6 database. The database program assigned a unique serial number to each survey's digital file. This identification number was hand marked at the top of each survey along with the name of the data enterer and the date the survey was entered.

Once the identification number was assigned, the program prompted the data enterer to enter his or her name, the name of the interviewer who conducted the survey, the provider location where the survey was conducted and whom the respondent completed the survey for (himself or herself or on behalf of someone else who was unable to respond). Survey responses were then recorded in the database using a data-entry interface similar in layout to the paper survey itself. Once data entry was complete, Filemaker's query function was used to perform the analysis contained in this report.

4. DEMOGRAPHIC PROFILE OF PARTICIPANTS

The 2007 consumer survey obtained responses from 745 PLWH/As, a larger number than any previous such survey conducted either in the Baltimore EMA or, IGS believes, nationwide. Of the 745 overall respondents, 730 resided in the Baltimore EMA at the time of survey administration. Of the 730 EMA-wide respondents, 603 lived in Baltimore City, and the remaining 127 lived in one of the other six EMA jurisdictions. Together, the 730 EMA respondents represent about 4 percent of the total prevalent cases in the Baltimore EMA (Flynn 2006). This section of the report presents demographic data collected by the surveys.

4.1 Age

Table 5 shows the ages of the survey respondents, the vast majority of whom were older than 24 and younger than 65. Over half of the total EMA respondents (54.1 percent) were ages 45-64, with another 43.3 percent in the 25-44 age range. Of the rest, 0.4 percent were ages 2-12, 1.2 percent were ages 13-24 and 0.5 percent were over 65. No data were collected on any PLWH/As under 2 years of age.

Table 5

Age Distribution of Respondents

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Under 2 years	0%	0%	0%
2 – 12 years	0.4%	0.5%	0.0%
13 – 24 years	1.2%	1.0%	2.4%
25 – 44 years	43.3%	43.9%	40.2%
45 – 64 years	54.1%	53.6%	56.7%
Over 65 years	0.5%	0.5%	0.8%
No response	0.3%	0.3%	0%

Source: 2007 Consumer Survey.

The basic shape of this distribution held both for the city and for the counties as a whole, with some minor variations. In Baltimore City, 43.9 percent of the respondents were 25-44 years old (a slightly larger proportion than in the EMA as a whole), while 53.6 percent were 45-64 years old (a slightly smaller proportion than the EMA's). The rest of the age groups were represented in proportions identical or nearly so to those seen EMA wide: 0.5 percent of city respondents were 2-12 years old, 1.0 percent were 13-24 and 0.5 percent were over 65. The counties' results were similar to the city's, although with larger proportions of 13-24-year-olds (2.4 percent) and 45-64-year-olds (56.7 percent) and a slightly smaller proportion of 25-44-year-olds (40.2 percent). These proportions are a shift from the 2004 consumer survey, which contacted a larger proportion of EMA 25-44-year-olds (55.2 percent) and a smaller proportion of EMA 45-64-year-olds (IGS 2005a). Such a shift is not surprising given a nationwide trend of PLWH/As' living longer due to advances in HIV treatment.

4.2 Sex

Just as in past surveys, most 2007 respondents were male. As table 6 shows, males constituted about 58 percent of the EMA-wide respondent pool, and females only about 40 percent. This differs somewhat from in 2004, when respondents were 54.1 percent male and 44.3 percent female. And the 2007 survey's sex distribution is also noticeably different from what Maryland AIDS Administration data would lead one to expect. According to the AIDS Administration, the EMA's PLWH/As are 62.8 percent male and 37.2 percent female (DHMH 2005). There is no readily apparent explanation for this discrepancy, although a combination of factors could conceivably come into play: perhaps female PLWH/As were more concerned than males about the risk of being "outed" by sitting for this survey, or perhaps they shoulder more domestic responsibilities than do male PLWH/As and so were able to find less time to take the survey.

Table 6

Sex of Respondents

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Male	57.9%	57.7%	59.1%
Female	40.1%	40.1%	40.2%
Transgendered (male to female)	1.2%	1.5%	0%
Transgendered (female to male)	0.1%	0.2%	0%
No response	0.5%	0.5%	0.8%

Source: 2007 Consumer Survey.

Also of interest in the 2007 survey's sex distribution is the fact that, while only 0.8 percent of the respondents to the 2004 survey were male-to-female transgendered (IGS 2005a), 1.2 percent of 2007 respondents identified themselves this way. This change suggests that this subpopulation, while small, may be growing in the EMA, although caution should be exercised when trying to identify trends affecting such small populations. (We are, after all, talking about only nine respondents in 2007.)

4.3 Race/Ethnicity

As is the case nation- and statewide, the proportion of EMA African-Americans infected with HIV/AIDS continues to be disproportionately large compared to whites and other races/ethnicities. Data from the Maryland AIDS Administration show that about 75 percent of the EMA's PLWH/As are African-Americans (non-Hispanic) and only 13.2 percent are white (non-Hispanic) (DHMH 2005). As this would suggest, respondents to the 2007 survey were much more likely to be black than white. Table 7 shows that more than 80 percent of EMA-wide respondents were African-American, while just 6.6 percent were non-Hispanic whites. In the city, nearly 87 percent of respondents were black; in the counties, 63 percent.

The observant reader will note that the survey contacted more blacks and fewer whites than the AIDS Administration data would have predicted. One reason for this may be that (a) respondents to this survey were mainly recipients of or eligible for Ryan White services, which are intended for those with low incomes, and (b) African-Americans tend to have lower incomes than whites.

However, this does not explain a similarly large discrepancy between the 2007 data and those collected in 2004, when respondents were 11.0 percent white and 84.6 percent black. It would be surprising to learn that the racial distribution among Ryan White clients had changed so much in just three years, so this may simply be one of the anomalies that can crop up when surveying a convenience — rather than random — sample.

Table 7

Race of Respondents

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Non-hispanic Af.-Am.	82.7%	86.9%	63.0%
Non-hispanic White	6.6%	3.3%	22.0%
Hispanic/Latino	3.6%	3.0%	6.3%
Other	5.1%	4.3%	8.7%

* Note: Percentages do not total 100 because categories are not mutually exclusive and/or not all surveys included complete race/ethnicity data.

Source: 2007 Consumer Survey.

4.4 Exposure Mode

As noted in section 2.2, injection drug use (IDU) and sex are, respectively, the most common modes of HIV/AIDS exposure in the Baltimore EMA, according to Maryland AIDS Administration data DHMH 2005. Table 8, which shows the exposure modes reported by 2007 survey respondents, finds a slightly different result: rather than IDU, heterosexual intercourse was the leading mode EMA-wide (38.9 percent of EMA residents), in Baltimore City (38.6 percent of city residents) and in the counties as a whole (40.2 percent of counties residents). EMA wide, IDU was the second most commonly reported mode (16.8 percent of EMA residents), with MSM

Table 8

Respondents' Mode of Exposure

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Heterosexual sex	38.9%	38.6%	40.2%
Injection drug use (IDU)	16.8%	18.6%	8.7%
MSM	14.5%	13.9%	16.5%
Other*	4.7%	4.0%	7.9%
Unknown**	25.1%	24.9%	26.8%

* Includes transmission from perinatal infection, blood products, hemophilia treatment and trading sex for money.

** Includes those who specified multiple exposure possibilities.

Source: 2007 Consumer Survey.

running a close third (14.5 percent), similar to the situation in Baltimore City (IDU: 18.6 percent; MSM: 13.9 percent). The story was slightly different in the counties, however, where *MSM* was the second most common transmission mode (16.5 percent) and IDU a distant third (8.7 percent). The "other" category — which includes transmission via perinatal infection, blood products,

> *"Rather than IDU, heterosexual intercourse was the leading virus transmission mode EMA-wide, in Baltimore City and in the counties as a whole."*

hemophilia treatment and trading sex for money — contained 4.7 percent of EMA respondents, 4.0 percent of city respondents and 7.9 percent of counties respondents. Responses that indicated uncertainty as to exposure mode, whether because the respondent indicated multiple modes or simply answered "I don't know," were placed into the "unknown" category.

Most exposure modes remained relatively constant between the 2004 and 2007 surveys. The largest difference was in the rate of IDU exposure, which decreased from accounting for about 23 percent of transmissions in 2004 to under 17 percent now (IGS 2005a). The reason for this decline is unclear, as it seems unlikely that there has been a similarly large decline in overall IDU activity in Baltimore during the ensuing years.

4.5 Residence

Table 9 shows respondents' jurisdictions of residence. Of the 730 participants who resided in the EMA at the time they took the survey, 603 (82.6 percent) lived in Baltimore City and 127 (17.4 percent) in one of the six surrounding counties. The majority of the counties residents lived in Baltimore County (41.7 percent of non-city dwellers), followed by 22.8 percent in Howard County, 15.7 percent in Harford County, 11.8 percent in Anne Arundel County, 6.3 percent in Carroll County and 1.6 percent in Queen Anne's County. These results varied somewhat from

Table 9

Respondents' Jurisdiction of Residence

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Anne Arundel County	2.1%	N/A	11.8%
Baltimore City	82.6%	100%	N/A
Baltimore County	7.3%	N/A	41.7%
Carroll County	1.1%	N/A	6.3%
Harford County	2.7%	N/A	15.7%
Howard County	4.0%	N/A	22.8%
Queen Anne's County	0.3%	N/A	1.6%

Source: 2007 Consumer Survey.

those in 2004, when interviewers spoke with relatively smaller proportions of respondents from Carroll, Harford, Howard and Queen Anne's counties (in 2004, these were 2.1, 11.4, 14.3 and 1.4 percent of counties respondents, respectively). As far as the Maryland AIDS Administration's data on the actual geographical distribution of HIV cases among the EMA jurisdictions would lead one to expect, respondents from Anne Arundel and Baltimore counties were under-represented (4.8 and 11.6 percent of the EMA's total cases reside in these counties, respectively), while respondents from Howard County were over-represented (only 1.6 percent of the EMA's total PLWH/As reside in Howard County) (DHMH 2005).

4.6 Housing

The survey asked respondents whether they had lived mostly in temporary or permanent housing during the year preceding survey administration. “Temporary housing” was defined as housing where one plans to live for 6 months or less; having moved twice within the past 12 months was also defined as having lived in temporary housing. “Permanent housing” was defined as a place from which the respondent cannot legally be removed (except in foreclosure/eviction proceedings), where the respondent’s name is on the lease or mortgage, and/or where there are bills listed in the respondent’s name. EMA wide, 66.2 percent of respondents reported living in permanent housing and 31.8 percent in temporary, as shown in table 10. City residents were much more likely than county residents to report living in temporary housing during this time, as was also the case in the 2004 survey (IGS 2005a). Almost 35 percent of 2007 Baltimore City respondents indicated having lived in temporary housing, compared with only 18.9 percent of counties respondents. Meanwhile, just under two thirds of Baltimore City respondents (63.5 percent) reported living in permanent housing, much less than the 78.7 percent of county respondents who reported the same.

Table 10

Respondents’ Housing Type

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Permanent	66.2%	63.5%	78.7%
Temporary	31.8%	34.5%	18.9%
No Response	2.1%	2.0%	2.4%

Source: 2007 Consumer Survey.

The 2007 survey reached smaller proportions of respondents living in temporary housing than was the case in 2004, most noticeably in the counties but in the city as well. In 2004, about 28 percent of counties respondents lived in temporary housing, compared to only 18.9 percent in 2007. Meanwhile, 39.8 percent of 2004 city-dwelling respondents were in temporary housing, a proportion that shrank to only 34.5 percent in 2007 (IGS 2005a).

4.7 Income Level

The survey asked residents to classify their household incomes based on multiples of the 2006 federal poverty threshold for a family of one, $9,800 (CB 2006b). Table 11 shows 68.1 percent of

Table 11

Respondents’ Income Level

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
$29,400 or more	4.9%	4.1%	8.7%
$19,600 - $29,400	4.8%	4.0%	8.7%
$9,800 - $19,600	17.5%	15.9%	25.2%
$9,800 or less	68.1%	70.8%	55.1%
No response or unknown	4.7%	5.1%	2.4%

Source: 2007 Consumer Survey.

all EMA respondents reporting an annual income at or below $9,800. Not surprisingly, given the higher overall poverty rate in the city than in the counties, a much larger proportion of Baltimore City than counties respondents reported living below the federal poverty line, 70.8 percent in the city and 55.1 percent outside it. This is a marked change from 2004, when only 43.6 percent of Baltimore City respondents reported income levels below that year's federal poverty line (IGS 2005a). However, the non-random nature of these surveys prevents concluding that poverty is necessarily increasing among the area's Ryan White service consumers.

4.8 Health Insurance Type

Interviewers asked respondents which forms of health insurance they had used in the previous 12 months. Medicaid, the most common by a wide margin, was used by 60.1 percent throughout the EMA, 63.2 percent in Baltimore City and 45.7 percent in the counties. Medicare was in second place, used by 20.0 percent of EMA respondents, 19.2 percent of Baltimore City respondents and 23.6 percent of counties respondents. EMA-wide, the third most popular choice was "other" (8.6 percent), followed in descending order by "none" (8.2 percent), "private" (7.8 percent), Maryland's Medicaid-administered Primary Adult Care (PAC) (5.8 percent), the Maryland Health Insurance Plan (MHIP) (4.8 percent), Veterans' Administration (VA) health coverage (1.9 percent) and "I don't know" (0.8 percent).

This EMA-wide ranking of choices was mirrored in both the city and the counties. However, counties respondents were much more likely than city respondents to have used MHIP (11.0 percent of counties residents; 3.5 percent of city respondents), Medicare (23.6 percent of counties respondents; 19.2 percent of city respondents), "private" (15.7 percent of counties; 6.1 percent of city) and "other" (12.6 percent of counties; 7.8 percent of city). City residents were much more likely to have used Medicaid (63.2 percent of city; 45.7 percent of counties) and to be uninsured altogether (9.0 percent of city; 4.7 percent of counties). Broadly speaking, these differences seem likely to be driven by the higher income levels in the counties than in the city and the consequent differences in eligibility for various forms of public insurance programs, not to mention the related ability/inability to afford private coverage.

Also, when specifying their "other" coverage, 30 EMA respondents (4.1 percent) said they used Ryan White as their health insurance, even though Ryan White is not a form of health insurance. These consumers may not have met the eligibility requirements or may have been on the waiting list for some form of health insurance. Either way, these 30 respondents should also be considered uninsured, raising the proportion of EMA-wide uninsured respondents to 12.3 percent.

Table 12

Respondents' Health Insurance Type

Response Category	***EMA (n=730)***	***Baltimore City (n=603)***	***Counties Only (n=127)***
Medicaid	60.1%	63.2%	45.7%
Medicare	20.0%	19.2%	23.6%
MHIP	4.8%	3.5%	11.0%
Primary Adult Care (PAC)	5.8%	5.6%	6.3%
Veteran's Administration	1.9%	2.0%	1.6%
Private	7.8%	6.1%	15.7%
None	8.2%	9.0%	4.7%
Don't Know	0.8%	0.5%	2.4%
Other	8.6%	7.8%	12.6%

Note: Columns do not total 100, as categories are not mutually exclusive.
Source: 2007 Consumer Survey.

Due to changes in eligibility requirements for Medicare with the creation of the Medicare Part D prescription-medication program in January of 2006, a dramatic increase in respondent utilization of Medicare as compared to 2004 was expected. However, there seems instead to have been a significant *decrease* in the number of EMA-wide respondents who utilized Medicare for their health insurance (from 51.9 percent in 2004 to 20.0 percent in 2007) and a significant increase in the use of Medicaid (21.6 percent in 2004 and 60.1 percent in 2007) (IGS 2005a). The reason behind this unexpected change is unclear, though client confusion as to the distinction between the two cannot be discounted altogether. Also, since Medicaid is an income-based program, the fact that the 2007 respondents were poorer than those in 2004 (see section 4.7 above) would predict a higher level of Medicaid usage than in 2004. Another point worth mentioning is that Medicare Part D is administered through non-government health-insurance providers, so some recipients may not think of their benefit as coming from "Medicare," as opposed to the name of the company printed on their benefit cards.

4.9 Medication Coverage

Respondents were asked who pays for most of their HIV/AIDS medications. Across the entire EMA, Medicaid was the most widely used medication coverage, reported by 39.2 percent of all respondents, followed by the Maryland AIDS Drug Assistance Program (MADAP) (23.0 percent). EMA-wide, the third most frequent choice was "other" (14.7 percent), followed in descending order by Medicare Part D (7.8 percent), "private" (7.1 percent), PAC (4.8 percent), "myself" (1.6 percent), "don't know" (1.4 percent) and vouchers (1.1 percent). County residents were more likely than city residents to mention MADAP (37.8 percent of county respondents; 19.9 percent of city respondents), "private" (11.8 percent of county; 6.1 percent of city), "other" (19.7 percent of county; 13.6 percent of city) and Medicare Part D (11.0 percent of county; 7.1 percent of city). City residents were more likely to have used Medicaid (42.3 percent of city; 24.4 percent of county). In all other categories, city and county proportions differed by no more than three percentage points, and the largest differences seem readily explained, again, by differences in income levels between the city and the counties.

Table 13

Respondents' Medication Coverage Type

Response Category	EMA (n=730)	Baltimore City (n=603)	Counties Only (n=127)
MADAP	23.0%	19.9%%	37.8%
Medicaid	39.2%	42.3%	24.4%
Medicare Part D	7.8%	7.1%	11.0%
Primary Adult Care (PAC)	4.8%	4.3%	7.1%
Vouchers	1.1%	1.3%	0%
Self	1.6%	1.8%	0.8%
Private	7.1%	6.1%	11.8%
Don't Know	1.4%	1.2%	2.4%
Other*	14.7%	13.6%	19.7%

*Includes VA, clinical trials, and provider-paid and free samples.
Note: Columns do not total 100, as categories are not mutually exclusive.
Source: 2007 Consumer Survey.

As with health insurance coverage, four percent of EMA respondents claimed Ryan White as their form of medication coverage. As with health insurance, this suggests that for most of the 12 months prior to the survey, these respondents may in fact have had no prescription-drug "coverage" as the term is properly understood, even though they were not paying the costs of the medication themselves.

4.10 Time in Primary Medical Care

When asked how long they had been receiving primary medical care for HIV, 84.1 percent of EMA-wide respondents indicated more than one year (see table 14). Of the 730 respondents who resided in the EMA, 18 (2.5 percent) said they were not receiving medical care for HIV/AIDS. All of those so responding lived in Baltimore City. Exactly 6 percent of EMA respondents had been in primary medical care for one year and 6.6 percent for the 6 months preceding survey administration. About three percent declined to answer. Results for the city and counties were nearly identical to those for the EMA as a whole.

Table 14

Respondents' Time in Primary Care

Response Category	EMA (n=730)	Baltimore City (n=603)	Counties Only (n=127)
More than 1 year	84.1%	83.9%	85.0%
For the past year	6.0%	6.1%	5.5%
For the past 6 months	6.6%	6.6%	6.3%
Not in care	2.5%	3.0%	0%
Other/no response	0.8%	0.4%	3.1%

Source: 2007 Consumer Survey.

4.11 Time between Diagnosis and Seeking Care

Table 15 shows the length of time it took for respondents to begin seeking care after diagnosis with HIV. The largest proportion of EMA-wide respondents reported seeking care less than one month after diagnosis (57.9 percent), followed, interestingly, by what might be called the opposite case: those who waited more than one year (19.7 percent). Over 13 percent waited 1-6 month, and exactly 7 percent first sought care 6-12 months after diagnosis.

Table 15

Respondents' Time between Diagnosis and Seeking Care

Response Category	*EMA (n=730)*	*Baltimore City (n=603)*	*Counties Only (n=127)*
More than 1 year	19.7%	20.6%	15.7%
6 - 12 months	7.0%	6.6%	8.7%
1 - 6 months	13.6%	13.1%	15.7%
Less than one month	57.9%	58.4%	55.9%
Other/no response	1.8%	1.3%	3.9%

Source: 2007 Consumer Survey.

Similar distributions occurred in both the city and the counties, although city residents were more likely than counties residents to both report to care in less than one month (cities: 58.4 percent; counties: 55.9 percent) and delay more than one year (city: 20.6 percent; counties: 15.7 percent). (The former discrepancy may speak to the greater availability of HIV-related service providers in the city, while the latter may result from the lower health literacy and higher acute competing survival needs that would both naturally follow from the city's high poverty rate.) Meanwhile, counties respondents were more likely than city respondents to fall into the 1-6-month (counties: 15.7 percent; city: 13.1 percent) and 6-12-month (counties: 8.7 percent; city: 6.6 percent) ranges. Counties respondents were three times more likely than city respondents to decline to answer (3.9 *versus* 1.3 percent).

> *"The trends suggest that the EMA's Ryan White service consumers may be waiting even longer than before to seek HIV care after being diagnosed."*

Some differences between these data and those collected by the 2004 consumer survey suggest cause for concern. Since 2004, while there has been a slight increase among Baltimore City respondents seeking care less than one month after being diagnosed (58.4 percent in 2007, up from 56.9 percent in 2004) — a positive development, to be sure — there was also a *decrease* in county respondents who did the same (55.9 percent in 2007, as against 59.3 percent in 2004). Even more concerning are the increases in rates of respondents waiting 6-12 months to seek care: EMA wide, the rate of such responses rose from 0.2 percent in 2004 to 7.0 percent in 2007; in Baltimore City, from 0 to 6.6 percent; and, in the counties, from 0 to 8.7 percent. There was also an increase in the already large proportion of EMA-wide respondents who took more than one year to access care after being diagnosed, from 17.7 percent in 2004 to 19.7 percent in 2007, just as there was among Baltimore City respondents, from 17.1 percent in 2004 to 20.6 percent in 2007 (IGS 2005a). Somewhat more encouragingly, the proportion of counties residents waiting more than one year remained nearly level from 2004 to 2007, at around 15 percent of counties respondents, although of course a decrease would have been preferred.

These trends suggest that the EMA's Ryan White service consumers may be waiting even longer than before to seek HIV care after being diagnosed, although it is an open question whether this is because (1) they are less concerned by their diagnoses, perhaps due to the increasingly widespread perception that HIV is not as dangerous as it once was, (2) they are discouraged from seeking care due to their financial situation or low health literacy (the 2007 survey spoke to an overall poorer sample than did the 2004 survey), or (3) they are discouraged/prevented from seeking care by some aspect of the EMA's continuum of care.

5. RESULTS AND ANALYSIS

As stated in section 3.1, the 2007 consumer survey was based on the one given in 2004, with only slight changes in the wording of some questions and a different ordering of service-category-related questions. (This changed order was simply in response to the reorganization of categories by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 into "core medical" and "support" services.) This section presents respondents' answers to the service-category questions, which focused on service demand, utilization and barriers to care. The survey asked about each service category eligible for funding in the Baltimore EMA, whether currently funded or not.

5.1 Service Demand and Unmet Need

Every service-category section in the 2007 survey contained at least the following three questions (paraphrased here).

1. Do you need this service?
2. Have you received this service in the last 12 months?
3. If you need but are not receiving this service, why?

As used in this report, the term "service demand" refers to a respondent's answering "yes" to the first of these questions, i.e., indicating the belief that he or she needs the service in question. "Unmet demand" exists when a respondent who needs the given service answers "no" to the second question. "Barriers to care" are whatever circumstances that prevented the respondent from obtaining the service, i.e., the answer to the third question.[9]

When considering the answers to these questions, it is important to remember that respondents were self-reporting their needs. Their opinions concerning their needs for particular services may differ from what a medical provider might recommend, and some respondents may also have reported "needing" a service for which they were not actually eligible, despite interviewers' best efforts to avoid such misunderstandings. While the latter circumstance does not necessarily disprove "need" in the abstract, it does mean that it would be inaccurate to describe this need as "unmet" relative to the Ryan White continuum of care, as it would in fact not be possible for Ryan White service providers to meet it. At any rate, the unmet demand found in this study needs to be understood as no more than an estimation.

Some readers may be familiar with two HRSA terms that seem relevant here, "unmet need" and "service gaps" (both mentioned earlier in this report). As explained in section 1.1, "unmet need" is HRSA's term for PLWH/As who are not receiving primary medical care (being HIV positive, their "need" for this service is considered implicit), while "service gap" refers to PLWH/As who are in primary medical care but are not receiving some other type of HIV-related service that they need (e.g., medical transportation, substance-abuse treatment, etc.); a separate "service gap"

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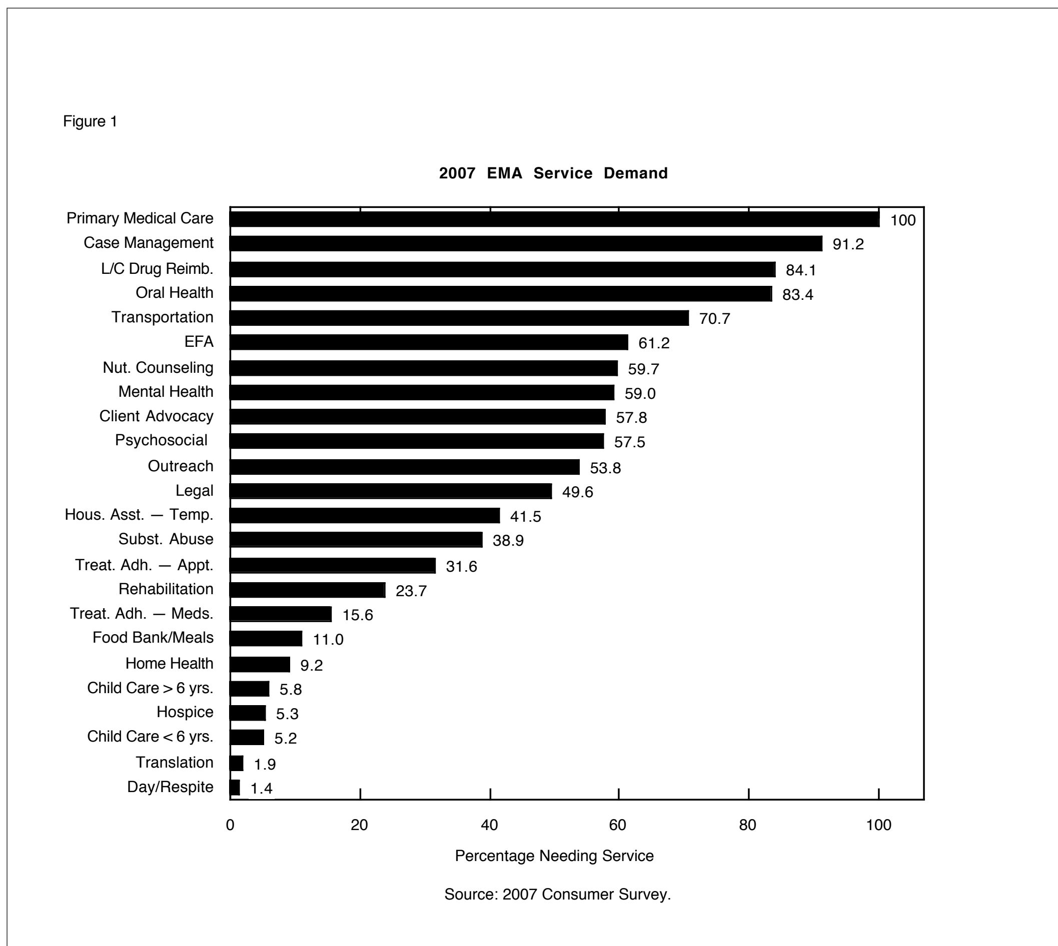
[9] It is worth noting that, while the first question asks about the respondent's *present* need, the second question asks about service utilization in the *past*, specifically the 12 months prior to survey administration. This opened the door for respondents to indicate to the interviewers that they "needed" a particular service at the time the interview was being conducted, but to give — as their reason for not having obtained the service in the prior 12 months — the answer that they had not needed it *then*. As a result, there is some ambiguity in the survey's findings of unmet demand, since this line of questioning was really conceived to capture need that *both* existed *and* was not met during the previous 12 months. Any instances where this problem was pronounced are indicated in the service-category sections below.

would exist for each individual service needed but not being received. The attentive reader will have noted that HRSA's terms carry meanings similar to how the term "unmet demand" was described above. This report uses the term "demand" so as to avoid having to distinguish between "unmet need" (for primary medical care) and "service gaps" (for everything else), as well as to emphasize that this survey's findings are based on *self-reported* need and so should be interpreted with more caution than if such need had somehow been independently assessed and verified in terms of eligibility and service definitions.

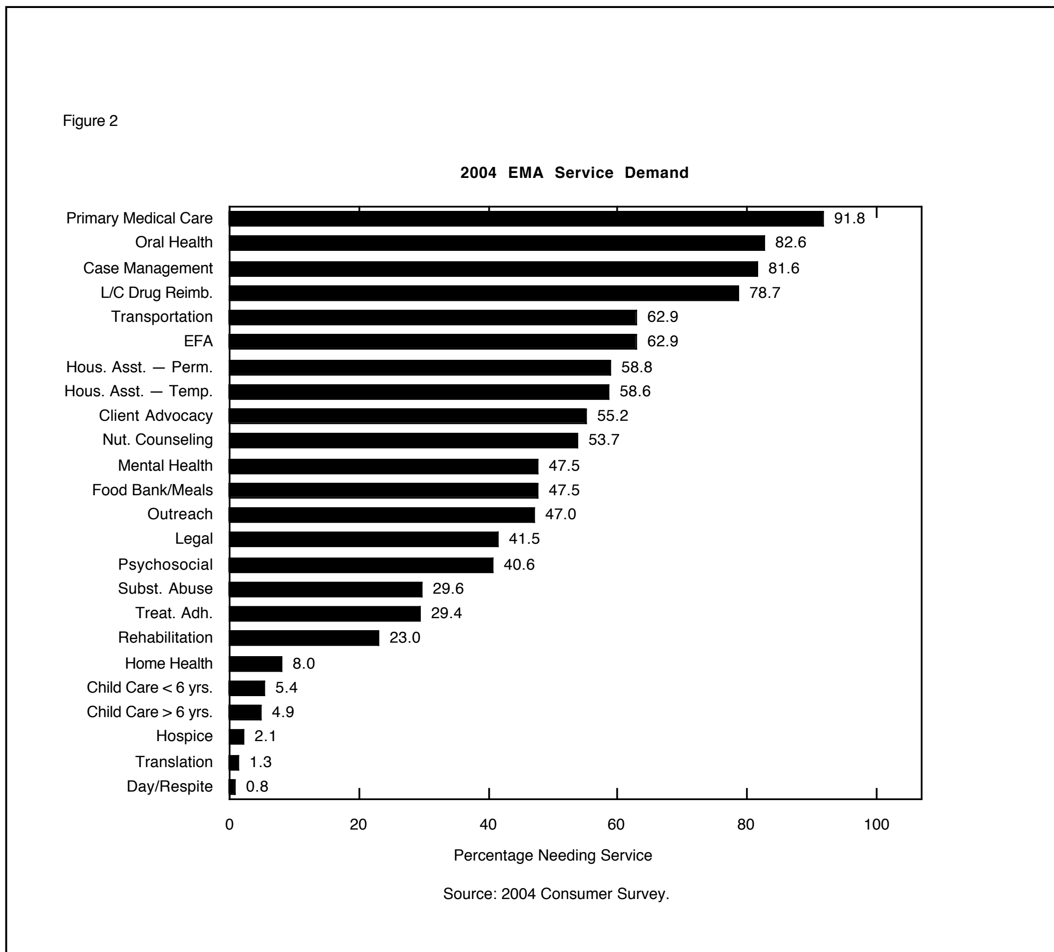
5.1.1 Service Demand

Figure 1 shows the levels of demand that the 2007 survey found for each service category, as a proportion of all 730 EMA respondents. There are 24 categories listed in figure 1 (although please note that the single category known as "treatment adherence" is here presented as though "treatment adherence — appointments" and "treatment adherence — medications" were two separate categories, which is not in fact the case). Out of these 24 categories, demand was above 50 percent in 11 of them.



As mentioned earlier, all PLWH/As are considered for planning purposes to "need" primary medical care, therefore the "demand" for this category was automatically 100 percent (as was the

related subcategory of obstetric/gynecological care).[10] The service with the second-highest demand was case management (91.2 percent), followed by the local/consortium drug reimbursement program (84.1 percent) and oral-health care (83.4 percent). The three least-demanded services were child care for children under 6 (5.2 percent), translation services (1.9 percent) and day/respite care (1.4 percent).



The similarities between the 2004 and 2007 survey instruments allow for comparison and, therefore, give a glimpse of the evolving needs of the EMA's PLWH/As. Figure 2 presents service-demand levels found by the 2004 survey. Comparing figure 1 to figure 2, demand increased in about 80 percent of the 21 comparable categories.[11] The most marked increases

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[10] Demand levels for all other non-primary-medical care categories were as reported by respondents, although in several categories interviewers asked not simply whether the respondent "needed" the service but rather whether a certain qualifying condition existed, as explained in more detail in the relevant service-category sections below.

[11] Though both figures list 24 categories, they are not all comparable because (1) the 2004 survey asked about demand for assistance finding permanent housing, while the 2007 survey asked only about temporary housing assistance, and (2) as mentioned earlier, the 2007 survey broke treatment adherence into two subcategories, while the 2004 survey asked about treatment adherence as a single category.

occurred in psychosocial services (an increase of 16.9 percentage points), mental health (an increase of 11.5 percentage points) and case-management services (an increase of 9.6 percentage points) (IGS 2005a).

Decreases in demand, meanwhile, occurred in four categories. Demand for emergency financial assistance (EFA) dropped slightly, from 62.9 percent in 2004 to 61.2 percent in 2007. There was an even smaller decrease in demand for child care for children under six, from 5.4 percent in 2004 to 5.2 percent, which is interesting in light of the fact that child care for children *over* six *increased* by 0.9 points, from 4.9 percent to 5.8 percent (IGS 2005a). And demand for temporary housing assistance plummeted 17.1 percentage points, from 58.6 percent in 2004 to 41.5 percent in 2007.

The most apparently dramatic decrease occurred within the "food bank and home-delivered meals" category, where demand seems to have dropped from 47.5 percent in 2004 to 11.0 percent in 2007. However, this decrease is probably almost entirely explained by one of the wording changes between the two survey versions mentioned earlier. The 2004 survey question for this service category simply asked respondents if they thought they needed free groceries or pre-cooked meals, and almost half (47.5 percent) of the 603 EMA-wide respondents said they did (IGS 2005a). The problem was that the 2004 wording of this question failed to capture respondents' *medical* need — i.e., whether they were *physically unable* to shop and/or cook for themselves — which is the defining eligibility requirement for receiving this service. For the 2007 survey, this service-category section was reworded to first ask respondents whether they had physical difficulty shopping for groceries or cooking, and it was to this entirely different question that such a smaller proportion of respondents answered in the affirmative.

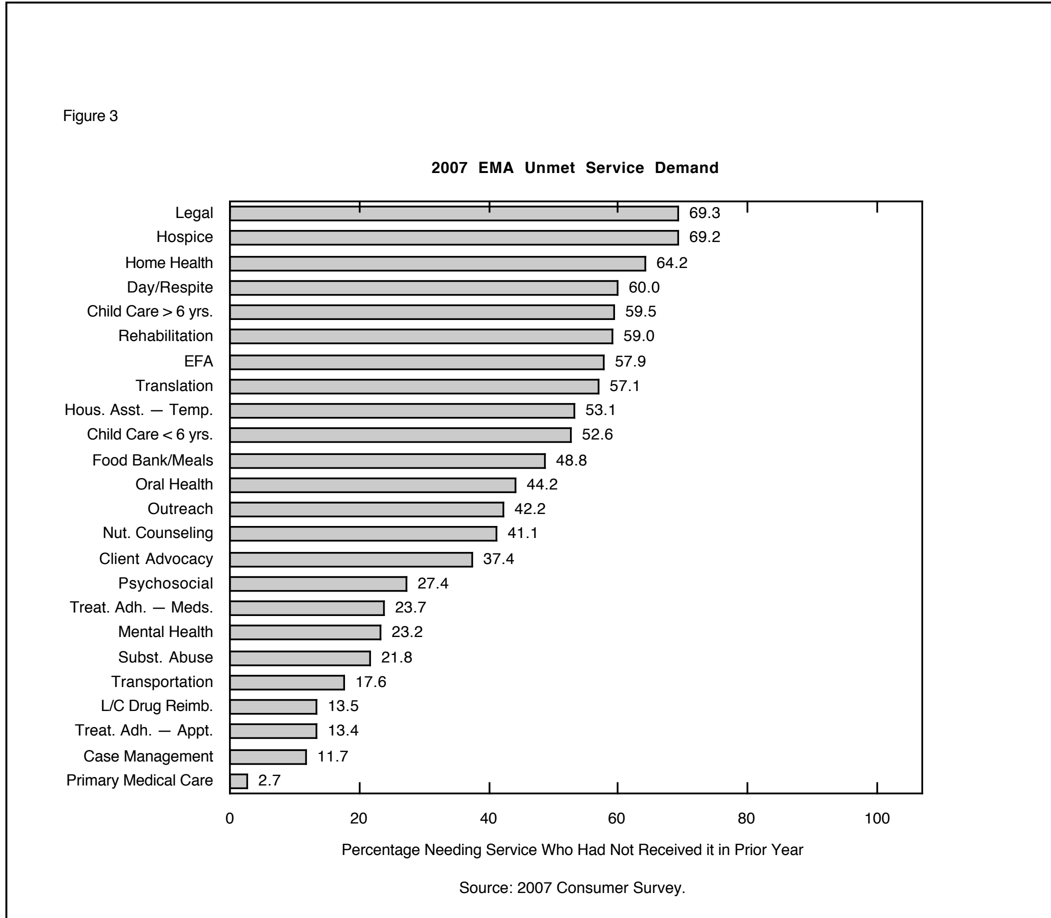
5.1.2 Unmet Service Demand

As mentioned earlier, once respondents expressed a need for a given service, they were then asked if they had received that service. Unmet service demand was then calculated by dividing (1) the number of respondents who said they needed but had not received the service by (2) the total number of respondents who indicated a need for the service. Figure 3 displays the service categories, this time ranked according to the proportion of respondents reporting unmet demand. At this point, it is important to emphasize that a high level of unmet demand does not necessarily imply that a large *number* of respondents failed to receive the service but, rather, only that a large proportion of those who expressed a need (however many or few) did not receive that service. For example, only 10 EMA-wide respondents (1.4 percent) expressed a need for day/respite care. Of those 10, 6 did not receive the service, which translates into a 60-percent unmet-demand level, the fourth highest out of all the categories. Yet the number of affected respondents — six — was really very small.

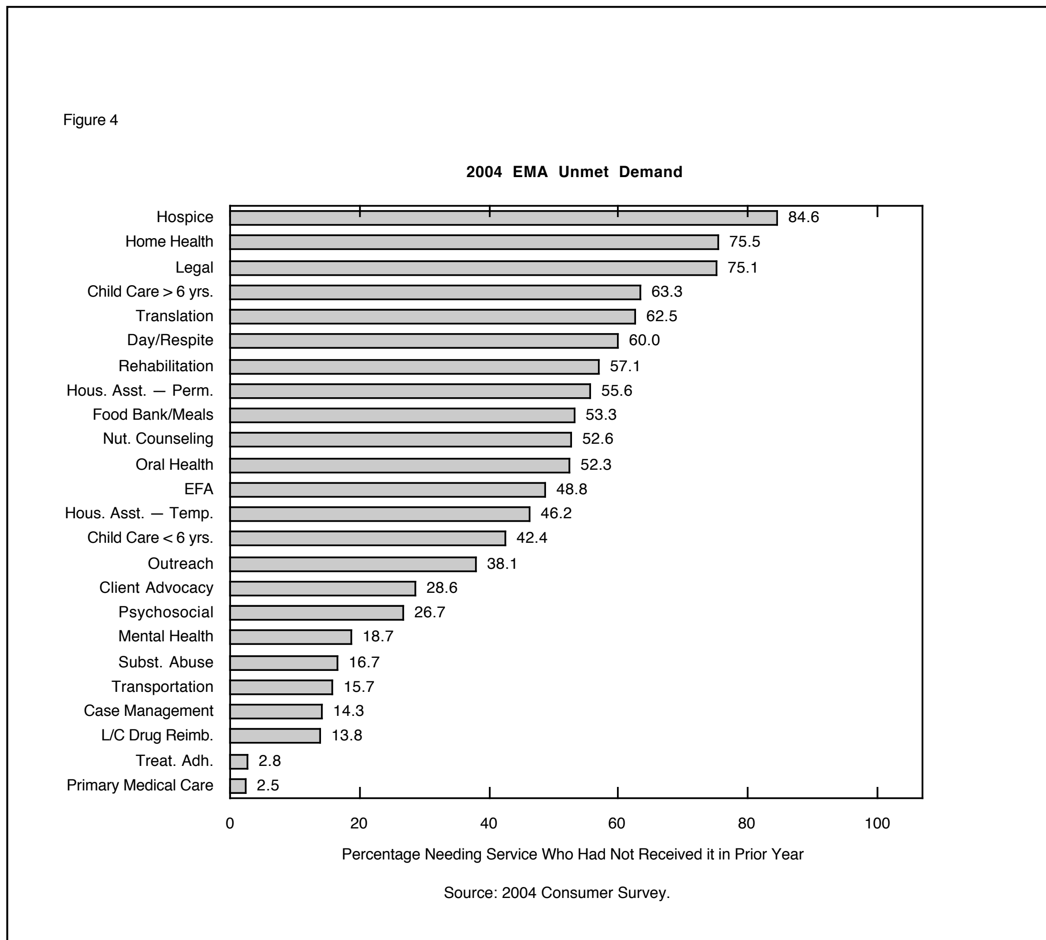
The three categories with the highest level of demand, shown earlier in figure 1, were — reassuringly — at the bottom in terms of *unmet* demand: primary medical care had the lowest unmet-demand level, at only 2.7 percent; case management the second lowest, at 11.7 percent; and local/consortium drug reimbursement the fourth lowest, at 13.5 percent. Less reassuringly, oral-health care, the category that had the fourth highest demand (see figure 1), is toward the middle of the pack in terms of unmet demand, with 44.2 percent of the respondents who said they needed this service not receiving it. Ten categories had levels of unmet demand over 50 percent, the highest of which were legal services (69.3 percent), hospice services (69.2 percent) and home health services (64.2 percent).

> *"The three categories with the highest level of demand were — reassuringly — at the bottom in terms of* unmet *demand."*

Interestingly, rates of unmet demand decreased since 2004 in 10 out of the 21 comparable categories (and remained level in 1), as can be seen by comparing figure 3 (2007 unmet demand) with figure 4 (2004 unmet demand). For example, though legal services moved from third to first place in unmet-demand ranking between 2004 and 2007, this was despite the fact that the level of unmet demand for this service actually *decreased*. It was simply the case that unmet demand for the two categories that were in first and second place on the 2004 survey decreased even more than that for legal services. Unmet demand for legal services in 2004 was 84.6 percent; in 2007, and, though it is now in first place, legal services' unmet-demand level was lower at 69.3 percent.



That decreases have been seen in so many categories' unmet-demand levels shows good progress toward meeting the service demands of the EMA's Ryan White consumers. However, the majority of comparable categories saw *increases* between 2004 and 2007, some of them rather large. Proportionally speaking, the biggest increase was in unmet demand for substance-abuse treatment, which jumped by about a third, from 16.7 percent in 2004 to 21.8 percent in 2007. A nearly identical proportional increase — also about a third — occurred in client advocacy (from 28.6 to 37.4 percent), followed by jumps of about a quarter in child care for children under 6 (from 42.4 to 52.6 percent), about a fifth in EFA (from 48.8 to 57.9 percent) and about a seventh in temporary housing assistance (from 46.2 to 53.1 percent).



5.2 Service Demand and Utilization by Category

The following subsections present survey results for each service category.

5.2.1 Primary Medical Care

The primary-medical-care section of the survey was unusual in that it asked questions not only about a main category — primary medical care — but also two sub-categories, obstetric/gynecological care and specialty care. And unlike virtually every other category, demand levels in all three were based not on self-reporting but rather on external, non-subjective factors, as explained in each subsection below.

5.2.1.1 Primary Medical Care

Primary medical care for HIV/AIDS was defined as care administered by a doctor, physician's assistant or nurse specifically for the treatment of HIV disease. Respondents were not asked if they thought they needed primary medical care; their need was considered implicit in their HIV-positive status. Only 18 of the 730 EMA-wide respondents (2.5 percent) were not receiving primary medical care, and all of these resided in Baltimore City.

Table 16

Primary Medical Care Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction (100% Need Assumed)*	*Needed but Not Received (n)*	*Needed but Not received (%)*
EMA	730	18	2.5%
Baltimore City	603	18	3.1%
Counties Only	127	0	0

Source: 2007 Consumer Survey.

Of the 127 respondents from the counties who received primary medical care, about 57 percent did so at their county health departments, about 30 percent at the Johns Hopkins University's Moore Clinic, about 20 percent at the University of Maryland's Evelyn Jordan Center and the remaining approximately 12 percent at Chase Brexton Health Services, Inc. (The proportions do not add to 100 because some respondents received care from multiple providers.)

There were 15 respondents interviewed who did not live in the Baltimore EMA for most of the previous 12 months (referred in this report to as non-EMA respondents). Of these non-EMA respondents, 13 had received primary medical care, 10 of them in the EMA (8 in Baltimore City, 1 in Baltimore County and 1 in Queen Anne's County). Of the two who did not receive care in the preceding year, one had moved to the EMA just prior to sitting for the survey, and the other had only recently been released from prison.

5.2.1.2 Obstetric and Gynecological Care

Obstetric and gynecological (OB/GYN) care, a component of primary medical care, was defined to respondents as services provided specifically to women by a medical professional (doctor, physician's assistant, obstetrician or gynecologist). All respondents were asked if they were receiving OB/GYN care, as interviewers were trained to make no assumptions about a respondent's sex based on appearance. Similar to primary medical care, demand for this service was assigned, this time on the presumption that all respondents who identified themselves as

female needed OB/GYN care. Therefore, since 40.1 percent of EMA-wide respondents were female (293 respondents), this report assumes a 40.1-percent service demand for OB/GYN care.

Table 17

OB/GYN Care Demand and Utilization

Jurisdiction	Female Respondents per Jurisdiction	Did Not Receive Care (n)	Did Not Receive Care (%)
EMA	293	47	16.0%
Baltimore City	242	43	17.8%
Counties Only	51	4	7.8%
Source: 2007 Consumer Survey.			

Of the 293 female EMA-wide respondents, 47 (16 percent) had not received OB/GYN care in the last 12 months. Compared to the EMA-wide results, the percentage of Baltimore City women with an unmet demand for OB/GYN care was slightly higher (17.8 percent). The proportion of unmet demand in this category had increased since 2004 by 1.2 percentage points in the EMA and 4.0 percentage points in Baltimore City. Unmet demand for OB/GYN care in the counties, however, decreased by more than half, from 18.8 percent in 2004 to 7.8 percent in 2007 (IGS 2005a).

When respondents who had not received OB/GYN care were asked why not, 23.4 percent said that they did not feel they needed it. While the proportion of women who felt they did not need this service has declined since the 2004 survey, when 34.1 percent cited this as their primary reason for not accessing OB/GYN care, these numbers remain high and suggest that many women may not understand the potentially life-and-death importance of such care (IGS 2005a).

5.2.1.3 Specialty Care

Specialty health care was defined as care provided by a medical professional trained in a specific area of medicine, such as cardiology or dermatology. For this service, demand was determined not by self-assessment, but instead by asking respondents if they had been referred for specialty

Table 18

Specialty Care Demand and Utilization

Jurisdiction	Respondents per Jurisdiction	Total Needing Service	Needed but Not Received (n)	Needed but Not Received (%)
EMA	730	289	48	16.6%
Baltimore City	603	229	40	17.5%
Counties Only	127	60	8	13.3%
Source: 2007 Consumer Survey.				

care by their doctors. There were 289 EMA respondents who had received such referrals, 48 of whom had not received the recommended care (16.6 percent). As with OB/GYN care, this unmet demand was greater among Baltimore City respondents (17.5 percent) than in the counties (13.3 percent). Comparing these results to those of the 2004 survey, the most striking change in unmet demand for specialty care occurred in the counties, where it declined from 22.1 percent in 2004 to 13.3 percent in 2007 (IGS 2005a).

When respondents who had not received specialty care despite a doctor's referral were asked why, 10.4 percent stated that they did not feel they needed the care. This highlights that, despite receiving advice from health-care professionals, there is still a population of consumers who base their health-care decisions on their own assessment of need, not their physicians'. It is not clear how the system can address this. Other leading barriers respondents cited were inability to afford the co-payment (10.4 percent) and not wanting the service (8.3 percent).

5.2.2 Oral Health

Oral-health services are those provided by dentists, dental specialists, hygienists or dental assistants. When asked if they felt they needed oral-health care, 609 respondents in the EMA answered yes. However, almost half (44.2 percent) of those in need had not received the service in the year before the survey. Similar results were evidenced among both Baltimore City and counties respondents, with over two fifths of their total respondents (44.8 percent and 41.4 percent, respectively) citing an unmet demand for oral health care. The proportion of EMA-wide

Table 19

Oral-health Care Demand and Utilization

Jurisdiction	Respondents per Jurisdiction	Total Needing Service	Needed but Not Received (n)	Needed but Not Received (%)
EMA	730	609	269	44.2%
Baltimore City	603	498	223	44.8%
Counties Only	127	111	46	41.4%

Source: 2007 Consumer Survey.

respondents who needed but did not receive oral-health care in 2007 was lower than that in the 2004 survey (44.2 percent in 2007 compared to 52.2 percent in 2004), suggesting that, while unmet demand remains high, there has been some improvement in oral-health service delivery since the 2004 survey (IGS 2005a). Of the EMA-wide respondents with unmet demand for this service, 25.0 percent stated that they did not know how to acquire oral health care, while another 15.0 percent said they could not afford the co-payment.

5.2.3 Mental Health

Mental-health care was defined as services for people with psychological problems such as depression, anxiety, schizophrenia or bipolar disorder.

Well over half of the respondents (about 59 percent) felt they needed mental-health services, up from 47.5 percent in 2004. Over one fifth of these (23.2 percent EMA-wide, 23.5 percent in Baltimore City and 21.5 percent in the counties) indicated an unmet demand, an overall increase from 2004 levels, which were 18.7 percent EMA-wide, 18.9 percent in Baltimore City, and 17.9 percent in the counties (IGS 2005a). When those expressing unmet demand were asked why they had not received this service, 23 percent felt they had not needed it at the time but did need it now,[12] while 12 percent said they were either unaware of or did not know how to access mental-health services.

[12] As mentioned earlier, the fact that the "do you need this service" question was in the present tense, while the "have you received…" and "if not, why not" questions referred to the prior 12 months, allowed respondents to say that, while they needed a given service *at the time of survey administration*, they had not received it in the previous year because they had not needed it *then*.

Table 20

Mental-health Care Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not received (%)*
EMA	730	431	100	23.2%
Baltimore City	603	366	86	23.5%
Counties Only	127	65	14	21.5%

Source: 2007 Consumer Survey.

Finally, 39 EMA-wide respondents indicated that they were receiving medications for a mental-health disorder, but were not receiving any accompanying mental-health services, a circumstance not considered to be a best practice in that field. Of these 39 respondents, 24 said they received their medication from a primary-care physician and 4 from a mental-health provider.

5.2.4 Substance-abuse Treatment

Substance-abuse treatment was defined as medical care or counseling to treat problems associated with alcohol or drug use (legal or illegal). There were 284 EMA-wide respondents indicating a need for treatment, and about 90 percent of them resided in Baltimore City (257). There were only 27 respondents in need of this service in the counties, but unmet demand was greater there than in the city (25.9 percent of counties respondents compared to 21.4 percent of city respondents). Of the EMA-wide respondents who needed this service, 62 (21.8 percent) had not received it in the prior 12 months; 8 of these respondents were also not receiving primary medical care.

Table 21

Substance-abuse Treatment Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	284	62	21.8%
Baltimore City	603	257	55	21.4%
Counties Only	127	27	7	25.9%

Source: 2007 Consumer Survey.

When asked why they had not received treatment, around 30 percent said they were still abusing drugs, and about a quarter said that they had not felt they needed it until too recently to have sought it out yet. Another 21 percent stated that they had not felt “ready” to begin treatment.

Compared to the 2004 survey results, the proportion of respondents in need of substance-abuse treatment in Baltimore City increased significantly, from 34.0 percent in 2004 to 42.6 percent in 2007, as did the city’s unmet service demand, which rose from 14.4 percent to 21.4 percent. Demand for this service among counties respondents increased from 19.3 to 21.4 percent, although unmet demand decreased (29.6 percent in 2004; 25.9 percent in 2007). The sizable increases in both demand and, in the city, unmet demand for this service — combined with the

fact that IDU is a leading transmission mode in the EMA — suggests that substance abusers must remain a population of particular focus in future planning.

5.2.5 Case Management

Case management was defined as a service that helps consumers plan, coordinate and receive all other needed services. Almost all of the respondents indicated a need for case management (91.2 percent, EMA-wide; 91.5 percent, Baltimore City; 89.8 percent, counties). Unmet demand for this service was relatively low: only 78 respondents (11.7 percent EMA-wide) stated that they needed case management but were not receiving it. Further analysis revealed that, of these 78 respondents, 67 (85.8 percent) reported having received primary medical care in the previous 12 months. Additionally, 53.7 percent of these in-care respondents who had not received case management stated that they did not know how to obtain such services, suggesting a possible missing link between primary-medical-care providers and case-management services.

Table 22

Case Management Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	666	78	11.7%
Baltimore City	603	552	75	13.6%
Counties Only	127	114	3	2.6%

Source: 2007 Consumer Survey.

Unmet demand for case management was greater among city residents than county residents (13.6 percent in the city compared to 2.6 percent in the counties). Unmet EMA demand in this category has declined since the 2004 survey, from 14.3 percent in 2004 to 11.7 percent in 2007 (IGS 2005a). However, a gap seems to remain even among those PLWH/As who are in care and should therefore have been referred to case management upon intake or soon thereafter .

5.2.6 Treatment Adherence

Treatment adherence consists of appointment and medication reminders intended to help consumers follow their treatment regimens. Some providers conduct these services as a matter of course, but — as with all categories — it was stressed by interviewers that respondents should indicate whether they felt they needed these reminders, regardless of whether or not they were receiving them.

Table 23

Treatment Adherence Demand and Utilization (Appointment Reminders)

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	231	31	13.4%
Baltimore City	603	193	29	15.0%
Counties Only	127	38	2	5.3%

Source: 2007 Consumer Survey.

Of the 231 EMA-wide respondents (31.6 percent) who indicated a need for appointment reminders, 13.4 percent said they had not received the service within the previous 12 months. This unmet demand was greatest in Baltimore City, where 15.0 percent of respondents who indicated a need for appointment reminders said they had not received any. In the counties, however, there was only a 5.3 percent unmet demand.

Table 24

Treatment Adherence Demand and Utilization (Medication Reminder)

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	114	27	23.7%
Baltimore City	603	104	25	24.0%
Counties Only	127	10	2	20.0%

Source: 2007 Consumer Survey.

Although there was a greater demand for appointment reminders (31.6 percent) than for medication reminders (15.6 percent) among EMA-wide respondents, the unmet demand for medication reminders was greater than that for appointment reminders (unmet demand for medication reminders: 23.7; unmet demand for appointment reminders: 13.4 percent). This was also true for the city's unmet-demand levels for the two types of reminders (medication reminders: 24.0; appointments: 15.0 percent), but it was most pronounced in the counties (medication reminders: 20.0 percent; appointment reminders: 5.3 percent).

The most common barrier to receiving treatment adherence services was not knowing how to do so, as reported by almost half (48.0 percent) of the EMA respondents. One possible barrier that the survey did not investigate was how readily reachable respondents were by telephone. Many respondents were homeless or living in temporary quarters, for example, and might reasonably be supposed to have been lacking not only personal telephone service but also any reliable way of receiving messages. Such a circumstance would of course pose formidable obstacles to any provider attempting to reach such respondents with appointment or medication reminders.

5.2.7 Client Advocacy

Client-advocacy services focus on providing short-term or urgent assistance for a single problem. This service may be provided by a peer or client advocate, social worker or other service provider. Client advocates offer advice for and assistance with obtaining support services but differ from case managers because they do not provide coordination or follow up on medical treatment (IGS 2003). Demand for client advocacy was reported by 57.8 percent of EMA-wide respondents, yet 37.4 percent of these had not received the service. Unmet demand for client advocacy was greater among Baltimore City respondents (38.7 percent) than among counties respondents (30.2 percent). Since the 2004 survey, unmet demand increased among EMA-wide respondents from 28.6 percent to 37.4 percent.

Table 25

Client Advocacy Demand and Utilization

Jurisdiction	Respondents per Jurisdiction	Total Needing Service	Needed but Not Received (n)	Needed but Not Received (%)
EMA	730	422	158	37.4%
Baltimore City	603	359	139	38.7%
Counties Only	127	63	19	30.2%

Source: 2007 Consumer Survey.

Of the 158 respondents who expressed unmet need for client advocacy, 120 stated that they did not know how to access this service even though they had received case management within the past year. Rather than a service gap, this may indicate a lack of understanding about client-advocacy services and how they overlap with those services provided under case management. Case managers often perform services that a client would otherwise have to seek from client advocates, meaning that consumers in case management may already be receiving the same services a client advocate would provide. Nonetheless, it seems doubtful that the unmet-demand level can be entirely chalked up to this sort of misunderstanding, as it seems unlikely that respondents would have expressed demand for this category if they felt that all of their needs in this area were being met.

Respondents were also asked if they thought they needed help reading documents or understanding paperwork, a need that could be addressed under client advocacy. Among EMA-wide respondents, 165 indicated a need for this assistance and, of these, 21.0 percent had not received it. When asked why, 12 people cited not knowing how to access assistance (of these 12 respondents, 3 had also reported receiving client-advocacy services and another 6 received case-management services). There were 16 respondents who expressed a need for these services that had arisen too recently for them to have sought such assistance yet.

5.2.8 Home Health Services

Home health care was defined to respondents as services provided in the home by a home health aide, caretaker, licensed nurse or other health-care professional. While only 9.2 percent of EMA-wide respondents expressed a need for this service, a striking 64.2 percent of these did not receive it. These proportions were similar between both city (9.8 percent demand, 62.7 percent unmet demand) and counties (6.3 percent demand, 75.0 percent unmet demand) respondents. Since 2004, overall EMA demand rose from 8.0 percent, and unmet demand decreased from 75.5 percent (IGS 2005a).

Table 26

Home Health Services Demand and Utilization

Jurisdiction	Respondents per Jurisdiction	Total Needing Service	Needed but Not Received (n)	Needed but Not Received (%)
EMA	730	67	43	64.2%
Baltimore City	603	59	37	62.7%
Counties Only	127	8	6	75.0%

Source: 2007 Consumer Survey.

Again, the self-reported nature of this study makes it difficult to differentiate between consumers' perceived need and an actual medical need as defined by the Ryan White program. Many respondents may have *felt* they needed the service, but in fact did not meet eligibility requirements. In that case, there would not be what HRSA would consider a "service gap." Of the EMA-wide respondents indicating an unmet demand for home health services, a plurality of 32.6 percent cited lack of knowledge as to how to access the service as their primary reason for not receiving it.

5.2.9 Medical Nutrition Therapy

Medical nutrition therapy was defined as menu planning, education about how consumers' diets and medications work together, evaluation of weight changes, and referrals to food programs such as the WIC (Women, Infants and Children) nutrition program. There was a large demand for this service, 59.7 percent EMA wide (436 respondents). In the city, 43.6 percent of those who

Table 27

Medical Nutrition Therapy Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	436	179	41.1%
Baltimore City	603	367	160	43.6%
Counties Only	127	69	19	27.5%

Source: 2007 Consumer Survey.

expressed a need did not receive the service, compared to the counties' unmet-demand level of only 27.5 percent. When asked about the barriers that had prevented them from accessing medical nutrition therapy, just over half of EMA respondents (51.4 percent) replied that they had not known how to access the service. By way of amplifying information, 72.0 percent of those respondents with unmet demand for medical nutrition therapy had annual incomes of $9,800 or less, and 10 percent also reported difficulty shopping for groceries and/or cooking for themselves.

5.2.10 Hospice Care

Hospice care was defined to respondents as room, board, nursing care, counseling and physician services for patients whose doctors have referred them due to their being in the final stages of a terminal condition. Such services are provided 24 hours a day in the client's home or a home-like

Table 28

Hospice Care Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	39	27	69.2%
Baltimore City	603	32	22	68.8%
Counties Only	127	7	5	71.4%

Source: 2007 Consumer Survey.

setting. Only 39 EMA respondents (5.3 percent) expressed a need for hospice care, but a majority of these consumers had not received the service, for an unmet-demand level of 69.2 percent.

However, there appears to have been some misunderstanding about eligibility. Only 2 of the 27 respondents who indicated unmet demand for this service had actually been referred for it by a doctor. Upon questioning as to the reason why these two doctor-referred respondents had not entered hospice care, one replied that he had not felt he needed the service, and the other cited ongoing illegal drug use. The other 25 respondents who indicated unmet demand for hospice services had been in care during the 12 months prior to the survey and, therefore, had had access to a doctor for a referral for this service (an eligibility requirement), suggesting that the 69.2-percent unmet-need figure is an over-estimation and that there was in reality very little service gap for hospice care.

5.2.11 Local/ Consortium Drug Reimbursement

Local/consortium drug reimbursement pays HIV/AIDS medication costs for consumers with no other funding source. To establish demand for this service, respondents were first asked if they thought they needed HIV/AIDS medication. Not surprisingly, demand was high: 84.1 percent EMA wide, 83.1 percent in Baltimore City and 89.0 percent in the counties.

Table 29

Local Consortium/Drug Reimbursement Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	614	83	13.5%
Baltimore City	603	501	75	15.0%
Counties Only	127	113	8	7.1%

Source: 2007 Consumer Survey.

Of particular interest in these responses were the proportions of people who said they needed but were not currently taking any HIV/AIDS medications: 13.5 percent of EMA respondents, 15.0 percent in Baltimore City and 7.1 percent of counties respondents. EMA wide, only 14.5 percent of those who were not taking HIV/AIDS medications were not in care.

Interviewers also asked respondents who pays for most of their medications. Among the 614 respondents taking medication for HIV/AIDS, the most commonly cited funding sources were Medicaid (36.4 percent), MADAP (21.8 percent), Medicare (7.8 percent), private insurance (6.7 percent) and Primary Adult Care (4.5 percent).

5.2.12 Rehabilitation Services

Rehabilitation services help maintain quality of life and improve one's ability to take care of oneself, especially after strokes and other injuries, or for people with degenerative conditions. These services may include physical or occupational therapy, speech therapy or low-vision training. While only 23 percent of the EMA-wide respondents expressed a need for rehabilitation services, 59.0 percent of these said they had not received any. The greatest unmet demand was reported among counties respondents (70.0 percent).

Table 30

Rehabilitation Services Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	173	102	59.0%
Baltimore City	603	153	88	57.5%
Counties Only	127	20	14	70.0%
Source: 2007 Consumer Survey.				

However, this high unmet need was experienced among only a small population (20 counties respondents in raw numbers) who were in need of rehabilitation services. The most common barrier to receiving these services was insufficient knowledge of how to access them, which was cited by 37.3 percent of EMA-wide respondents.

5.2.13 Outreach Services

Outreach workers attempt to locate PLWH/As and increase their awareness of available HIV-related services. Over half (53.8 percent) of the EMA-wide respondents indicated a need for outreach services and 166 (42.2 percent) reported unmet demand, an increase from the 2004 survey results (38.1 percent unmet demand). Among those 166 respondents with unmet demand, 58 respondents (34.9 percent) resided in the ZIP codes with the highest HIV/AIDS prevalence in Baltimore City (21215, 21217, 21218) (Flynn 2006). These respondents were asked why they thought they had not received services from outreach workers: 17 said they had never seen an outreach worker, while 23 replied that they had not known how to obtain outreach services, essentially the same answer where this category is concerned.

Table 31

Outreach Services Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	393	166	42.2%
Baltimore City	603	334	138	41.3%
Counties Only	127	59	28	47.5%
Source: 2007 Consumer Survey.				

These responses imply a service gap in areas that have some of the greatest need for outreach services, although it is worth asking if the design of the survey itself confuses the question of unmet demand for this service. Just as all PLWH/As are presumed to need primary medical care, perhaps no one who is in care should be asked if he or she is in need of outreach, a service that, after all, has the main goal of simply bringing PLWH/As into care in the first place. Regardless of each respondent's actual need for this service, however, it still seems significant that over 29 percent of respondents residing in the city's hardest-hit ZIP codes had never even *seen* outreach workers there.

5.2.14 Housing Services

Housing assistance was defined for respondents as short-term or emergency financial assistance with temporary or transitional housing, with the purpose of enabling the client to receive or maintain HIV-related medical care. There were 303 EMA-wide respondents who expressed a need for this service. Of these, more than half (53.1 percent) said they had not received it. The greatest unmet demand (56.3 percent) existed among counties respondents; however, it should be added that, in hard numbers, this was 18 of just 32 respondents. Nonetheless, this is a considerable proportional increase from 2004, when only 41.9 percent of counties respondents reported unmet housing-assistance demand (IGS 2005a).

Table 32

Temporary Housing Assistance Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	303	161	53.1%
Baltimore City	603	271	143	52.8%
Counties Only	127	32	18	56.3%

Source: 2007 Consumer Survey.

Among the respondents who had received temporary housing assistance within the past 12 months, about 17 percent received rent money to prevent eviction, and almost 80 percent were helped to enter transitional housing. The most commonly cited barrier to receiving this service was not knowing how to get it, cited by around 40 percent of the EMA respondents who needed this service.

Interviewers also asked respondents whether they had been provided information or otherwise helped by someone knowledgeable about permanent housing programs (local, state and/or federal) within the 12 months prior to the survey. There were 284 EMA-wide respondents who said that they had received this sort of assistance. Of those 284 respondents, 53 (18.7 percent) had been provided help with first month's rent and 210 (73.9 percent) had received advice on where to find or how to get permanent housing.

5.2.15 Emergency Financial Assistance (EFA)

Emergency financial assistance (EFA) helps consumers manage short-term, temporary crises by paying for food, utilities and/or medicines. Respondents residing in Baltimore City expressed the

Table 33

Emergency Financial Assistance Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	447	259	57.9%
Baltimore City	603	380	228	60.0%
Counties Only	127	67	31	46.3%

Source: 2007 Consumer Survey.

greatest demand for EFA, at 63.0 percent. Baltimore City also had the greatest unmet demand (60.0 percent), about an 11-percentage-point increase from 2004 (IGS 2005a). Respondents from the counties expressed lower unmet demand: of the 67 residents reporting a need for EFA, 46.3 percent had not received it. This 2007 unmet demand among counties respondents was down from 48.1 percent in 2004 (IGS 2005a).

Further analysis found that 76.4 percent of the 259 EMA-wide respondents with an unmet demand for EFA had annual incomes of less than $9,800. Not knowing how to acquire EFA was cited by 49.8 of respondents with unmet demand as the reason why they had not utilized the service, though almost all of these reported having received case-management services within the past year. In instances such as these, where widespread ignorance of how to obtain a service seems incongruous with high case-management utilization, it is unclear whether (1) the case managers are themselves ignorant of the service in question or (2) there is some communication breakdown between case managers and clients on the subject.

5.2.16 Medical Transportation

Medical transportation services assist PLWH/As in getting to medical or social-services appointments, whether by providing rides through special contractors or volunteers or by paying taxi and/or bus fare. Not surprisingly, given the Ryan White program's low-income clientele, there is high demand for transportation services: 70.7 percent of EMA-wide respondents reported this need (516 of 730 respondents).

Table 34

Medical Transportation Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	516	91	17.6%
Baltimore City	603	442	79	17.9%
Counties Only	127	74	12	16.2%

Source: 2007 Consumer Survey.

Unmet demand was relatively low (17.6 percent EMA-wide; 17.9 percent Baltimore City; 16.2 percent counties), but had increased slightly since 2004, when it was 15.7 percent EMA wide, 17.0 percent in Baltimore City and 11.6 percent in the counties (IGS 2005a). Transportation has long been known to providers as a particular barrier to counties residents receiving other services, so it is surprising that both demand and unmet demand were lower there (58.2 percent demand; 16.2 percent unmet) than in the city (73.3 percent demand; 17.9 percent unmet).

Among those with unmet demand, not knowing how to access medical transportation services was cited as a barrier by about half.

The survey also asked what forms of transportation respondents had used through this service in the past year. Public transportation was the most common form, utilized by 79.0 percent of EMA-wide respondents. Another 35.5 percent had used cabs, and 17.6 percent had ridden in medical vans. Volunteer drivers and HIV transportation services were least utilized (5.5 percent and 7.2 percent, respectively).

5.2.17 Child Care Services

This service provides temporary care for a consumer's HIV-infected or -affected child. Such care may be full time (several hours per day, every day), such as when the consumer needs help during an acute illness, or part-time (a few hours per week) to allow the consumer to go to medical or support-service appointments. Respondents were asked about their need for child care for children six years old and younger, as well as for children over six years old.

Table 35

Child Care Demand and Utilization (6 and Under)

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	38	20	52.6%
Baltimore City	603	33	17	51.5%
Counties Only	127	5	3	60.0%

Source: 2007 Consumer Survey.

Overall, demand for child care for both children six and under (5.2 percent) and children over six (5.8 percent) was low. However, unmet demand for both categories was relatively high, with over half of EMA-wide respondents who indicated need for child care for either age group failing to receive it (52.6 percent for children six and under; 59.5 percent for children over six).

Table 36

Child Care Demand and Utilization (Over 6)

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	42	25	59.5%
Baltimore City	603	34	21	61.8%
Counties Only	127	8	4	50.0%

Source: 2007 Consumer Survey.

Among those who needed and utilized child-care services, the most commonly used service in both age groups was full-time day care when the respondent was sick (52.9 percent for children under six and 57.1 percent for children over six). Part-time day care to attend medical appointments was the next most popular (23.5 percent for children six and under; 35.7 percent for children over six).

5.2.18 Psychosocial Services

Psychosocial services were defined as support and counseling activities (such as support groups), pastoral care (counseling provided by a member of the clergy) and grief counseling (counseling for those whose loved ones have died). These services are available to PLWH/As, caregivers, family and household members to help them cope with any fear, anxiety, worry or loneliness they may feel as they face their own or a loved one's HIV diagnosis. Over half of the EMA respondents (57.5 percent, or 420 respondents) felt they needed psychosocial services. Of these, 27.4 percent had not received the service. The results among Baltimore City respondents were

similar, with an unmet demand of 26.0 percent. Unmet demand was much higher in the counties, however, with 35.6 percent of non-city respondents needing but not receiving psychosocial services. Unmet demand dropped slightly among Baltimore City respondents since 2004 (26.7 percent in 2004; 26.0 percent in 2007), but it increased by 8.7 percentage points among counties respondents (from 26.9 percent in 2004 to 35.6 percent in 2007) (IGS 2005a).

Table 37

Psychosocial Services Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	420	115	27.4%
Baltimore City	603	361	94	26.0%
Counties Only	127	59	21	35.6%

Source: 2007 Consumer Survey.

Among the EMA-wide respondents who had received psychosocial support, 190 (63.8 percent) had participated in educational groups and 147 (49.3 percent) in peer-to-peer groups; 67 (22.5 percent) had visited a drop-in center; and 60 (20.1 percent) had had pastoral or bereavement counseling.

5.2.19 Food Bank and Home-delivered Meals

As mentioned earlier, the category of food bank and home-delivered meals was carefully defined to respondents as the delivery of groceries, meals or nutritional supplements to consumers who are physically unable to shop and/or cook for themselves in the opinion of a physician. In a change from the 2004 survey's wording in this section, respondents were first asked if they had *physical difficulty* shopping for groceries or cooking. (The 2004 survey had simply asked respondents if they thought they needed free groceries or meals.) The purpose of this change was to differentiate between those who felt they needed free groceries or home-delivered meals for financial reasons and those who were actually *physically unable* for medical reasons to shop and/or cook for themselves. Only an affirmative answer to this initial question sufficed to establish demand for this service.

Of the 730 EMA-wide respondents, 80 (11.0 percent) stated that they had physical difficulty cooking or shopping for groceries. Almost half of those respondents (48.8 percent) had not received the service (i.e., food bank and home-delivered meals) within the past 12 months. There was a greater unmet demand among Baltimore City respondents for this service (50.7 percent) than among counties respondents (36.4 percent), though it bears repeating that in both cases overall need was quite small.

Table 38

Food Bank and Home-delivered Meals Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	80	39	48.8%
Baltimore City	603	69	35	50.7%
Counties Only	127	11	4	36.4%

Source: 2007 Consumer Survey.

Further analysis of the 39 EMA-wide respondents with unmet need for this service category revealed that 26 of them (66.7 percent) had received medical nutrition therapy and 4 (10.3 percent) reported having been admitted to the hospital more than five times in the past year. Of the 39 respondents with unmet demand, 17 said they did not know how to access the service. It is important to note that consumers must have a doctor's referral in order to receive these services. Therefore, the 48.8 percent unmet demand may indicate a service gap (low though the need may be in raw numbers), but it could also mean that the consumers' assessment of their own needs differed from their doctors'.

Of the 650 EMA respondents who did *not* express a need for food bank or home-delivered meals, 54 (8.3 percent) nonetheless reported receiving the service within the prior 12 months, an unexpected set of responses. It is possible that some of the clients who reported receiving this service in fact simply received meals brought to them by non-Ryan White charities or other organizations and confused this with the service category in question.

Given the wording changes in the question establishing need for this service, comparison with 2004 findings is not instructive.

5.2.20 Legal Services

HIV-related legal services were defined as assistance in the preparation of medically related legal documents such as wills, do-not-resuscitate orders and powers of attorney. It was emphasized to respondents that Ryan White legal services do not assist with bankruptcy or criminal charges.

Table 39

Legal Services Demand and Utilization

Jurisdiction	*Respondents per Jurisdiction*	*Total Needing Service*	*Needed but Not Received (n)*	*Needed but Not Received (%)*
EMA	730	362	251	69.3%
Baltimore City	603	294	206	70.1%
Counties Only	127	68	45	66.2%

Source: 2007 Consumer Survey.

Nearly half of all respondents in both the EMA and Baltimore City (49.6 percent and 48.8 percent, respectively) expressed a need for legal services, joined by more than half of the counties respondents (53.5 percent). Unmet demand among EMA-wide respondents (69.3 percent) and Baltimore City respondents (70.1 percent) had decreased since the 2004 consumer survey (from 75.1 percent EMA wide and 78.9 percent among Baltimore City respondents). However, the

unmet demand for legal services increased among counties respondents, from 64.7 percent in 2004 to 66.2 percent today (IGS 2005a). As with the majority of the service categories, the most common barrier to receiving this service was not knowing how to access it, cited by nearly half (48.6 percent) of the EMA-wide respondents.

5.2.21 Day/Respite Care

Day/respite care provides temporary professional care-giving assistance for a consumer in order to give that consumer's regular (i.e., non-professional) caregiver some time off. This service is offered either in the consumer's home or some other setting and may occur either during the day or overnight. To establish need for this service, interviewers asked respondents if they had a caregiver, such as a friend or family member. If not, this section of the survey was skipped; if yes, the interviewer proceeded with the standard series of questions.

Table 40

Day/Respite Care Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	10	6	60.0%
Baltimore City	603	9	5	55.5%
Counties Only	127	1	1	100%

Source: 2007 Consumer Survey.

Only 10 EMA-wide respondents indicated a need for day/respite care (1.4 percent). Although demand was low for this service, there was, on paper, high unmet demand (60 percent, or 6 respondents). In the city, there was 1.5 percent demand and 55.5 percent unmet demand. Only one counties respondent indicated a need for day/respite care; she had not received it. These results are nearly identical to those of the 2004 survey, which also found a 60.0 percent unmet demand, based on similarly low overall need (IGS 2005a). Overall, 33.3 percent of the EMA respondents indicating unmet need for day/respite care — that is, 2 of the 6 — said their reason was not knowing how to get it.

5.2.22 Translation Services

Professional translation services assist consumers who have difficulty speaking or understanding English (including those who communicate primarily through American Sign Language, or ASL) in communicating with service providers and understanding documents. (These services are distinct from receiving this kind of assistance from a friend or family member). Only 14 EMA

Table 41

Translation Services Demand and Utilization

Jurisdiction	***Respondents per Jurisdiction***	***Total Needing Service***	***Needed but Not Received (n)***	***Needed but Not Received (%)***
EMA	730	14	8	57.1%
Baltimore City	603	11	7	63.6%
Counties Only	127	3	1	33.3%

Source: 2007 Consumer Survey.

respondents (1.9 percent) indicated a need for translation services. However, 8 (or 57.1 percent) of these had not received these services within the prior 12 months. Interviewers obtained similar results from Baltimore City respondents: 1.8 percent demand, with 63.6 percent unmet.
Only 3 counties respondents expressed need for translation services (2.4 percent), and only 1 of these said this need had gone unmet. Unmet demand for this service has decreased since 2004, when it was 62.5 percent among EMA-wide respondents, 75.1 percent in Baltimore City and 50.3 percent among counties respondents (IGS 2005a).

5.3 Service Demand and Utilization by Location

Considering service utilization by jurisdiction is crucial to understanding the needs of PLWH/As in the EMA. In particular, it is very common for PLWH/As to cross from one jurisdiction to another in search of services, given the close proximity of the EMA's jurisdictions to each other. The following sections describe tables 42-49, which display service demand and utilization — including cross-border utilization — by jurisdiction.

Tables 42 and 43 show information for the suburban counties combined and for Baltimore City, respectively, the basic breakdown that was used throughout the service-category analyses presented earlier. Tables 44-49 present detailed information for each county, though they vary slightly from the city table, as explained further below. Each of these tables provides a variety of information, but most relevant to this section's purpose is the information tables 42-49 offer concerning the frequency with which respondents left their home jurisdictions to receive each service. Tables 42 (the counties) and 43 (the city) present this information in columns 7-10, which show, both in actual numbers and proportionally, how many times city residents received a given service either inside or outside the city.

Using table 42, it is possible — by scanning column 10 — to quickly see the rate at which counties respondents received care in the city. But since table 42 lumps all counties jurisdictions together (column 8), it conceals the extent to which respondents left one county to receive care in another.

Tables 43-49 offer the jurisdiction-level view. On table 43 (Baltimore City), which need only distinguish between "the city" and "the counties" to get at how often city residents left their home jurisdiction for care, one need only consult column 10 to answer this question: the higher the percentage in column 10, the higher the rate at which city residents obtained care from counties providers. Tables 44-49, however, require an additional pair of columns to communicate cross-jurisdictional service utilization, since — for the counties — it is necessary to know not only whether a respondent went to the city (column 7: actual numbers; column 8: percentage) but also whether he or she went to another county, shown here in columns 9 (actual numbers) and 10 (percentages). For convenience, tables 44-49 combine the percentages in columns 8 ("location received: Baltimore City") and 10 ("location received: other EMA counties") in a new column 11, which offers the quickest view of the rate at which a county's residents received each service some place other than their home jurisdiction, i.e., in either the city or some other county.

Therefore, though the table layouts vary somewhat, all contain information concerning the frequency of cross-jurisdictional service utilization in their right-most columns, column 10 on tables 42 and 43 and column 11 on tables 44-49.

The information in tables 42-49 concerning cross-jurisdictional service utilization was obtained by asking respondents, for each service category, the jurisdiction in which they received the

service.[13] A separate question, in the demographics section, asked how often and why each respondent left his or her jurisdiction to obtain services. Highlights from the responses to this latter question, which do not appear on tables 42-49, are described in the relevant jurisdiction sections below.

5.3.1 Counties Residents

There were 127 counties respondents, representing 17.3 percent of the total number of respondents EMA-wide. Overall, 75 counties respondents (59.1 percent) said they had entered the city to receive HIV services at least once in the 12 months prior to the survey, 30 of whom said they did this at least once a month. Of these 75, 14 went to the city because they thought the care better there than in their home jurisdictions, 13 said it was easier to get all services in the city and 8 felt more comfortable in the city.

As shown in column 10 of table 42, there were four service categories for which counties residents entered the city at rates of 50 percent or more: child care for children under 6 (100 percent received this service in the city), child care for children over 6 (75.0 percent), assistance with temporary housing (50.0 percent) and legal services (50.0 percent). But please note that the actual numbers of people represented by these percentages are quite small, in all cases fewer than a dozen people, as can be seen in column 9 of the table. More than one third of counties respondents also went to the city for primary medical care (41.3 percent), oral health care (39.3 percent), mental-health care (36.0 percent) and/or substance-abuse treatment (33.3 percent).

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[13] Note that the locations in which services were received are not mutually exclusive, as any one respondent may have received a given service more than once and, therefore, in more than one jurisdiction.

Table 42

Counties Residents' Service Demand and Utilization by Service Category*

Service Category	*1. EMA*	*2. Counties*	*3. Need Svc. (n)*	*4. Need Svc. (%)*	*5. Rec'd Svc. (n)*	*6. Rec'd Svc. (%)*	*7. Location Rec'd: Counties (n)*	*8. Location Rec'd: Counties (%)*	*9. Location Rec'd: B. City (n)*	*10. Location Rec'd: B. City (%)*
Primary Medical Care	730	127	127	100	126	99.2	76	60.3	52	41.3
Oral Health	730	127	111	87.4	61	55.0	33	54.1	24	39.3
Mental Health	730	127	65	51.2	50	76.9	33	66.0	18	36.0
Substance-abuse Treatment	730	127	27	21.3	18	66.7	12	66.7	6	33.3
Case Management	730	127	114	89.8	109	95.6	88	80.7	22	20.2
Treatment Adherence — Appointments	730	127	38	29.9	36	94.7	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	730	127	10	7.9	8	80.0	N/A	N/A	N/A	N/A
Client Advocacy	730	127	63	49.6	42	66.7	37	88.1	8	19.0
Home Health Care	730	127	8	6.3	2	25.0	2	100	0	0
Nutrition Counseling	730	127	69	54.3	50	72.5	38	76.0	13	26.0
Hospice	730	127	7	5.5	1	14.3	0	0	0	0
L/C Drug Reimbursement	730	127	113	89.0	102	90.3	N/A	N/A	N/A	N/A
Rehabilitation	730	127	20	15.7	6	30.0	N/A	N/A	N/A	N/A
Outreach	730	127	59	46.5	30	50.8	24	80.0	8	26.7
Housing Assistance — Temporary	730	127	32	25.2	14	43.8	8	57.1	7	50.0
EFA	730	127	67	52.8	34	50.7	28	82.4	8	23.5
Transportation	730	127	74	58.3	59	79.7	N/A	N/A	N/A	N/A
Child Care ≤6	730	127	5	3.9	2	40.0	0	0	2	100
Child Care >6	730	127	8	6.3	4	50.0	1	25.0	3	75.0
Psychosocial Services	730	127	59	46.5	38	64.4	31	81.6	9	23.7
Food Bank/Meals	730	127	11	8.7	7	63.6	5	71.4	2	28.6
Legal Services	730	127	68	53.5	22	32.4	14	63.6	11	50.0
Day/Respite Services	730	127	1	0.8	0	0	0	0	0	0
Translation	730	127	3	2.4	2	66.7	2	100	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.2 Baltimore City Residents

The 603 respondents from Baltimore City constituted 82.6 percent of the survey's total respondents. Of those 603 respondents, only 22 (3.6 percent) received some of their HIV services in another jurisdiction. Of those, nine reported feeling more comfortable in another jurisdiction, eight thought that care was better in another jurisdiction, four felt it was easier to get all needed services in a different jurisdiction, another four indicated that the services they needed were not all available in Baltimore City and two gave confidentiality concerns as their reason for seeking care outside Baltimore City. (Categories on this list are non-exclusive, as respondents were able to give multiple responses to this question.)

As can be seen in column 10 of table 43, rates of residents leaving the city for care were below 5 percent for every service category save substance-abuse treatment, which 5.3 percent of recipients received outside the city. After substance-abuse treatment, the next four categories that city residents were most likely to receive outside the city were outreach (4.7 percent), client advocacy (4.3 percent), mental-health care (4.0 percent) and legal services (3.5 percent). The only other categories with rates above 3.0 percent were case management (3.4 percent), temporary housing assistance (3.2 percent), primary medical care (3.1 percent) and oral-health care (3.0 percent).

Table 43

Baltimore City Residents' Service Demand and Utilization by Service Category*

Service Category	1. EMA Total	2. B. City Total	3. Need Svc. (n)	4. Need Svc. (%)	5. Rec'd Svc. (n)	6. Rec'd Svc. (%)	7. Location Rec'd: B. City (n)	8. Location Rec'd: B. City (%)	9. Location Rec'd: Counties (n)	10. Location Rec'd: Counties (%)
Primary Medical Care	730	603	603	100	585	97.0	558	95.4	18	3.1
Oral Health	730	603	498	82.6	270	54.2	259	95.9	8	3.0
Mental Health	730	603	366	60.7	273	74.6	259	94.9	11	4.0
Substance-abuse Treatment	730	603	257	42.6	188	73.2	165	87.8	10	5.3
Case Management	730	603	552	91.5	474	85.9	444	93.7	16	3.4
Treatment Adherence — Appointments	730	603	193	32.0	160	82.9	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	730	603	104	17.2	77	74.0	N/A	N/A	N/A	N/A
Client Advocacy	730	603	359	59.5	211	58.8	201	95.3	9	4.3
Home Health Care	730	603	59	9.8	21	35.6	19	90.5	0	0
Nutrition Counseling	730	603	367	60.9	204	55.6	188	92.2	6	2.9
Hospice	730	603	32	5.3	7	21.9	6	85.7	00	00
L/C Drug Reimbursement	730	603	501	83.1	421	84.0	N/A	N/A	N/A	N/A
Rehabilitation	730	603	153	25.4	61	39.9	N/A	N/A	N/A	N/A
Outreach	730	603	334	55.4	190	56.9	182	95.8	9	4.7
Housing Assistance — Temporary	730	603	271	44.9	126	46.5	119	94.4	4	3.2
EFA	730	603	380	63.0	145	38.2	134	92.4	4	2.8
Transportation	730	603	442	73.3	355	80.3	N/A	N/A	N/A	N/A
Child Care ≤6	730	603	33	5.5	15	45.5	15	100	0	0
Child Care >6	730	603	34	5.6	10	29.4	10	100	0	0
Psychosocial Services	730	603	361	59.9	260	72.0	246	94.6	6	2.3
Food Bank/Meals	730	603	69	11.4	33	47.8	33	100	0	0
Legal Services	730	603	294	48.8	85	28.9	79	92.9	3	3.5
Day/Respite Services	730	603	9	1.5	1	11.0	1	100	0	0
Translation	730	603	11	1.8	4	36.4	3	75.0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.3 Anne Arundel County

There were 15 survey respondents who resided in Anne Arundel County, 2.1 percent of all EMA respondents. Of those respondents, eight reported leaving the county for HIV services. The most commonly cited reasons for doing so were lack of availability of needed services (six respondents) and better care available elsewhere (four respondents).

As shown in table 44, column 11, Anne Arundel County respondents left their county to receive services in a total of twelve categories. The categories in which the largest proportions of recipients obtained service in another jurisdiction were substance-abuse treatment (100 percent of people who received the service, for a total of 2 respondents) and child care for children under 6 (also 100 percent, or 1 respondent), followed by primary medical care (53.3 percent, or 8 respondents), child care for children over six (50.0 percent, or 1 respondent), legal services (also 50.0 percent, or 2 respondents), mental-health care (44.2 percent, or 4 respondents), oral-health care (40.0 percent, or 2 respondents), temporary housing assistance (33.3 percent, or 1 respondent), case management (30.8 percent, or 4 respondents), outreach (25.0 percent, or 1 respondent), client advocacy (16.7 percent, or 1 respondent) and nutrition counseling (12.5 percent, or 1 respondent).

Table 44

Anne Arundel County Residents' Service Demand and Utilization by Service Category*

17 Total Respondents in Anne Arundel County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Anne Arundel County (n)*	*6. Loc. Rec'd: Anne Arundel County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	15	100	15	100	7	46.7	8	53.3	0	0	53.3
Oral Health	12	80.0	5	41.7	3	60.0	2	40.0	0	0	40.0
Mental Health	11	73.3	9	81.8	4	44.4	3	33.3	1	11.1	44.2
Substance-abuse Treatment	2	13.3	2	100	0	0	1	50.0	1	50.0	100
Case Management	13	86.7	13	100	9	69.2	3	23.1	1	7.7	30.8
Treatment Adherence — Appointments	7	46.7	7	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	4	26.7	4	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	8	53.3	6	75.0	5	83.3	1	16.7	0	0	16.7
Home Health Care	2	13.3	1	50.0	1	100	0	0	0	0	0
Nutrition Counseling	9	60.0	8	88.9	7	87.5	0	0	1	12.5	12.5
Hospice	1	6.7	0	0	0	0	0	0	0	0	0
L/C Drug Reimbursement	14	93.3	13	92.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	1	6.7	1	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outreach	7	46.7	4	57.1	3	75.0	1	25.0	0	0	25.0
Housing Assistance — Temporary	5	33.3	3	60.0	2	66.7	0	0	1	33.3	33.3
EFA	8	53.3	5	62.5	5	100	0	0	0	0	0
Transportation	10	66.7	8	80.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	1	6.7	1	100	0	0	1	100	0	0	100
Child Care >6	2	13.3	2	100	1	50.0	1	50.0	0	0	50.0
Psychosocial Services	6	40.0	4	66.7	4	100	0	0	0	0	0
Food Bank/Meals	2	13.3	1	50.0	1	100	0	0	0	0	0
Legal Services	6	40.0	4	66.7	2	50.0	2	50.0	0	0	50.0
Day/Respite Services	1	6.7	0	0	0	0	0	0	0	0	0
Translation	0	0	0	0	0	0	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.4 Baltimore County Residents

Most of the counties respondents — 53 of them, or 41.7 percent — resided in Baltimore County. Of these, 36 (67.9 percent) reported leaving Baltimore County for services. The reasons cited most frequently for doing so were easier access to services elsewhere (nine respondents) and unavailability of needed services in the county (seven respondents).

As shown in table 45, column 11, Baltimore County residents received 14 categories of services in another jurisdiction. Once again, child care for children under 6 was one of the most likely services to be sought elsewhere, along with child care for children over 6 and food bank/home-delivered meals: all three categories saw 100 percent of respondents who received this service obtaining it elsewhere, although in each case this represented only one respondent. These 3 categories were followed by temporary housing assistance (66.7 percent, or 4 respondents), nutrition counseling (63.2 percent, or 12 respondents), mental-health care (62.6 percent, or 10 respondents), primary medical care (59.6 percent, or 31 respondents), substance-abuse treatment (57.1 percent, or 4 respondents), EFA (50.0 percent, or 4 respondents), oral-health care (45.5 percent, or 10 respondents), psychosocial services (40.0 percent, or 6 respondents), case management (38.1 percent, or 16 respondents), outreach (37.5 percent, or 3 respondents) and client advocacy (30.0 percent, or 3 respondents).

Table 45

Baltimore County Residents' Service Demand and Utilization by Service Category*

53 Total Respondents in Baltimore County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Balt. County (n)*	*6. Loc. Rec'd: Balt. County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	53	100	52	98.1	19	36.5	29	55.8	2	3.8	59.6
Oral Health	43	81.1	22	51.2	11	50.0	10	45.5	0	0	45.5
Mental Health	23	43.4	16	69.6	7	43.8	9	56.3	1	6.3	62.6
Substance-abuse Treatment	9	17.0	7	77.8	4	57.1	4	57.1	0	0	57.1
Case Management	46	86.8	42	91.3	25	59.5	15	35.7	1	2.4	38.1
Treatment Adherence — Appointments	11	20.8	9	81.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	3	5.7	3	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	17	32.1	10	58.8	7	70.0	3	30.0	0	0	30.0
Home Health Care	1	1.9	1	100	1	100	0	0	0	0	0
Nutrition Counseling	29	54.7	19	65.5	8	42.1	11	57.9	1	5.3	63.2
Hospice	2	3.8	1	50.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
L/C Drug Reimbursement	43	81.1	35	81.4	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	6	11.3	0	0	0	0	0	0	0	0	0
Outreach	19	35.8	8	42.1	5	62.5	3	37.5	0	0	37.5
Housing Assistance — Temporary	12	22.6	6	50.0	3	50.0	4	66.7	0	0	66.7
EFA	20	37.7	8	40.0	4	50.0	4	50.0	0	0	50.0
Transportation	33	62.3	29	87.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	1	1.9	1	100	0	0	1	100	0	0	100
Child Care >6	1	1.9	1	100	0	0	1	100	0	0	100
Psychosocial Services	24	45.3	15	62.5	9	60.0	6	40.0	0	0	40
Food Bank/Meals	3	5.7	1	33.3	0	0	1	100	0	0	100
Legal Services	27	50.9	0	0	0	0	0	0	0	0	0
Day/Respite Services	0	0	0	0	0	0	0	0	0	0	0
Translation	0	0	0	0	0	0	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.5 Carroll County Residents

Interviewers spoke to only eight Carroll County residents, or 1.1 percent of total EMA-wide respondents (see table 46). Only three of these reported receiving services in another jurisdiction, each one doing so for only one service apiece — legal services, oral-health care and primary medical care — and representing 50.0, 25.0 and 12.5 percent of Carroll County respondents receiving these services, respectively.

Two of these respondents did not share their reasons for seeking care outside Carroll County. The third said he left for services which were only available elsewhere.

Table 46

Carroll County Residents' Service Demand and Utilization by Service Category*

8 Total Respondents in Carroll County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Carroll County (n)*	*6. Loc. Rec'd: Carroll County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	8	100	8	100	7	87.5	1	12.5	0	0	12.5
Oral Health	8	100	4	50.0	2	50.0	0	0	1	25.0	25.0
Mental Health	4	50.0	1	25.0	1	100	0	0	0	0	0
Substance-abuse Treatment	1	12.5	0	0	0	0	0	0	0	0	0
Case Management	8	100	8	100	8	100	0	0	0	0	0
Treatment Adherence — Appointments	4	50.0	4	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	1	12.5	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	5	62.5	1	20.0	1	0	0	0	0	0	0
Home Health Care	3	37.5	0	0	0	0	0	0	0	0	0
Nutrition Counseling	5	62.5	3	60.0	3	100	0	0	0	0	0
Hospice	3	37.5	0	0	0	0	0	0	0	0	0
L/C Drug Reimbursement	8	100	7	87.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	3	37.5	0	0	0	0	0	0	0	0	0
Outreach	6	75.0	3	50.0	3	100	0	0	0	0	0
Housing Assistance — Temporary	3	37.5	0	0	0	0	0	0	0	0	0
EFA	4	50.0	0	0	0	0	0	0	0	0	0
Transportation	4	50.0	1	25.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	3	37.5	0	0	0	0	0	0	0	0	0
Child Care >6	2	25.0	0	0	0	0	0	0	0	0	0
Psychosocial Services	4	50.0	1	25.0	1	0	0	0	N/A	N/A	N/A
Food Bank/Meals	0	0	0	0	0	0	0	0	0	0	0
Legal Services	7	87.5	2	28.6	1	0	0	0	1	50.0	50.0
Day/Respite Services	0	0	0	0	0	0	0	0	0	0	0
Translation	0	0	0	0	0	0	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.6 Harford County Residents

Twenty survey respondents resided in Harford County, representing 2.7 percent of all EMA respondents. Of these, 15 (75.0 percent) received some of their HIV services in another jurisdiction. Nine did so because of non-availability of certain services in Harford County, five felt that care was better in a different jurisdiction, three felt more comfortable in a different jurisdiction and another three felt it easier to access all services in a different jurisdiction.

Harford County residents left their home jurisdiction for service in 14 categories, as shown in table 47, column 11. The leader was once again child care, this time for children over 6, though once again the 100 percent rate at which this service was received outside this jurisdiction referred to only one person. Next came oral-health care, for which 88.9 percent of county residents who received this service (which percentage represented 8 respondents) went to another jurisdiction, followed by temporary housing assistance (75.0 percent, or 3 respondents), psychosocial services (42.9 percent, or 3 respondents), legal services (40.0 percent, or 2 respondents), client advocacy (36.4 percent, or 4 respondents), nutrition counseling (33.3 percent, or 2 respondents), mental-health care (25.0 percent, or 12 respondents), case management (23.5 percent, or 4 respondents) and substance-abuse treatment (16.7 percent, or 1 respondent).

Table 47

Harford County Residents' Service Demand and Utilization by Service Category*

20 Total Respondents in Harford County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Harford County (n)*	*6. Loc. Rec'd: Harford County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	20	100	20	100	12	60.0	8	40.0	2	10.0	50.0
Oral Health	19	95.0	9	47.4	1	11.1	8	88.9	0	0	88.9
Mental Health	9	45.0	8	88.9	6	75.0	2	25.0	0	0	25.0
Substance-abuse Treatment	8	40.0	6	75.0	4	66.7	1	16.7	0	0	16.7
Case Management	18	90.0	17	94.4	17	100	3	17.6	1	5.9	23.5
Treatment Adherence — Appointments	7	35.0	7	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	2	10.0	1	50.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	15	75.0	11	73.3	10	90.9	4	36.4	0	0	36.4
Home Health Care	1	5.0	0	0	0	0	0	0	0	0	0
Nutrition Counseling	9	45.0	6	66.7	4	66.7	2	33.3	0	0	33.3
Hospice	1	5.0	0	0	0	0	0	0	0	0	0
L/C Drug Reimbursement	17	85.0	16	94.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	2	10.0	1	50.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outreach	12	60.0	6	50.0	5	83.3	4	66.7	0	0	66.7
Housing Assistance — Temporary	7	35.0	4	57.1	1	25.0	3	75.0	0	0	75.0
EFA	11	55.0	9	81.8	7	77.8	4	44.4	0	0	44.4
Transportation	13	65.0	12	92.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	0	0	0	0	0	0	0	0	0	0	0
Child Care >6	2	10.0	1	50.0	0	0	1	100	0	0	100
Psychosocial Services	7	35.0	7	100	6	85.7	3	42.9	0	0	42.9
Food Bank/Meals	3	15.0	2	66.7	1	50.0	1	50.0	0	0	50.0
Legal Services	10	50.0	5	50.0	3	60.0	2	40.0	0	0	40.0
Day/Respite Services	1	5.0	0	0	0	0	0	0	0	0	0
Translation	2	10.0	1	50.0	1	100	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.7 Howard County Residents

Respondents from Howard County numbered 29, the second-largest number of counties respondents and 4.0 percent of all EMA respondents. Of those 29, 12 reported leaving the county for services, most often for the reason that the services they needed were unavailable at home.

As can be seen in column 11 of table 48, Howard County residents traveled to another jurisdiction for services in only six categories. Of the 10 county residents who received legal services, 7 (or 70.0 percent) did so elsewhere, followed by primary medical care (31.0 percent, or 9 respondents), mental-health care (25.0 percent, or 4 respondents), oral-health care (21.1 percent, or 4 respondents), psychosocial services (10.0 percent, or 1 respondent) and case management (3.7 percent, or 1 respondent).

Table 48

Howard County Residents' Service Demand and Utilization by Service Category*

29 Total Respondents in Howard County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Howard County (n)*	*6. Loc. Rec'd: Howard County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	29	100	29	100	22	75.9	6	20.7	3	10.3	31.0
Oral Health	27	93.1	19	70.4	13	68.4	3	15.8	1	5.3	21.1
Mental Health	18	62.1	16	88.9	13	81.3	4	25.0	0	0	25.0
Substance-abuse Treatment	6	20.7	3	50.0	3	100	0	0	0	0	0
Case Management	27	93.1	27	100	27	100	1	3.7	0	0	3.7
Treatment Adherence — Appointments	8	27.6	8	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	17	58.6	13	76.5	13	100	0	0	0	0	0
Home Health Care	1	3.4	0	0	0	0	0	0	0	0	0
Nutrition Counseling	15	51.7	12	80.0	12	100	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0
L/C Drug Reimbursement	29	100	29	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	8	27.6	4	50.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outreach	14	48.3	9	64.3	8	88.9	0	0	0	0	0
Housing Assistance — Temporary	3	10.3	1	33.3	1	100	0	0	0	0	0
EFA	22	75.9	12	54.5	12	100	0	0	0	0	0
Transportation	12	41.4	7	58.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	0	0	0	0	0	0	0	0	0	0	0
Child Care >6	0	0	0	0	0	0	0	0	0	0	0
Psychosocial Services	17	58.6	10	58.8	10	100	1	10.0	0	N/A	10.0
Food Bank/Meals	3	10.3	3	100	3	100	0	0	0	0	0
Legal Services	17	58.6	10	58.8	6	60.0	7	70.0	0	0	70.0
Day/Respite Services	0	0	0	0	0	0	0	0	0	0	0
Translation	1	3.4	1	100	1	100	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

5.3.8 Queen Anne's County Residents

Interviewers only spoke with two Queen Anne's County residents, or 0.3 percent of EMA respondents. Of these, as can be seen in table 49, only one left the county to receive a service, oral-health care; he reported doing so because the service was not available in Queen Anne's County.

Table 49

Queen Anne's County Residents' Service Demand and Utilization by Service Category*

2 Total Respondents in Queen Anne's County

Service Category	*1. Need Svc. (n)*	*2. Need Svc. (%)*	*3. Rec'd Svc. (n)*	*4. Rec'd Svc. (%)*	*5. Loc. Rec'd: Q.A. County (n)*	*6. Loc. Rec'd: Q.A. County (%)*	*7. Loc. Rec'd: B. City (n)*	*8. Loc. Rec'd: B. City (%)*	*9. Loc. Rec'd: Other EMA Co. (n)*	*10. Loc. Rec'd: Other EMA Co. (%)*	*11. Left Co. For Care*
Primary Medical Care	2	100	2	100	2	100	0	0	0	0	0
Oral Health	2	100	2	100	1	50.0	1	50.0	0	0	50.0
Mental Health	0	0	0	0	0	0	0	0	0	0	0
Substance-abuse Treatment	1	50.0	0	0	0	0	0	0	0	0	0
Case Management	2	100	2	100	2	100	0	0	0	0	0
Treatment Adherence — Appointments	1	50.0	1	50.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Treatment Adherence — Medications	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Advocacy	1	50.0	1	50.0	1	50.0	0	0	0	0	0
Home Health Care	0	0	0	0	0	0	0	0	0	0	0
Nutrition Counseling	2	100	2	100	2	100	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0
L/C Drug Reimbursement	2	100	2	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rehabilitation	0	0	0	0	0	0	0	0	N/A	N/A	N/A
Outreach	1	50.0	0	0	0	0	0	0	0	0	0
Housing Assistance — Temporary	2	100	0	0	0	0	0	0	0	0	0
EFA	2	100	0	0	0	0	0	0	0	0	0
Transportation	2	100	2	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Care ≤6	0	0	0	0	0	0	0	0	0	0	0
Child Care >6	1	50.0	0	0	0	0	0	0	0	0	0
Psychosocial Services	1	50.0	1	50.0	1	50.0	0	0	0	0	0
Food Bank/Meals	0	0	0	0	0	0	0	0	0	0	0
Legal Services	1	50.0	1	50.0	1	50.0	0	0	0	0	0
Day/Respite Services	0	0	0	0	0	0	0	0	0	0	0
Translation	0	0	0	0	0	0	0	0	0	0	0

* Location categories are not mutually exclusive.

Source: 2007 Consumer Survey.

6. CONCLUSION AND PLANNING IMPLICATIONS

Analysis of the survey results identified common themes across each of the seven Baltimore EMA jurisdictions. Unmet demand appeared to have declined in many service categories since the 2004 consumer survey; however, it had increased and/or was still markedly high within some others. The most common barrier to care cited by respondents was lack of knowledge that a service existed or how to go about obtaining it. Additionally, some results suggested that outreach, client advocacy, primary medical care and case management could be better integrated. In particular, there may be room for improvement in information sharing among these and other providers in order to respond as effectively as possible to consumers' needs as they evolve over time.

6.1 Unmet Demand

One purpose of the planning council's triennial consumer surveys is to quantify unmet service demand so that possible problems can be addressed and barriers to care eliminated, at least to the extent practical with limited funds. It was reassuring to see, then, that unmet-demand levels decreased in many categories between the 2004 and 2007 survey. It is impossible to eliminate all unmet demand, particularly in categories for which a relatively low proportion of people have need in the first place. Indeed, in a world of finite resources, high unmet demand in low-demand categories may indicate a sensible allocation of resources that must be stretched so as to accomplish the most good for the most people.

> *An important question is whether there are very many high-demand services that also have high unmet need. The three most demanded service categories on the 2007 survey are all within the bottom four in terms of* unmet *demand, meaning that consumers' most universally pressing needs are being met relatively efficiently.*

An important question, then, is whether there are very many *high*-demand services that also have high unmet need. The 2007 survey did not find this to be the case. Out of 24 categories (23 official categories, with treatment adherence broken in two subcategories), only 3 of the top 12 most demanded categories were also in the top 12 in terms of *unmet* demand. These were legal services (twelfth in demand, first in unmet demand), emergency financial assistance (sixth in demand, seventh in unmet demand) and oral-health care (fourth in demand and twelfth in unmet demand). And legal services is a good example of the overall improvements seen in unmet demand levels since 2004: though it is today the category with the highest unmet demand, its current unmet-demand level, 69.3 percent, is considerably decreased from its 2004 level of 75.1 percent. Best of all, the three most demanded service categories on the 2007 survey (primary medical care, case management and local/consortium drug reimbursement) are all within the bottom four in terms of unmet demand (ranked 24th, 23rd and 21st out of 24, respectively), meaning that consumers' most universally pressing needs are being met relatively efficiently.

6.2 Most Common Barriers to Care

The most commonly cited barrier to care was insufficient knowledge of how to access services. Although other explanations may exist, the most likely seem to be that either (1) consumers were never made aware of available services or (2) they had not received adequate information as to how to access the services they needed. Either way, consumers would benefit from increased

efforts to educate them not only about the availability of various services but also their own role in seeking them out and monitoring progress.

Though not strictly speaking a barrier to care, another explanation given by respondents as to why they had not received services for which they indicated need was that such need had arisen only recently, i.e., they had not yet had time to work on obtaining the services in question. This explanation was a frequent one and speaks to the speed with which PLWH/As' needs can evolve over time, an important fact to keep in mind for anyone working to meet those needs.

6.3 Recommendations to Address Barriers to Care

Thanks to medical advances, the average PLWH/A has a longer life span than was the case in the earlier years of the epidemic. As a result, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 places even greater emphasis than ever on managing care and treatment over time, as opposed to responding to HIV diagnosis as a relatively acute crisis. PLWH/As obviously have an important role to play by managing their own care, since they are most familiar with their own needs. But such self-management and self-advocacy will be successful only to the extent that PLWH/As are given the best information possible — and in a form they can use.

Judging by survey responses, one of the simplest steps that could be taken toward this end is improvement in the dissemination of information concerning (1) what services are available and (2) what eligibility requirements exist for each service. For example, even when respondents to the 2007 survey knew of the availability of a particular service, they were often confused as to the precise definition of that service, i.e., what the service in question actually provides. Such confusion would of course directly affect consumers' ability to request and/or get the most out of certain needed services. Along the same lines, many consumers seem not to understand the eligibility requirements for certain services and may therefore believe themselves discriminated against when they are not provided such services, unaware that they do not meet set, standard criteria applied to all applicants. In the results of the 2007 survey, this problem seemed particularly pronounced where hospice care was concerned. Both of these problems seem linked to the high rate of respondents indicating that they did not know how to obtain various services they needed, as mentioned above. Thus, increased education efforts with the goal of improving consumers' understanding of the service definitions, eligibility requirements and the procedure for accessing services seem warranted.

One simple and cost-effective corrective to the problem of so many consumers' lacking knowledge of available services might be to create a simple, one-page handout listing all available services and explaining them in terms easily understood by a lay person with low health literacy.

Outreach workers, case managers, client advocates and primary-care providers are probably best positioned to play the information-dissemination role described above, but survey results suggest that these entities could improve their effectiveness at working together on this issue. For example, 75.9 percent of EMA respondents with unmet demand for client advocacy had received case-management services within the previous year, yet almost half of them (45.8 percent) claimed not to know how to obtain client-advocacy services. And while case management had low unmet demand (11.7 percent), 85.8 percent of those who needed and did not receive this service were in primary medical care, from which they should have been referred for case management as a matter of course.

One simple and cost-effective corrective to the problem of so many respondents' — and therefore, most likely, many other consumers' — lacking knowledge of available services might

be to create a simple, one-page handout listing all available services and explaining them in terms easily understood by a lay person with low health literacy. This handout could be explained to consumers at intake and reviewed with them during medical appointments by their primary-care provider or case manager. It seems likely that returning to the list over time would be key, since — human nature being what it is — many consumers will be likely to latch onto the services they know they need at the moment they first encounter this list and may not recall the others as their needs shift.

Another useful tool, not only for improving information sharing but also for accomplishing a host of other desirable purposes (de-duplication of services, retention in care, monitoring inter-jurisdictional service utilization, etc.), would be a central database containing a record for each Ryan White consumer in the EMA. Such a database would improve providers' ability to communicate with one another about each clients' needs and could perhaps even be audited from time to time to see if patterns in certain clients' records suggest additional services they might benefit from.

But any steps, no matter how small or incremental, that can be taken to continue to reduce communication barriers among providers and between providers and consumers will not only improve the quality of services but also foster closer provider-consumer relationships, enabling providers to continue to refine their ability to address the evolving needs of consumers.

7. BIBLIOGRAPHY

CB 2006a: United States Census Bureau (CB). 2006. County fact sheets generated on Census Bureau's American Factfinder Internet site (http://factfinder.census.gov/home/saff/main.html?_lang=en), downloaded December 3, 2007.

CB 2006b: _____. 2006. "Poverty Thresholds 2006." Internet site (http://www.census.gov/hhes/www/poverty/threshld/thresh06.html), downloaded April 26, 2007.

DHMH 2005: State of Maryland, Department of Health and Mental Hygiene (DHMH), AIDS Administration. 2005. *The Maryland 2005 HIV/AIDS Annual Report.* Internet Site (http://www.dhmh.state.md.us/AIDS/Data&Statistics/Statistics/2005AnnualReport.htm), downloaded December 4, 2007.

DHR 2005: State of Maryland, Department of Human Resources (DHR). 2005. *2005 DHR Fact Pack.* DHR Internet site (http://www.dhr.state.md.us/pi/), downloaded April 27, 2007.

Flynn 2006: Colin Flynn, AIDS Administration, Department of Health and Mental Hygiene, State of Maryland. 2006. "HIV/AIDS Epidemiologic Profile Baltimore: Maryland EMA Ryan White Title I Services." Presentation to the Greater Baltimore HIV Health Services Planning Council, July 18.

HRSA 2003: United States Department of Health and Human Services, Health Resources and Services Administration (HRSA). 2003. *Ryan White CARE Act Title I Manual.* Internet site (ftp://ftp.hrsa.gov/hab/T1M2003.pdf), downloaded May 1, 2007.

IGS 2003: InterGroup Services, Inc. (IGS). 2003. *Greater Baltimore HIV Health Services Planning Council Standards of Care: Fiscal Year 2004*. Baltimore, Md.: IGS, October.

IGS 2005a: _____ 2005. *Greater Baltimore HIV Health Services Planning Council Consumer Survey, Baltimore EMA, 2004*. Baltimore, Md.: IGS, March.

IGS 2005b: _____ 2005. *Greater Baltimore HIV Health Services Planning Council Consumer Survey Trend Analysis, 1998-2004*. Baltimore, Md.: IGS, May.

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