Sacramento EMA

2004 - 2006 COMPREHENSIVE HIV SERVICES PLAN

Prepared for

The Sacramento HIV Health Services Planning Council

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Abbreviations

ADAP	AIDS Drug Assistance Program
API	Asian / Pacific Islander
ASO	AIDS Service Organization
CDC	Center for Disease Control
Council	Ryan White Title I Planning Council
EMA	Eligible Metropolitan Area
HARS	HIV/AIDS Reporting System
HET	Heterosexual
HHSPC	HIV Health Services Planning Council
HRSA	Health Resources and Services Administration
IDU	Injecting drug user
LAC	Los Angeles County
MSM	Men-who-have-sex-with-men
NAC	Needs Assessment Committee of the Council
OI	Opportunistic infection
PAC	Priorities and Allocation Committee of the Council
PAG	Planning Advisory Group
PCH	Partnership for Community Health
PLWH/A	Person living w/ HIV/AIDS
RWCA	Ryan White Care Act
SAPA	Sacramento Alliance to Prevent AIDS
SEMAS	Sacramento County Department of Health and. Human Services database
SSC	Service Standards Committee of the Council
STD	Sexually transmitted disease
TB	Tuberculosis
TG	Transgender
VA	Veteran's Assistance
Youth	PLWH/A 24-years of age or younger

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INTRODUCTION

The Sacramento EMA HIV/AIDS Comprehensive Care Plan (Plan) presents a road map of the EMA's response to the HIV/AIDS epidemic. It focuses on describing the journey made by the HIV Health Services Planning Council (Council) to address the epidemic, while presenting future routes anticipated in its mission of decreasing HIV/AIDS mortality and morbidity, improving the quality and availability of comprehensive HIV/AIDS-related services to needy individuals and families, collaborating with other HIV/AIDS services organizations to assess and identify emerging HIV/AIDS services delivery needs, and facilitating a coordinated and community-based viable regional voice for HIV-impacted populations.

The first section addresses the question of "where the epidemic is now". It reviews the history of the HIV/AIDS epidemic in the Sacramento EMA while reviewing and assessing the current HIV/AIDS service delivery system. This section:

- Reviews the existing HIV/AIDS Continuum of Care in the Sacramento EMA and suggests a revised continuum that is more concurrent with current HRSA directives to prioritize unmet need and prevention for positives.
- Profiles the emerging demographic and economic trends and income and poverty for each planning area as well as trends in new infections including suggested planning within the five supervisory districts in Sacramento County, plus El Dorado and Placer Counties.
- Summarizes the epidemiology of the HIV/AIDS epidemic in the Sacramento EMA and describes the positive outcomes of the care system by looking at declining death rates and estimates of the PLWH/A including their demographic and geographic profile. The epidemiology focuses on people living with HIV/AIDS, as this will be the population that must be served by the continuum of HIV/AIDS care.
- Suggests who is out-of-care and estimates unmet need.
- Discusses stages of Infection and OIs.
- Reviews access to health care for PLWH/A including different insurance and assistance programs, including private insurance, COBRA, health insurance risk pool, Veteran's Administration Medical Center, SSDI, Medical, SSI, TANF, CHIP, ADAP, HOPWA, and the non-insured.
- Shows the positive outcomes of the care system.
- Highlights the current state of medication adherence.
- Describes HIV within a larger fabric of community needs, and discusses how the co-morbidities of STDs, substance abuse, psychiatric need, and homelessness intersect and affect the HIV/AIDS service needs of PLWH/A.
- Reviews the resources for HIV/AIDS Care throughout the Continuum of HIV Services. Additionally it discusses the process of priorities and allocations. This looks at the service integration gap analysis and resources available. It also considers trends in funding and non-RWCA funding sources.

- Summarizes the needs, unmet needs, service gaps, barriers, and disparities to services confronting PLWH/A based on the 2003 needs assessment survey, focus groups and supporting data from a variety of empirical studies and economic analyses. The needs of different ethnic and risk group subpopulations are presented, highlighting the needs and barriers of the target populations and those out-of-care. Included in this section are templates for each service that summarizes data presented in the Needs Assessment and includes financial information.
- Proposes how Ryan White CARE Act funds can fill critical gaps in the continuum of care or be used to build bridges to existing services within its capacity that may meet complementary needs of PLWH/A while looking at the geographical location of service providers.
- Describes the perceived barriers to care reported by PLWH/A.
- Summarizes each care service in a "template" that is a one-page summary of the epidemiology, funding, and perceived need for the services and gap in obtaining it.

The second section addresses the question "where are we going?" It reviews the overall context of the plan by describing the shared vision and values for a continuum of care and services. It outlines core competencies and weaknesses of the care services system as well as delineates the HIV/AIDS service system's primary goals and objectives for the next three years, creating a timeline of tasks and responsibilities.

The third and final section discusses how the Council will monitor the progress and outcomes of the Comprehensive Care Plan. For each objective, mechanisms to monitor the process and measure outcomes will be detailed. Both quantitative and qualitative measures are discussed. As work continues on the Plan, the Council should continue the development of data sources and indicators. Where current data is reliable, benchmarks are noted. Where data is not available, data that is needed for benchmarks and subsequent measurements of progress are identified.

Purpose of the Plan

The Plan is both a reference document for information collected and analyzed in the needs assessment and priority and allocation process, and a roadmap for planners to use in maintaining and developing services for PLWH/A. For consumers it documents the continuum of care and presents their voice in assessing the services. Further, it provides a guide to where HIV care services are evolving. Finally it is plan for which the consumers can assess the Council's success. It allows consumers to hold the Council accountable and provides measures by which they can monitor the Council's progress.

It is a "living document" in the sense that it must be periodically modified to reflect new trends in the epidemic and new initiatives and directives implemented by the Council. Ideally it will be a reference and reminder to Council members of services they plan to provide and it will be used to reference consumer feedback on their needs, barriers, and gaps in services.

1. WHERE ARE WE NOW?

HIV CONTINUUM OF SERVICES (HCS) IN THE SACRAMENTO EMA

An HCS represents a comprehensive range of HIV prevention and care services accessed by individuals, partners, and groups. They facilitate adopting safer drug use and sexual behaviors, accessing prevention and care services and maintaining care services that stabilize and improve the physical and mental health status of PLWH/A. This continuum incorporates the vision for HIV prevention and care that is based on creating specifying different services to meet goals and establishing eligibility and standards for each service.

The HCS identifies:

- Clear goals multiple measurable outcomes for the system.
- An agreed upon array of coordinated care services for PLWH/A based on consumer need.
- Clear eligibility and standards for services that are easily understood.
- Quantifiable outcomes that can be measured.

The HCS presented is the outcome of community planning in the Sacramento EMA. It broadens the existing continuum that categorizes services into: 1) core services, 2) primary linking and access services, 3) support services, and 4) community capacity building services by integrating prevention and care and recognizing the importance of public support.

Through eligibility and standards of care, services are prioritized by need. As noted in the Needs Assessment, need varies by the socio-economic and experience with the system. The HCS is flexible to assure that those in them ore mature epidemic can access required medical care, monitoring, and adherence support while those newly entering the HCS can obtain the case management and wrap around services necessary to improve access to services.

Goals of a HIV Continuum of Services (HCS)

The HCS specifies and shows the linkages between a full range of cost-effective prevention and care services aimed at improving general public knowledge and support of HIV prevention and targeted to those at-risk for becoming infected, those who are likely to spread HIV infection, and those infected who need care services. It ensures that all persons at-risk for HIV and living with HIV, regardless of race, gender, or income, are served by a system that provides a comprehensive continuum of services that limits transmission, stabilizes, and improves the health status of PLWH/A. It assures that services are:

- Available throughout communities at-risk for HIV infection.Accessible to those eligible for services.Affordable to those eligible for services.Appropriate to the cultural norms of the community, the cognitive abilities of the recipients of services, and the specific needs of those new to the service system and those who are familiar with the system.Accountable to the funders and consumers of services.

Objectives for a HCS

The objectives of the continuum of care are shown in Table 1-1.

Table 1-1 Objectives and Outcomes for HCS

OBJECTIVES	OUTCOME
A. Increasing public awareness of the risk of HIV infection	1. Public support for prevention services. 2. Individual assessment of risk for HIV infection.
B. Outreach to at-risk populations	1. Knowledge of serostatus. 2. Knowledge of related co-morbidities. 3. Increased safer behaviors (condom and needle use). 4. Lower rates of STDs and TB. 5. Understanding about abstinence from sex / drug use.
C. Prevention services to HIV -	1. Maintain negative status. 2. Adopt and maintain safer sex and needle use activities. 3. Lower rates of STDs and TB. 4. Understanding of abstinence from sex / drug use.
D. Care and prevention services to PLWH/A	1. Increased percentage of PLWH/A receive and maintain primary care. 2. Decreased gap between need and utilization of support services related to seeking medical care. 3. Maintain and improve health status of PLWH/A. 4. Maintain and improve the physical and emotional health status of PLWH/A. 5. Increased use of primary care by those who are out-of-care. 6. Improved adherence to drug regimens. 7. Increased LOA for linkages and increased number of referrals to appropriate services. 8. Increased adoption and maintenance of safer behaviors.
E. Prevention and care services to partners where one or both are HIV positive	1. New and implemented protocols for family support services. 2. Increased partner notification. 3. Increased number of mutual commitments to safer sex and needle use strategies.
F. Training and technical assistance services to providers	1. Increased capacity to provide effective care and prevention services.
G. Assessment and evaluation of services by grantee	1. Accountability of funds and services to consumers and funders. 2. Improved client satisfaction and reduction of barriers to care and prevention services.

A comprehensive system:

1. Emphasizes linkages to non-Ryan White funded programs such as TB and STD prevention, family planning, and substance abuse treatment programs, veteran's benefits, reimbursed insurance and private treatment and medication services, HIV counseling and testing, law enforcement services directed toward illegal substance use[1], and faith-based efforts to provide outreach to those infected but do not know their status and prevention and care to PLWH/A.
2. Builds feedback into the system for accountability, including consumer satisfaction, quality control, and planning through assessments, evaluations, and needs assessments.
3. Uses scientific and research findings, best practices, and accepted medical protocols in specifying services.
4. Establishes a dynamic system where movement of persons from one service to another and from one "track" to another is clear. Consumers access services depending on their needs.

Process Outcomes of a HCS

The process outcomes for a comprehensive coordinated HCS include that services be:

1. Community-centered: At-risk communities must have input into defining their needs, assessing services, and modifying/changing services to meet their needs. This is achieved by assuring the:
   1.1. Participation of at-risk communities in the planning process.
   1.2. Feedback from at-risk communities through needs assessments and consumer satisfaction surveys and an accessible grievance procedure.
2. Proactive: The HIV Care Councils, State and local Prevention Planning Groups (Sacramento Alliance to Prevent AIDS), and providers must anticipate the changing needs of communities at-risk. The HCS has to be flexible to meet new needs. Epidemiological surveillance and needs assessments are used to highlight trends such as the growing rates of infection among women, heterosexuals, and communities of color, the increase in "unknown" risk factors, and the decreased mortality and morbidity reflecting the need to increase services to communities of color and reach PLWH/A who remain sexually active with effective prevention-for-positives programs.
3. Inclusive of all services: In order to determine gaps in services it includes care services funded through County, State, and other federal programs, privately funded programs and prevention funded through CDC and other sources.

Graphic Description of HIV Continuum of Services

Based on the objectives shown in Figure 1-1, the HCS might be visualized as a seven-track system that identifies those at-risk, identifies those infected, provides care and support services to PLWH/A, and assures that the services are of high quality and accountable to funders and consumers. As shown in Figure 1-1, the tracks are defined by their starting point

[1] The mention of law-enforcement services is not an endorsement of current policies. Rather it notes the potential role of law enforcement in controlling illegal substance use and providing referrals to those in need of substance abuse and HIV/AIDS services.

– the objective. This is shown in the black bar on top on each section in Figure 1-1. Each track has outcomes that are measurable and those are shown in the gray bars beneath the black bars. The services offered to achieve the outcomes are shown in the lightly shaded boxes in Figure 1-1.

The tracks represent the general type of services, some of which are funded by Ryan White Care Act, CDC, other federal, State, local, private and other sources. For the services provided to PLWH/A the major funding sources are insurance, including Medicaid, Medicare, and private insurance. One of the difficulties in determining gaps in services is determining the existing capacity of the system outside of the Ryan White Care Act funded services. Five of the tracks are for consumers: 1) public, 2) high-risk populations, 3) HIV negative, 4) HIV positive, and 5) partners where one or both are HIV positive. Another track is for providers and shows services that support prevention and care providers. Last, there is a track targeted to the grantee, Council and Prevention Planning Group, who are responsible for assessment and evaluation of services.

Each track has eligibility criteria and a desired outcome. For example, those eligible for tracks four and five must be HIV positive or partnered with someone HIV positive, and those eligible for track three have to be engaged in high-risk behaviors or be members of high-risk communities (e.g. MSM, IDUs, "party-drug" users, bath-house patrons, heterosexuals with IDU partners, sexually active heterosexual in high incidence areas, incarcerated, and recently released). As shown by the arrow, only those who know their HIV status (through counseling and testing) are eligible for tracks three through five. Because infection is spread by activities of partners, certain prevention services are directed to negative, positive, and discordant couples that allow them to negotiate safer practices with the outcome being a commitment to use safe practices.

In order to assure that services are effectively implemented, providers should be trained to identify and develop individualized service plans and have the organizational skills to provide services. Consequently, there are infrastructure development and training services to increase provider capacity to provide services. Listed next to services in parenthesis is the corresponding ranking as decided by the Council for 2004-2005.

Finally, in any effective HCS there is a feedback mechanism for assuring the system is self-adjusting and dynamic. This involves the assessment and evaluation of services to assure that prevention services are accountable and to modify services to better meet the needs of consumers.

Figure 1-1 HIV Continuum of Services

Track 1: Increasing Public Awareness Of The Risk Of HIV Infection		
Outcomes	*1. Public Support*	*2. Personal Risk Assessment*
Services	Place Advertisements / PSAs in mass and small media, billboards, brochures, and leaflets. Write articles & editorials advocating HIV/AID prevention. Circulate newsletters. Conduct group educational intervention such as HIV/AIDS prevention curriculum, drama or theater presentation, and World AIDS day presentation. Have a hotline or other type of information exchange, etc. Organize rallies, public meetings, write-in campaigns. Use advocacy / educational volunteers or interns. Provide advocacy / educational training. Solicit financial support for HIV/AIDS prevention advocacy.	

▼

Track 2: Outreach To At-Risk Populations				
Outcomes:	*1) Knowledge of serostatus*	*2) Knowledge of co-morbidities and lower rate of STDs*	*3) Increased safer behaviors*	*4) Abstinence from sex and drug use*
Services:	Offer HIV Testing and Counseling	Health education and risk reduction through targeted group and community level interventions including schools, street outreach, house parties, health fairs, public sex venues such as parks or bath houses, bars, STD and health care clinics, etc. Conduct 1-1 contact with high –risk individual. Operate a mobile van. Advocate on behalf of availability of clean needles. Distribute bleach kits. Distribute condom. Offer STD testing. Offer TB testing. Offer Substance Abuse treatment, detox, and methadone maintenance. Offer 12-step and other abstinence. Offer care at neonatal and other women's clinics. Offer family planning to populations at high risk for HIV infection.		

▼

	Track 3: Prevention Services To HIV-	**Track 4: Care and Prevention Services to PLWH/A**	**Track 5: Prevention And Care Services To Partners Where One Or Both Are HIV Positive**
Outcomes:	1) Maintain negative status	1) Maintain and improve health status 2) Linkages to, initiating, and maintaining health care 3) Commitment to safer behaviors	
	1) Obtain STD treatments and lower rates of STDs 2) Abstinence from sex/drug use 3) Adopt and maintain safer behaviors (condom and needle use) 4) Maintain or improve quality of life		
Prevention Services:	Offer HIV/AIDS re-test Offer 1-1- counseling / prevention case management.	Provide adherence programs. Monitor HIV status. Offer 1-1- counseling / prevention case management. Work with criminal justice system.	Develop partner agreements. Partner notification Provide partner negotiation. Partner counseling and referral.
	Provide skill-building workshops (Condom use, needle cleaning, partner negotiation). Conduct behavioral modification programs. Provide peer education / support. Circulate newsletters. Offer support groups.		

Track 6 Services To Providers
OUTCOMES: *Increase capacity to provide effective services*
Services: Training. Infrastructure support. Program development. Newsletters.

Track 7 Program Assessment & Evaluation
OUTCOMES: *1 Accountability to consumers and funders* *2. Improvement of services*
Program Monitoring. Needs Assessment. Consumer Satisfaction.

Care Services (for HIV+ and Partners only) ** Number in Parenthesis is 2004-5 priority.* *** Not ranked*	**Core:** Ambulatory medical, specialty, care & labs (1)* Dental care (3) Substance abuse (residential) (7) Substance abuse services (outpatient, counseling) (9) Mental health services (individual and group) (5) Hospice and residential care (PLWA) (12) Adherence counseling (Pediatric) (14) Home health care** **Primary Linking and Access Services** Case Management (2) Benefits Counseling Advocacy Transportation (voucher and trips) (8) Insurance continuation (15) Outreach** **Support Services** Emergency financial asst (4) Medical reimbursement / medication (non-ADAP) ADAP co-pay assistance Food vouchers, utility assistance, other critical need Housing (Emergency housing, referrals, long term housing) (6) Food bank/home delivered meals (10) Psycho-social support services / groups (11) Nutritional counseling (non-nutritionist) Peer counseling Complementary (acupuncture, chiropractic, massage) Child care (13)

DEMOGRAPHICS PROFILE OF THE SACRAMENTO EMA

The Sacramento EMA, located in central California, includes Sacramento, El Dorado, and Placer counties and has a population of 1,699,868. The EMA has both urban and rural characteristics and is geographically, racially, and ethnically diverse with variations in each county.

As shown in Table 1-2, the EMA is 64% Anglo, 14% Latino, 9% Asian Pacific Islander, 8% African American, and about 5% other ethnicities including Native Americans and mixed races. Sacramento County is the most ethnically diverse county within the EMA with 58% Anglos, 16% Latinos, 10% African Americans, and about 16% all other ethnicities combined. The ethnic profiles of Placer and El Dorado have very similar ethnic profiles with about 84% Anglo, 9% to 10% Latino and under 1% African American.

Table 1-2 also shows that the gender distribution is very similar across the EMA, with the majority (51%) of the residents being female.

Table 1-2 Demographic Profile

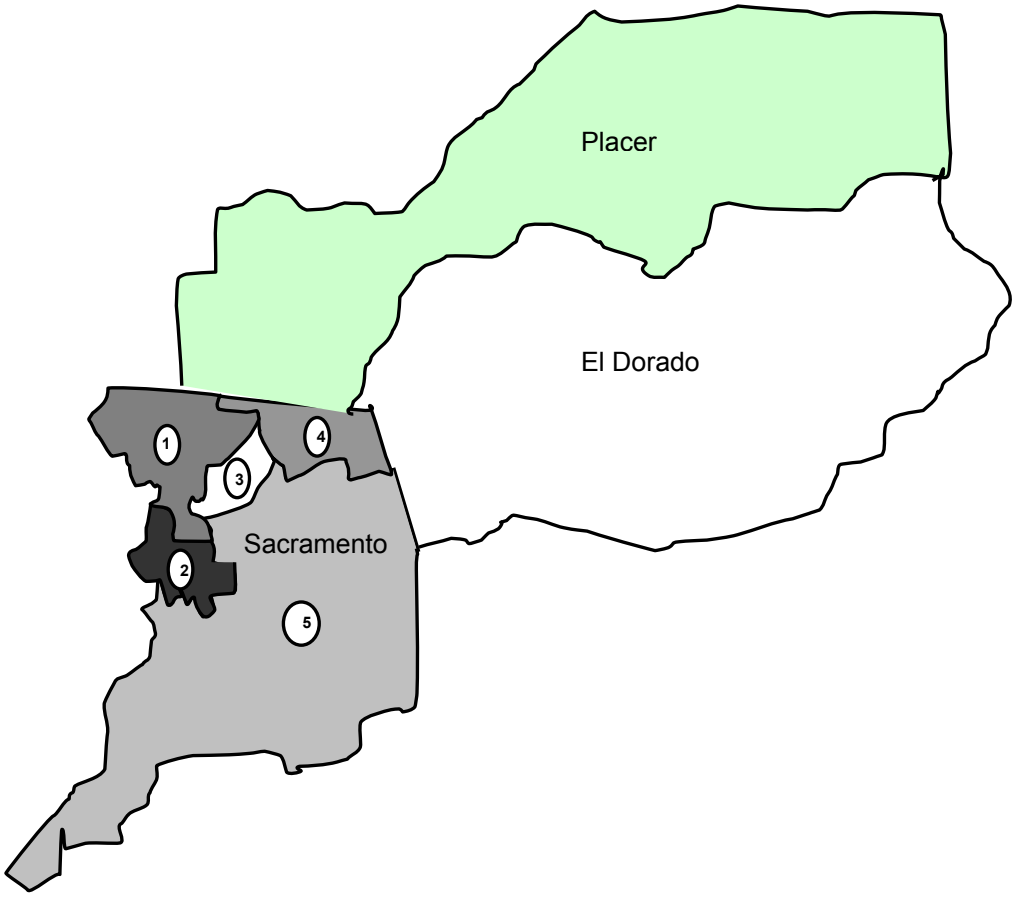
	El Dorado County		Placer County		Sacramento County		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Population	**162,586**	**9.6%**	**268,512**	**15.8%**	**1,268,770**	**74.6%**	**1,699,868**	**100.0%**
Gender								
Female	81,456	50.1%	136,673	50.9%	648,341	51.1%	866,470	51.0%
Male	81,130	49.9%	131,839	49.1%	620,429	48.9%	833,398	49.0%
Ethnicity/Race								
Anglo/white	138,036	84.9%	223,939	83.4%	733,349	57.8%	1,095,324	64.4%
African American	813	0.5%	2,148	0.8%	126,877	10.0%	129,838	7.6%
Latinos	15,120	9.3%	26,046	9.7%	203,003	16.0%	244,169	14.4%
Other	8,617	5.3%	16,379	6.1%	205,541	16.2%	230,537	13.6%

Regional Planning

Sacramento County is divided into five districts. The Board of Supervisors is the governing body of the County of Sacramento and each of the five members of the Board represent one of five districts. In addition, the EMA includes Placer County to the North East and El Dorado County to the East. The Council has decided to use the five supervisory districts in Sacramento County plus El Dorado County and Placer County to geographically distinguish the needs of PLWH/A in the Sacramento EMA. A map of Sacramento County's five supervisor districts and El Dorado and Placer Counties is shown in Figure 1-2.

Creating and supporting accessible services to all PLWH/A is an integral part of the Commission's mission and values. HIV/AIDS services tend to be centrally located in Sacramento County, where there about 90% of the people living with HIV/AIDS reside in the EMA. Still there are over 100 PLWA and probably over 100 persons living with HIV in the rural areas of Placer and El Dorado counties that require services.

Figure 1-2 EMA Plus Sacramento Regional Districts



HIV AND AIDS EPIDEMIOLOGICAL PROFILE & TRENDS

When planning for HIV and AIDS services, knowing the number of persons living with HIV and AIDS, and the number currently accessing services, provides a theoretical referent for the number of PLWH/A who could seek services in the continuum of care and the number who have sought services in the past.

The HIV/AIDS Reporting System (HARS) documents 1,435 people living with AIDS as of December 2002, nearly a 20% increase since 1997. There were 180 new AIDS diagnoses in the last two years, or 12% of living AIDS cases. Ninety-one percent (91%) of living AIDS cases is in Sacramento, with about five percent (5%) in Placer and four percent (4%) in El Dorado. Table 1-3 shows PLWA are disproportionately male, African American, and MSM.

- MSM represent 58% of living AIDS cases in the Sacramento EMA.
- MSM/IDU account for a larger share of the epidemic in the EMA than in most other parts of the country. They account for 12% of living AIDS cases, and over 40% of all injection-related HIV cases in the EMA, compared to only 6% of national cases.

- People of color represent about 31% of all AIDS cases prior to 1990, but account for 53% of new cases diagnosed in 2002.

Figure 1-3 indicates that there is an estimated 3,422 people living with HIV and AIDS in the Sacramento EMA who know their HIV status. At the end of 2002, there were about 1,435 PLWA and an estimated 1,987 people living with HIV (not AIDS) in the EMA (Department of Public Health, 2003). An estimated 95 HIV cases are in Placer and 86 HIV cases in El Dorado County. A disproportionate number of HIV/AIDS cases are among African Americans. They comprise only 8% of the Sacramento EMA's population, yet 22% of living AIDS cases, 29% of estimated HIV infections, and 27% of people newly diagnosed with AIDS.

According to the SEMAS database, there are over 1,770 PLWH/A accessing CARE-funded services. People of color make up 39% of clients receiving Title I-funded services (in contrast to representing about 36% of all PLWH/A), women make up about 18%, and IDUs represent about 16% of the PLWH/A in care.

MSM continue to be the vast majority of people living with HIV/AIDS and the community most affected by the epidemic in the EMA. MSM includes both those men who identify as gay or bisexual and those who reported male same sex transmission of HIV.

Table 1-3 Demos of General Population, PLWA and PLWH

		GENERAL POP*	PLWA 2002**	PLWH 2002+	TOTAL PLWH/A
	Population	**1,699,868**	**1,435**	**1,987**	**3,422**
Gender**	Male	49%	86%	80%	82%
	Female	51%	14%	20%	18%
Race	African American	8%	22%	29%	26%
	Anglo	64%	63%	58%	61%
	Asian/Pacific Islander	9%	1%	1%	1%
	Latino	14%	12%	10%	10%
	Other	5%	2%	2%	2%
Risk Group***	MSM	NA	58%	53%	54%
	MSM/IDU	NA	12%	17%	11%
	IDU	NA	15%	10%	16%
	HET	NA	15%	20%	18%

* Census Bureau, 2002 ** HARS + RWCA Title I Application, 2004-2005

Detailed Demographic Description

Figure 1-4 provides a detailed demographic profile of PLWH/A living in the Sacramento EMA[2], based on the weighted consumer survey sample of 383 PLWH/A. Below are some demographic highlights of PLWH/A:

[2] The data was weighed back to Placer and El Dorado County populations and therefore is not generalizable to those counties.

- 82% are males, 18% are females. Women represent a far greater proportion of African Americans living with HIV/AIDS than other ethnic populations.
- The majority of the PLWH/A are non-Latino Anglo (61%), followed by African Americans (26%), Latinos (10%), and other ethnicities, including Asian Pacific Islanders and Native Americans at about 3%.
- People of color as a group, including African Americans, Latinos, Native Americans, and Asian/Pacific Islanders, represent 39% of PLWH/A.
- Among Anglos, 93% are male, and 68% percent of them are MSM. Twenty-five percent (25%) report a history of IDU, and 8% are heterosexual.
- African Americans PLWH/A are 44% female and 42% report being heterosexual. Thirty-five percent (35%) report a history of IDU, and 29% report being MSM.
- Latinos have a profile similar to Anglos: Mostly male (88%), about a quarter (23%) with IDU history, and 16% heterosexual.
- PLWA represent 58% of the sample and PLWH account for 42% of the sample. This distribution is actually the opposite of the breakdown presented in the Title I application. Notably in this sample, Anglos (representing majority MSM) are much more likely to have progressed to AIDS. This could reflect the greater likelihood of survey participants, who are recruited through care services, of being in later stages of HIV infection.

Table 1-4 Demographic Analysis (N=383)*

	TOTAL	Anglo	African Am	Latino	API /Other
TOTAL N	**383***	**232**	**100**	**40**	**10**
Gender					
Male	82%	93%	57%	88%	78%
Female	18%	7%	44%	12%	22%
Risk group					
MSM	55%	68%	23%	62%	66%
MSM/IDU	11%	15%	6%	6%	4%
IDU	16%	10%	29%	17%	14%
Hetero	18%	8%	42%	16%	16%
Stage of Infection					
HIV asymptomatic	23%	17%	34%	30%	17%
HIV symptomatic	19%	16%	26%	20%	0%
AIDS asymptomatic	18%	19%	17%	20%	7%
AIDS symptomatic	40%	48%	22%	30%	76%

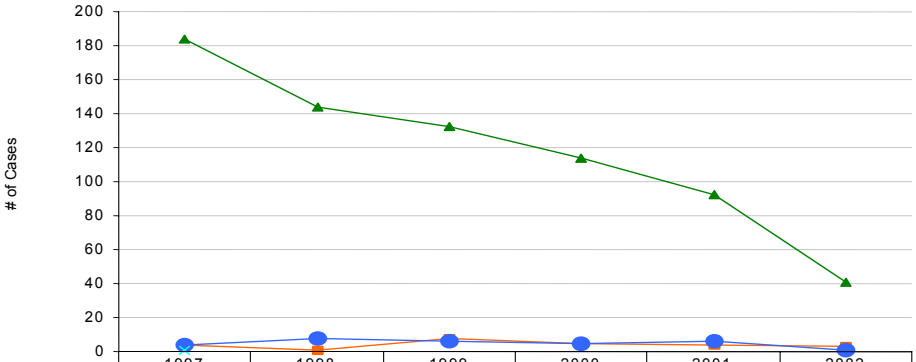
*Weighted sample from the Needs Assessment Survey. The total count may not sum to 383 due to weighting and rounding effect.

Progression from HIV to AIDS

Early treatment of HIV disease has greatly reduced the progression of HIV to AIDS, and this trend is important in planning for care because of the more limited reimbursement of medical services for PLWH, combined with the need for early treatment.

In 1997, 192 persons were diagnosed with AIDS in the Sacramento EMA, while in 2002, less than a quarter of that amount, 45 persons were diagnosed, representing a decline of about 77%. Figure 1-3 shows that for the past six years over 90% of the new cases have been in Sacramento County. While El Dorado accounts for a much smaller proportion of the total population in the EMA than Placer, both counties have about the same number of cases each year.

Figure 1-3 AIDS Cases by Year of Diagnosis by County

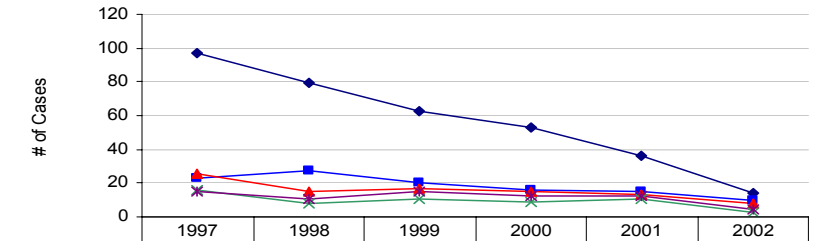


	1997	1998	1999	2000	2001	2002
Sacramento	184	144	132	114	92	41
Placer	4	1	8	5	4	3
El Dorado	4	8	6	5	6	1
Total EMA	**192**	**153**	**146**	**124**	**102**	**45**

New AIDS Cases by District

Figure 1-4 displays the decline in AIDS cases reported yearly in the five supervisor districts in Sacramento County. Consistently, since 1997, District 1 has accounted for the largest proportion of all PLWH/A, with an average of about 48% of the cases over the past six years, followed by District 2 with an average of about 18% of the newly diagnosed cases over the past six years. In District 1, 97 AIDS cases were diagnosed in 1997 and 14 in 2002. Districts 1 and 4 have had fastest decline in newly diagnosed AIDS cases since 1997.

Figure 1-4 AIDS Cases by Year of Diagnosis by District



	1997	1998	1999	2000	2001	2002
District 1	97	79	63	53	36	14
District 2	23	27	20	16	15	10
District 3	26	15	17	15	13	8
District 4	16	8	11	9	11	3
District 5	15	11	15	12	12	4

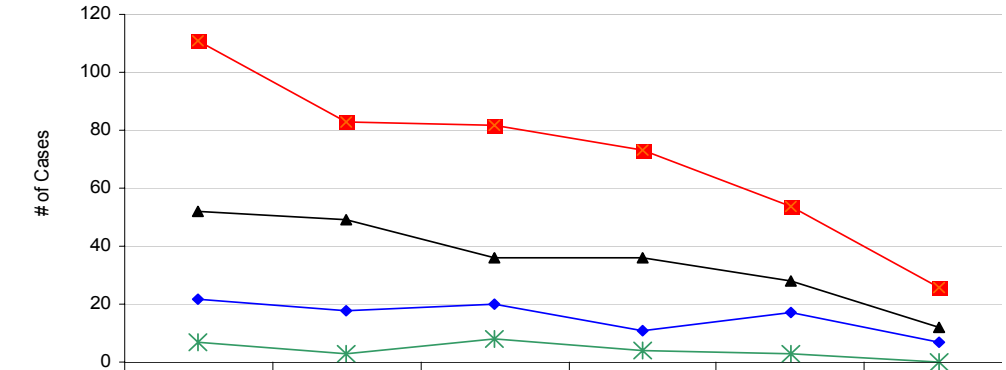
New AIDS Cases by Ethnic Populations

Figure 1-5 shows that there has been a consistent decline in newly diagnosed cases from 1997 to 2002 among all ethnic populations. Since 1997, the decline in AIDS rate has been between 73% and 80% among Latinos, Anglos, and African Americans. Yet, while African Americans have experienced the greatest decline in AIDS rate (80%), in 2002, the AIDS rate among African Americans (9 per 100,000) was more than double that of Latinos (4) and three times the rate among Anglos (3).

The growing Latino and African American populations in Sacramento are disproportionately impacted by AIDS. While Latinos account for about 14% of the population they account for 16% of the newly diagnosed AIDS cases. Similarly, African Americans represent 8% of the Sacramento population, yet, they account for more than a quarter (27%) of the newly diagnosed cases in 2002. In terms of absolute numbers, Anglos are not disproportionately impacted by AIDS, yet, they will continue to contribute the largest number of AIDS cases over the next several years accounting for nearly 60% of the new cases in 2002.

Therefore in planning services for the newly diagnosed, the most units of service have to be allocated for the Anglos living with HIV and AIDS. At the same time, the system must prepare for the growing number of African Americans living with HIV and AIDS.

Figure 1-5 New AIDS Cases by Year of Diagnosis by Race



	1997	1998	1999	2000	2001	2002
Af Am	52	49	36	36	28	12
Anglo	111	83	82	73	54	26
Latino	22	18	20	11	17	7
Other	7	3	8	4	3	0

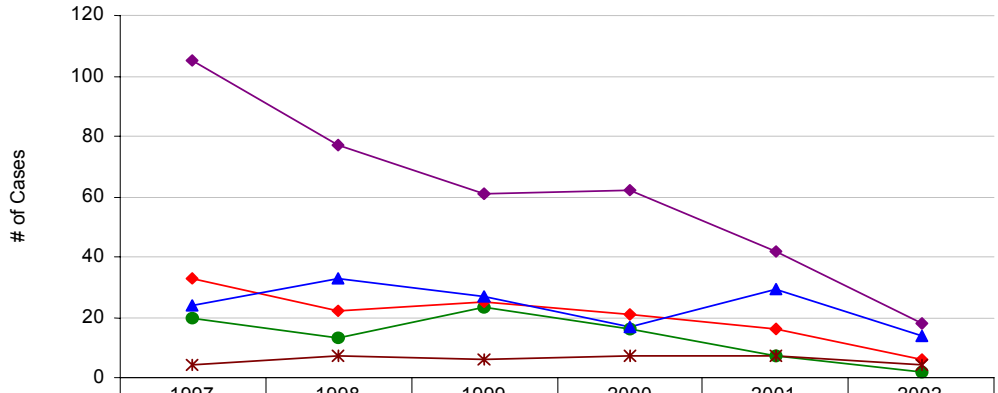
New AIDS Cases by Risk Group

Figure 1-6 shows an unequal decline in diagnosed AIDS cases for risk groups. MSM (men having sex with men) show a significant decline in number of AIDS cases diagnosed yearly from 1997 through 2002. Still, in 2002, MSM account for 40% of the newly diagnosed cases.

The rate of decline in newly diagnosed AIDS cases among MSM in Sacramento is different than what is observed in other EMAs and other parts of California. While the national rate of newly diagnosed cases among MSM has leveled off and in some cases even increased, incidence of AIDS among MSM in Sacramento continues to decline.

Since 1997, MSM/IDU have shown the largest decline in newly diagnosed AIDS cases. Similarly, the rate of new cases among IDUs has declined. Overall, there appears to be a shift in new infections toward heterosexuals in the epidemic where by 2002, heterosexuals account for 31% of the newly diagnosed AIDS cases. Heterosexuals show a decrease in incidence of about 41% since 1997, compared to over an 80% decrease among IDUs, MSM, and MSM/IDUs.

Figure 1-6 AIDS Cases by Year of Diagnosis by Risk Group



	1997	1998	1999	2000	2001	2002
MSM	105	77	61	62	42	18
MSM/IDU	20	13	23	16	7	2
IDU	33	22	25	21	16	6
Het	24	33	27	17	29	14
Not Classified	4	7	6	7	7	4

Persons Living With HIV and AIDS

While the most reliable data is for PLWA, planning for services is for all PLWH/A. Consequently, the following graphs detail the demographics of several specific subpopulations living with HIV and AIDS based on the needs assessment survey. Because respondents were largely sampled from providers funded through Ryan White Care, it will over-represent those with lower incomes and those without private insurance.

Gender

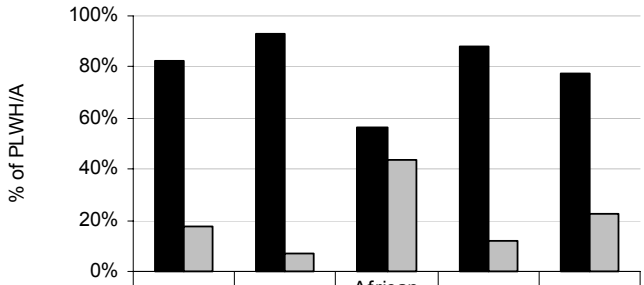
Figure 1-7 shows that women represent 18% of the PLWH/A sample, yet among ethnic groups, women make up the largest percentage of the African American population at 44% and the smallest percent of the Anglo population at 7%.

Figure 1-8 further shows that women represent 68% of the heterosexuals, and 36% of the IDUs. As newcomers to the HIV epidemic, women are more likely to be HIV positive without an AIDS diagnosis. In general, women are about evenly distributed among the asymptomatic and symptomatic PLWH/A. However, as shown in Figure 1-8 women living with HIV are more likely to be asymptomatic (40%) than symptomatic (29%), but women living with AIDS are much more likely to be symptomatic (21%) than asymptomatic (11%).

The detailed demographic analysis in the needs assessment further reveals:

- Women are more likely than men to postpone seeing a doctor after receiving their initial HIV diagnosis. Twenty percent (20%) of women have waited at least seven months to see a doctor compared to 15% of men.
- Women (35%) are more likely than men (27%) to have lived with HIV less than six years. Less than one third of women have lived with HIV 12 years or more compared to over 41% of men.
- Women are much less likely to live alone than men and are more likely to consider their home safe, habitable, and stable.
- Women have a higher history of homelessness than men, with over 25% having lived in a homeless shelter over the last two years and almost 40% report having lived in the street or in a car.
- Considering the high incidence of homelessness among women living with HIV/AIDS in Sacramento it is surprising that a lower percentage of women have been diagnosed with depression and anxiety than men. This may reflect their greater access to mental health therapy than men. For instance, 28% of women have received group counseling compared to 13% of men. Women are also far more likely than men to have received peer counseling, family counseling, and bereavement counseling.

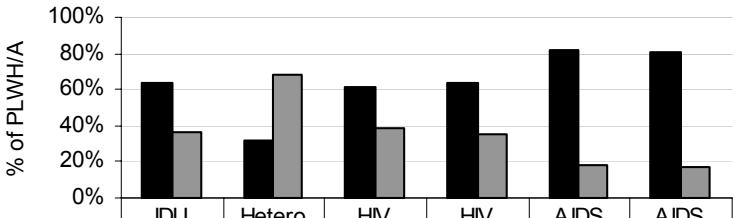
Figure 1-7 Gender by Ethnicity*



	TOTAL	Anglo	African Am	Latino	Other
Male	82.3%	92.8%	56.4%	87.7%	77.6%
Female	17.7%	7.2%	43.6%	12.3%	22.4%

*Based on weighted sample.

Figure 1-8 Gender by Mode and Stage of Infection*



	IDU	Hetero	HIV	HIV	AIDS	AIDS
Male	64.1%	32.3%	61.5%	63.6%	81.5%	80.9%
Female	35.9%	67.7%	38.5%	35.1%	18.5%	17.6%

*Based on weighted sample

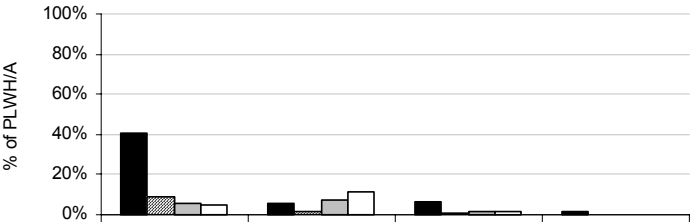
Ethnicity/Race and Mode of Transmission

Figure 1-9 shows the overall profile of PLWH/A in Sacramento. It is divided by race and risk group. For example, the first bar shows that in of all PLWH/A in Sacramento, 41% are MSM. Figure 1-9 indicates that:

- Anglo MSM (41%) represent the largest number of PLWH/A, followed by African American heterosexuals (11%), and Anglo MSM/IDU (9%).
- IDUs represent 16% of all PLWH/A and are distributed among African Americans (8%), Anglos (6%), and Latino (2%). The majority of MSM/IDU are Anglo (9%), while the majority of IDUs are African American (8%).
- Heterosexuals represent 18% of all PLWH/A. They are mostly African Americans (11%), with about 5% Anglos, and 2% Latinos and other ethnicities.
- MSM represents the largest proportion of PLWH/A in all ethnic groups, except among the African Americans. MSM represents over 60% of Anglos and Latinos living with HIV/AIDS, but they represent less than a quarter of the PLWH/A among African Americans.
- African Americans show the widest distribution in exposure categories. 42% of African Americans report being heterosexual, 29% IDU, 23% MSM, and about six percent (6%) are MSM/IDU.

- Needs assessment data also reveals that:
- In nearly every ethnic group, the largest proportion of women report heterosexual exposure. Within the Anglos, 71% of women report heterosexual contact, the highest of all ethnic groups.
- Latinas report the largest IDU exposure with more than 38% reporting IDU as their mode of transmission.

Figure 1-9 Ethnicity by Mode of Transmission



	Anglo	African Am	Latino	API and other
MSM	41.0%	6.1%	6.4%	1.7%
MSMIDU	8.9%	1.6%	0.6%	0.1%
IDU	6.1%	7.5%	1.8%	0.3%
Hetero	4.7%	11.0%	1.6%	0.4%

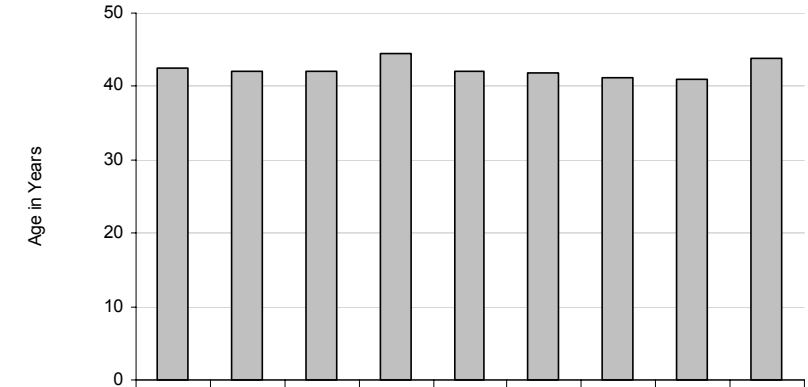
Age Distribution

The average age of PLWH/A who participated in the survey is 43 years. Four percent (4%) are under 30, 84% are between 30 and 50, and 13% are over 50.[3] Latinos and African Americans are slightly younger, indicating their later entry into the epidemic. In the SEMAS database, about 7% of PLWH/A are between 18 and 30.

Figure 1-10 shows the average age by mode and stage of HIV infection. The data indicates:

- Amongst risk groups, IDUs are the oldest, averaging 45 years of age.
- Reflecting the progression of HIV to AIDS, PLWA are older than those living with HIV.

Figure 1-10 Age by Mode and Stage of Infection



	TOTAL	MSM	MSMIDU	IDU	Hetero	HIV asymp	HIV symp	AIDS asymp	AIDS symp
Average age	42.5	42.1	42.2	44.6	42.2	41.9	41.1	41.0	43.8

[3] Based on the epidemiology of PLWA at the end of 2002, the sample is slightly younger but, since it includes PLWH, it is likely to approximate the population.
Using that same estimate, approximately 95 cases would be found in Placer and 86 cases in El Dorado. Therefore, there would be approximately 2,162 estimated cases of PLWH in the Sacramento EMA.

Relationships

In determining the care needs of PLWH/A, the support system of a PLWH/A can play a significant role in providing their care, or if other family members are HIV positive, can indicate situations where additional care is needed. PLWH/A who are married or living with partners often have a caregiver, but may also have larger financial needs if the partner is not working or disabled. PLWH/A with families also have particular needs, including day care and services for children when seeking care.

- 11% PLWH/A reported living with children in the same household. African Americans (25%) are more likely than Latinos (19%) and Anglos (5%) to live with children.
- 35% of PLWH/A report living alone. Men are more likely (39%) to live alone than women (19%). Sixteen percent (16%) of PLWH/A live with an HIV positive partner.

Income

In order to receive Ryan White and state supported benefits, the current HIV/AIDS care system has income restrictions depending on the service provided. For instance, in order to qualify for the AIDS Drug Assistance Program (ADAP) or other state-funded medication reimbursement programs, PLWH/A are eligible if they don't surpass 400% of the Federal poverty levels (between $33,000 and $34,000 a year for a single person).

The sample drawn from Ryan White funded providers is likely to over-represent persons living at or near the poverty level. Still, only 2% of the sample report making over $35,000, making the vast majority eligible for Ryan White care services including ADAP.

Figure 1-11 shows income levels by gender and mode. It indicates that:

- In general, those participating in the survey have low incomes, with about 87% reporting earning less than $16,500 and approximately 48% reporting earning less than $8,600.
- Women report significantly lower income than men. Seventy-two percent (72%) of women report an annual income of $8,600 or less.
- Among risk groups, the vast majority of IDUs (98%) and heterosexuals (96%) have incomes of $16,500 or less per year. MSM have the highest income with 18% making more than $16,500 followed by MSM/IDU (16%). While MSM living with HIV/AIDS are at every income level, heterosexuals and IDUs tend to be very poor or have incomes above $16,500. However, even among MSM and MSM/IDU, less than 4% report earning more then $35,000 – the usual limit to qualify for ADAP.

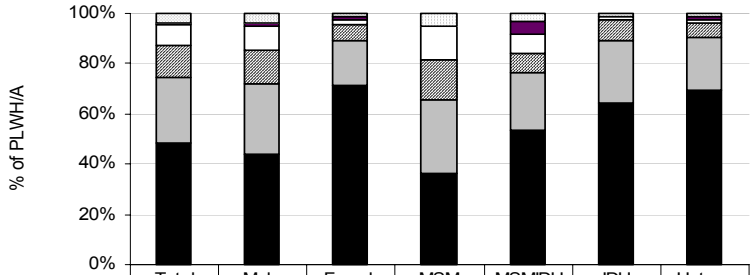
Figure 1-12 shows income by ethnicity. This graphic indicates that:

- Over half the Latinos and African Americans report earning $8,600 per year or less.
- Anglos report the highest income of any group, with 17% earning $16,500 or more per year.

Needs assessment data further indicates that:

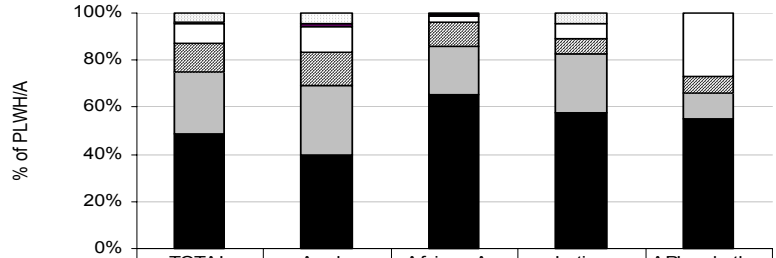
- Over 80% of the homeless and recently incarcerated report earning less than $11,600 a year with over 60% report earning less than $8,600 a year.
- PLWH report the lowest income, suggesting that the newly infected are from the lowest socio-economic brackets, and are coming into the epidemic with a high level of need of social and medical services.

Figure 1-11 Income by Gender and Mode



	Total	Male	Female	MSM	MSMIDU	IDU	Hetero
Greater than $26,001	3.5%	4.0%	1.3%	5.0%	3.2%	1.4%	1.3%
$23,201 - $26,000	0.9%	0.8%	1.3%	0.2%	4.8%	0.0%	1.3%
$16,501 - $23,200	8.5%	9.9%	2.0%	13.1%	8.0%	0.9%	1.1%
$11,601 - $16,500	12.3%	13.5%	6.3%	16.3%	7.6%	8.3%	6.2%
$8,601 - $11,600	26.2%	28.0%	17.5%	28.9%	23.2%	25.2%	20.6%
$8,600 or less	48.6%	43.7%	71.6%	36.5%	53.2%	64.2%	69.5%

Figure 1-12 Income by Ethnicity



	TOTAL	Anglo	African Am	Latino	API and other
Greater than $26,001	3.5%	4.7%	0.9%	4.3%	0.0%
$23,201 - $26,000	0.9%	1.3%	0.5%	0.0%	0.0%
$16,501 - $23,200	8.5%	10.7%	2.6%	6.4%	26.7%
$11,601 - $16,500	12.3%	14.4%	9.9%	6.9%	7.5%
$8,601 - $11,600	26.2%	29.5%	20.4%	24.7%	10.7%
$8,600 or less	48.6%	39.4%	65.7%	57.7%	55.1%

Employment Status

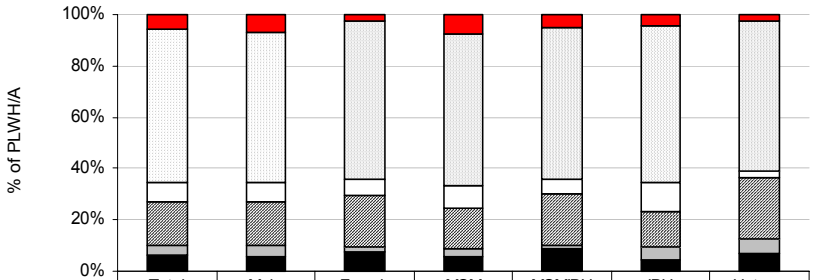
Figure 1-13 and Figure 1-14 shows employment status by gender and mode and by ethnicity. The figures show the following:

- The majority of PLWH/A are not currently working (89%). Seventeen percent (17%) of those not working are actively looking for work, 7% are students or homemakers, 6% are

retired, and 59% are not looking for work. About 10% are either employed part- or full-time.

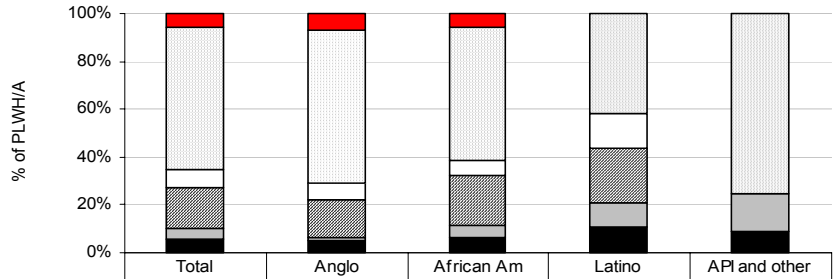
- Men and women are equally likely to not be working, however, more women (20%) report looking for work than men (17%), and slightly more women are employed full time (7.3%) compared to men (5.6%).
- Among risk groups, MSM/IDU have the highest percent of persons employed full-time (9%), followed by heterosexuals (7%), MSM and IDUs at 5%.
- Among ethnic populations, Latinos have the highest percent of PLWH/A who are currently employed full-time at 11%. More Latinos (23%) and African Americans (21%) report looking for work than any other ethnic group.

Figure 1-13 Employment Status by Gender and Mode



	Total	Male	Female	MSM	MSMIDU	IDU	Hetero
Retired	5.8%	6.5%	2.4%	7.4%	4.8%	4.4%	2.5%
Not working/not looking for work	58.8%	58.2%	61.5%	58.4%	59.2%	61.3%	57.3%
Not working - student/ homemaker	7.4%	7.5%	6.8%	8.4%	5.6%	10.9%	2.2%
Not working/looking for work	17.2%	16.6%	19.7%	15.6%	20.0%	13.8%	23.4%
Employed part-time	3.8%	4.1%	2.2%	3.3%	1.3%	5.2%	5.7%
Employed full-time	5.9%	5.6%	7.3%	5.4%	8.8%	4.5%	6.7%

Figure 1-14 Employment Status by Ethnicity



	Total	Anglo	African Am	Latino	API and other
Retired	5.8%	7.0%	5.9%	0.0%	0.0%
Not working/not looking for work	58.8%	62.5%	55.3%	41.9%	74.1%
Not working - student/ homemaker	7.4%	6.7%	6.6%	14.7%	0.0%
Not working/looking for work	17.2%	15.4%	20.7%	22.7%	0.0%
Employed part-time	3.8%	1.7%	5.1%	9.8%	15.6%
Employed full-time	5.9%	4.7%	6.5%	10.9%	8.8%

OUT-OF-CARE

HRSA and CDC have placed emphasis on identifying those with unmet need (those out-of-care) and bringing them into medical services. For planning, it is helpful to know the number of PLWH/A who are out-of-care and, if the system is successful in identifying them and brining them into care, the impact on the needed services and capacity of the continuum of care.

Estimated Number and Profile of Out-of-Care

When talking about out-of-care it is useful to divide the populations into three segments:

- A pattern of starting care after a period of delay and continuing care,
- Those who have started care and stopped, and
- Those who have an inconsistent pattern of starting and stopping care.

Earlier it was noted that there are an estimated 3,422 PLWH/A who know their status in the Sacramento EMA and they would be the individuals that have a possibility of seeking AIDS services. The SEMAS system shows about 1,770 clients receive services funded by Ryan White Care. For all services that would suggest that about half of PLWH/A who know their status and have an income of 300% of the federal poverty level are not receiving Ryan White funded services (although they may be accessing services through other sources).

Using the recommended CDC estimate that 25% of all those infected don't know their status, there would be an estimated 4,600 PLWH/A in the EMA. Based on the estimate that 96% of the PLWH/A accessing Ryan White Care services are at or below 300% poverty level, nearly 4,400 would be eligible for Ryan White funded services, and as outreach expands to reach those out of service, the system will have to accommodate new clients in the care system.

Given the number of men who are infected, there are more men and MSM out-of-care. However, women are disproportionately represented among delayed care seekers. Proportionately, African Americans are much more likely to delay care, access care inconsistently, and stop care.

Delayed care seeking is related to education, and the data indicate that those with less education are more likely to name lack of knowledge as a barrier to seeking care. Low literacy and Spanish language campaigns to inform person about where and when to seek care could make a significant impact. Delayed care seekers and those out-of-care are much more likely to have been recently incarcerated, and there is ample evidence to show that care in jails is not adequate.

Those currently out of care are much more likely to say that reasons for not going to care is some problem with a provider and a feeling that there are few alternatives. Where there are few alternatives for where to access care, providers need to assure that there is an accessible grievance procedure.

Those unconnected to care name structural problems with getting into the system as greater barriers, and it is clear from the data that basic home and food needs trump HIV/AIDS care services as necessities.

STAGE OF INFECTION AND OPPORTUNISTIC INFECTIONS

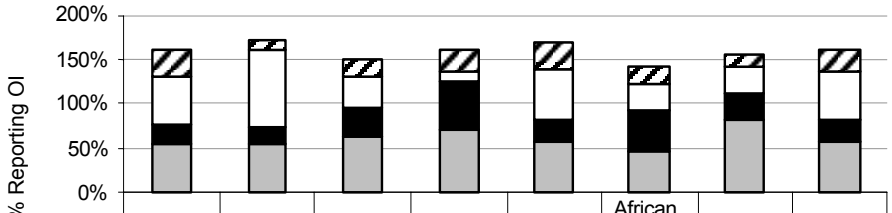
Based on the Table 1-3, 41% of the PLWH/A have been diagnosed with AIDS and 58% have HIV and have not progressed to AIDS. (Notably, a majority of the sample of PLWH/A used in the needs assessment survey report having AIDS, suggesting a slight over-representation of those at more advanced HIV disease.)

Based on the survey data, using accepted medical criteria, it is estimated that 68% of PLWH/A are likely to need medical treatment for their infection. And for those in early stages of HIV, there is considerable support for early intervention; about 20% of the participants reported becoming infected in the last three years, and a significant part of that population is likely to be eligible for early intervention. Consistent with the length of time of infection and the trend in the epidemic, currently Anglos (47%), MSM (47%), and men (42%) are more likely than other populations to have T-cell counts below 350 cells/uL.

As shown in Figure 1-15:

- Almost 60% of the people reporting OIs said they had herpes or shingles. Latinos and heterosexuals report herpes and shingles more frequently.
- Just over 50% of all PLWH/A who report OIs, and 75% of MSM/IDU say they have had thrush or Candidiasis.
- Over a quarter of those who have had an OI report a history of PCP or pneumonia. It is surprising to see that it is most frequently reported by those newest to the epidemic, heterosexuals and African Americans. It is much greater among women (not shown in the figures), although this finding may not be reliable due to small sample sizes.

Figure 1-15 Opportunistic Infections



	MSM	MSM/IDU	IDU	Hetero	Anglo	African Am	Latino	Total
Wasting	28.2%	12.7%	20.3%	22.9%	28.4%	19.5%	14.7%	24.9%
Thrush	54.3%	84.3%	35.1%	12.1%	57.4%	30.3%	29.5%	51.9%
PCP	22.7%	20.4%	32.0%	53.9%	23.8%	45.1%	29.3%	26.5%
Herpes	54.8%	54.2%	63.6%	71.1%	57.8%	47.9%	82.3%	57.3%

ACCESS TO HEALTH CARE

Where PLWH/A Go For Medical Care

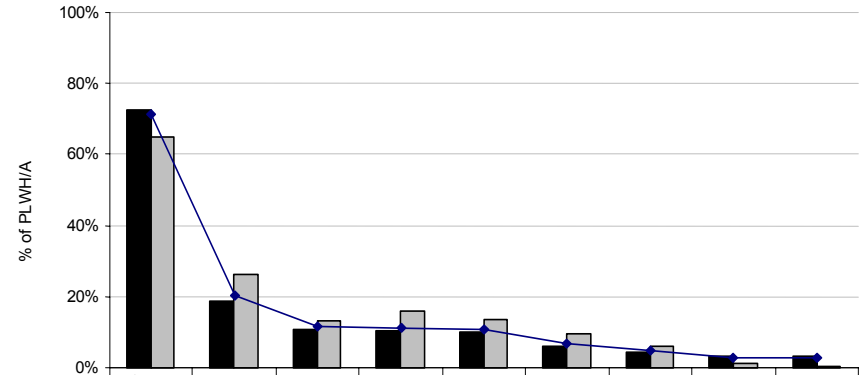
Ryan White Care Act has an objective of 100% access to care for all persons living with HIV/AIDS, regardless of ability to pay. Because Ryan White Care Act funds are to be used as a last resort, it is important to know how many persons have different types of benefits and what those benefits cover.

The vast majority of PLWH/A, whether insured or not, access medical care through a number of clinics and community organizations in Sacramento. By far the largest medical provider to PLWH/A is the community clinic at CARES but UC Davis, private doctors, VA, Kaiser, ER, and other clinics offer HIV/AIDS care as well.

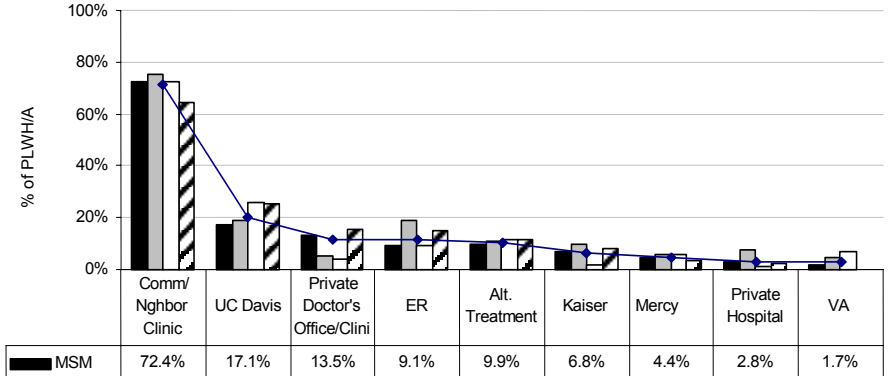
In the survey participants were asked where they received their medical care most often. Of the 383 participants, all but twelve (3%) noted a place of care. About two-thirds reported one place for medical care, 17% report two, and 8% report three. Figure 1-16 displays the sites for the total sample, sex/gender subpopulations, race/ethnicity, and risk group. They are not mutually exclusive – as noted above over a quarter of the PLWH/A reported more than one site where they usually receive their medical care. Overall:

- The vast majority (71%) of PLWH/A receive medical care from community clinics such as CARES and County Clinics.
- While community clinics are the most common site for all populations, Latinos (88%) are more likely than other populations to use community clinics for their care.
- Men living with HIV and AIDS use community clinics, private hospitals, and the VA more than women living with HIV/AIDS, while women use all the other care facilities slightly more than men.
- About 20% of PLWH/A report using UC Davis Medical Center, with women, IDUs, African Americans, and Latinos being more likely to use this site for medical care.
- Slightly more than 11% of the PLWH/A say they use a private doctor or private clinics. Women, heterosexuals, and Anglos are more likely to use private facilities. Because the sample was recruited through community-based providers this may be an underestimate.
- Emergency rooms are visited by about 11% of PLWH/A. Women and MSM/IDU are more likely to go to the emergency room than other subpopulations.
- About 11% of PLWH/A receive their medical care from alternative treatment facilities (not the ER, hospital, doctor's office or clinic). Alternative treatments are used more by women than by men. Of those reporting alternative care, most also report receiving clinic based medical care. About 30% say they use UC Davis, and about 22% use private doctors, clinics or hospitals.
- About 8% of PLWH/A report using Mercy Hospital and Kaiser Permanente Hospital System.
- About three percent (3%) of PLWH/A report using the VA. Not surprisingly men are much more likely to report using the VA than women. IDUs are also more likely to use the VA for medical care than other populations.

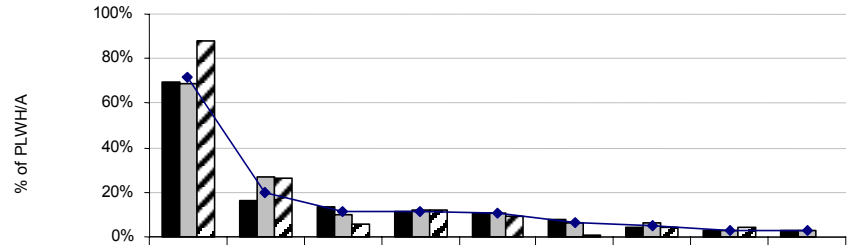
Figure 1-16 Medical Care Sites



	Comm/ Nghbor Clinic	UC Davis	Private Doctor's Office/Clini	ER	Alt. Treatment	Kaiser	Mercy	Private Hospital	VA
Male	72.7%	18.9%	11.0%	10.3%	9.9%	6.0%	4.5%	3.3%	3.1%
Female	65.0%	26.2%	13.3%	16.0%	13.5%	9.5%	5.8%	1.1%	0.4%
TOTAL	71.3%	20.2%	11.4%	11.3%	10.6%	6.6%	4.7%	2.9%	2.6%



	Comm/ Nghbor Clinic	UC Davis	Private Doctor's Office/Clini	ER	Alt. Treatment	Kaiser	Mercy	Private Hospital	VA
MSM	72.4%	17.1%	13.5%	9.1%	9.9%	6.8%	4.4%	2.8%	1.7%
MSMIDU	75.3%	19.2%	5.1%	19.2%	10.8%	10.0%	6.0%	7.2%	4.8%
IDU	72.7%	25.9%	3.8%	9.1%	11.7%	1.8%	6.0%	1.0%	7.1%
Hetero	64.2%	25.1%	15.5%	15.1%	11.5%	7.9%	3.7%	2.4%	0.0%
TOTAL	71.3%	20.2%	11.4%	11.3%	10.6%	6.6%	4.7%	2.9%	2.6%



	Comm/ Nghbor Clinic	UC Davis	Private Doctor's Office/Cli	ER	Alt. Treatme nt	Kaiser	Mercy	Private Hospital	VA
Anglo	69.3%	16.6%	13.4%	11.5%	10.9%	7.6%	4.4%	3.0%	2.9%
African Am	68.8%	26.7%	10.1%	11.7%	10.7%	6.7%	6.1%	2.7%	2.6%
Latino	88.2%	26.6%	5.4%	11.7%	9.2%	0.5%	4.2%	4.2%	0.0%
TOTAL	71.3%	20.2%	11.4%	11.3%	10.6%	6.6%	4.7%	2.9%	2.6%

Insurance Coverage

Non-Insured

In the survey participants were asked to report if they had insurance and, if so, the various forms of health insurance coverage they have. Twenty percent (20%) of the PLWH/A who were surveyed reported having no form of insurance.

- Despite that fact that poor women often have more insurance options than men, women (23%) and MSM/IDU (26%) are more likely to report not having insurance than other populations of PLWH/A. However, about 87% of the women with at least one child report having insurance.
- Latinos are more likely than any of the other ethnic populations to not be insured.
- People with HIV are slightly more likely to be non-insured, and those that are HIV asymptomatic are much more likely to be noninsured.

In other EMAs women are more insured than men. In California, they have greater access to insurance though various sources including Medi-Cal, and Healthy Families (SCHIP) and California Children's Services (CCS) and have access to care and benefits through programs related to WIC and TANF. While a greater percentage of women in Sacramento receive WIC and TANF than men, a substantially lower percentage report receiving SSI, SSDI, or Medi-Cal/Medicaid.

Insurance Profile

About 80% of the PLWH/A interviewed report some type of insurance. There appears to be an impact of counseling in obtaining benefits as HIV disease progresses; about two-thirds of HIV asymptomatic participants have insurance.

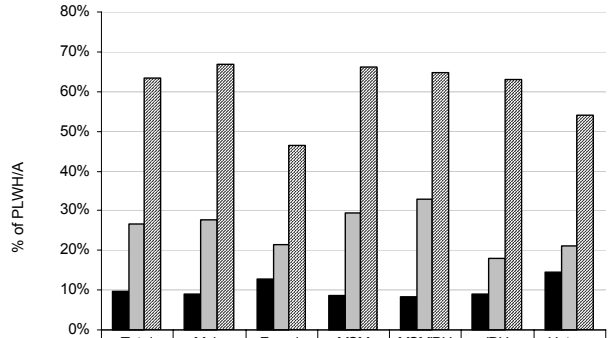
Confirming that insurance is a barrier to obtaining care, only 56% of those out-of-care report having insurance (this may be an unstable estimate due to the small sample size (N=23).

While the level of insurance is not dramatically different by subpopulations, the types of insurance vary by life experience. As expected, Anglos and MSM, due to their generally higher incomes and past work experience, and greater likelihood of having AIDS, are more likely to be eligible for Medi-Cal and/or Medicare. Interestingly, IDUs (83%) are more likely to be insured than other risk groups, while MSM/IDU (74%) are least likely to report having any form of health insurance.

As shown in Figure 1-17 and Figure 1-18 several types of insurance are reported by PLWH/A. Figure 1-17 and Figure 1-18 indicate that the different types of coverage vary by population.

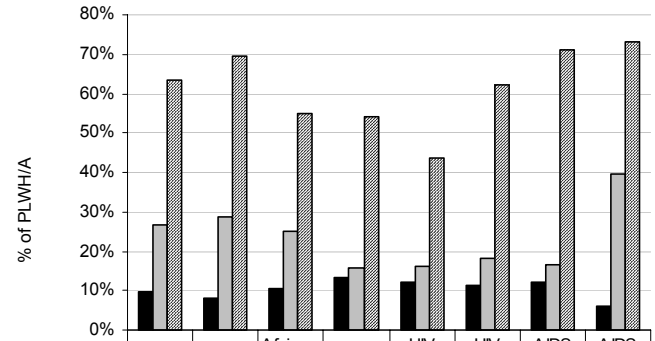
- Medi-Cal/ Medicaid are by far the most common form of insurance for all populations infected with HIV/AIDS in the Sacramento area, with men, Anglos, and PLWA being the groups most likely to have this type of insurance.
- Medicare is the second most common form of insurance for PLWH/A in Sacramento. Overall, more than one quarter of PLWH/A report receiving Medicare. However, a much lower percentage of IDUs, Latinos, and asymptomatic PLWH report receiving Medicare than other groups.
- Overall, a much lower percentage of PLWH/A (10%) report having private insurance than Medi-Cal or Medicare. However, women, heterosexuals, and Latinos report the highest private insurance coverage. This is consistent with their reported higher level of employment.

Figure 1-17 Insurance Coverage – Gender and Exposure Category



	Total	Male	Female	MSM	MSMIDU	IDU	Hetero
Private/COBRA	9.8%	9.1%	12.9%	8.7%	8.4%	9.1%	14.7%
Medicare	26.5%	27.6%	21.4%	29.5%	32.8%	17.9%	21.0%
Medi-Cal / Medicaid	63.3%	66.9%	46.5%	66.1%	64.8%	63.0%	54.2%

Figure 1-18 Insurance Coverage – Ethnicity and Stage of Disease



	Total	Anglo	African Am	Latino	HIV asymp	HIV symp	AIDS asymp	AIDS symp
Private/COBRA	9.8%	8.2%	10.6%	13.4%	12.2%	11.2%	12.1%	6.2%
Medicare	26.5%	28.7%	25.2%	15.7%	16.0%	18.3%	16.5%	39.6%
Medi-Cal / Medicaid	63.3%	69.7%	54.9%	54.0%	43.7%	62.4%	71.2%	73.2%

Non-insurance Entitlements and Benefits

PLWH/A access health care through non-insurance benefits, including Veteran's Assistance (VA), public health services, WIC, and through drug reimbursement programs, like ADAP.

VA and Public Health Services

About three percent (3%) of the PLWH/A report VA benefits and an additional one percent (1%) report receiving CHAMPUS, a form of VA for non-military personnel. Among the recipients of VA benefits, about 12% report having no insurance.

Less than one percent of the PLWH/A report receiving public health services or Bureau of Indian Affair benefits. Which is consistent with the small percentage of Native Americans who participated in the needs assessment survey.

Drug Reimbursement

The data suggest that PLWH/A do not have a clear sense of how their medication is purchased. While up to 22% and 44% of the PLWH/A report that ADAP or Medi-Cal/Medicaid paid for their medications, respectively, more than 30% do not know the amount of prescriptions paid for by any of their sources of drug reimbursement.

In addition, 6% of the PLWH/A report that their medication was reimbursed by private insurance, 7% of PLWH/A reports out-of-pocket medication cost, and about two percent (2%) report receiving VA benefits to cover their medications.

Other Benefits

PLWH/A receive other benefits, such as food, housing, and financial assistance that are funded through a variety of sources. These entitlement and benefits are triggered by low income and disability. When PLWH/A are asked if they qualify for benefits, eight percent (8%) report not being eligible for benefits with an additional six percent (6%) not knowing whether they qualify or not.

Disability

About 24% of PLWH/A report being on long term disability. As expected the rate of disability is higher among those infected earlier, such as males, Anglos, MSM, MSM/IDU, and symptomatic PLWA. Latinos, heterosexuals, women and PLWH are the least likely to receive long term disabilities.

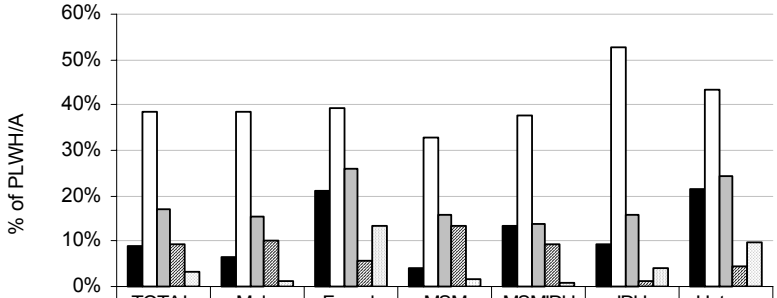
Supplementary Income

Income supplements include Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF), emergency financial assistance, rent assistance, food stamps, and long-term and short-term disability payments. SSI and TANF are based on family income and SSI also required a status of disability. Those on SSI usually qualify for Medi-Cal/Medicaid. Emergency assistance paid for by Ryan White usually covers rent, utilities, food, or medication reimbursements. Access to emergency financial assistance is through a case manager.

The proportion of PLWH/A reporting supplemental sources of income is shown in Figure 1-19 and Figure 1-20. The data show that:

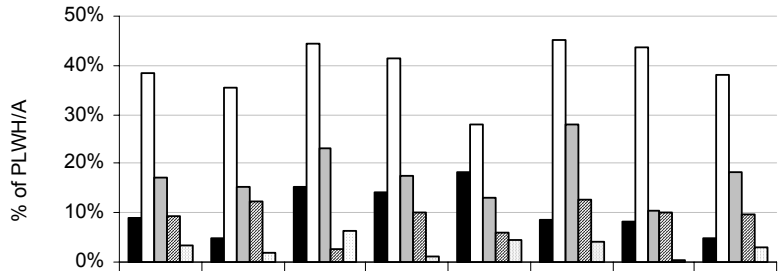
- Indicative of the low income of PLWH/A, more than one-third (39%) report receiving SSI and 17% report receiving housing subsidies. IDUs, heterosexuals, African Americans, and symptomatic PLWH are more likely to receive SSI. With the exception of IDUs, these are basically the same groups that receive rental subsidies. In addition, women are much more likely than men to receive rent supplements.
- About 9% of the PLWH/A report receiving direct emergency financial assistance (DEFA), usually used for utilities, rent, or emergency medical treatment. However, women, African Americans, heterosexuals, IDUs, and asymptomatic PLWH are the least likely to receive DEFA.
- Surprisingly, only 9% report receiving food stamps and three percent (3%) report receiving TANF/CalWorks. However, women (21%), heterosexuals (22%), and African Americans (15%) are much more likely to receive food stamps than any other group. Not surprisingly, women (13%) are much more likely to receive TANF/CalWorks than men.

Figure 1-19 Supplemental Income – Gender and Exposure Category



	TOTAL	Male	Female	MSM	MSMIDU	IDU	Hetero
Food stamps	9.1%	6.5%	21.1%	4.0%	13.3%	9.4%	21.6%
SSI	38.6%	38.4%	39.2%	33.0%	37.9%	52.9%	43.5%
Subsidized housing	17.1%	15.2%	26.0%	15.9%	13.9%	15.7%	24.4%
DEFA	9.3%	10.2%	5.5%	13.3%	9.2%	1.3%	4.4%
TANF / CalWorks	3.3%	1.1%	13.4%	1.4%	0.8%	3.9%	9.9%

Figure 1-20 Supplemental Income-- Ethnicity and Stage of Disease



	TOTAL	Anglo	African Am	Latino	HIV asymp	HIV symp	AIDS asymp	AIDS symp
Food stamps	9.1%	4.8%	15.4%	14.2%	18.3%	8.5%	8.2%	4.9%
SSI	38.6%	35.6%	44.6%	41.4%	28.1%	45.0%	43.8%	37.9%
Subsidized housing	17.1%	15.2%	23.0%	17.4%	12.9%	28.1%	10.3%	18.3%
DEFA	9.3%	12.5%	2.7%	10.2%	6.0%	12.7%	10.1%	9.8%
TANF / CalWorks	3.3%	2.0%	6.3%	1.3%	4.6%	4.3%	0.4%	2.9%

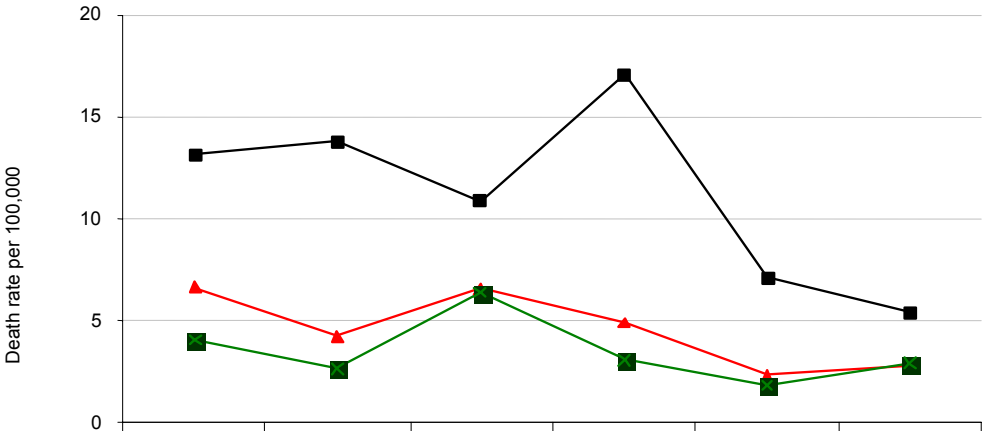
OUTCOMES OF CARE SYSTEM

Mortality

To assess the success of a continuum of care, medical and social outcomes must be measured and tracked. Basic outcomes for the HIV/AIDS continuum of care are mortality, morbidity, and quality of life.

The continuum of care is having the expected positive impact on mortality and morbidity. There has been a sharp decline in death rates of all PLWH/A. However, as shown in Figure 1-21, the death rate among the African American population has remained higher than that of the Anglo and Latino populations. At the end of 2002, the death rate among African Americans was almost twice as high as that of Anglos and Latinos.

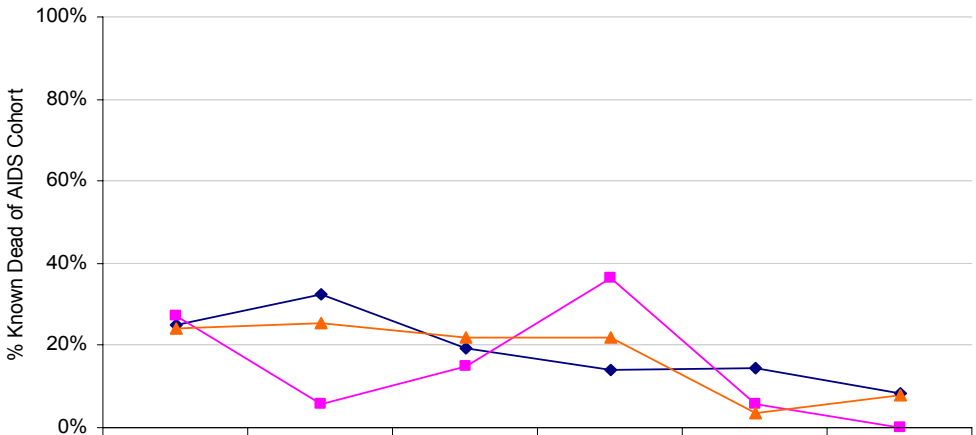
Figure 1-21 HIV/AIDS Deaths by Ethnicity per 100,000 of Sacramento County Population



	1997	1998	1999	2000	2001	2002
African Am	13.2	13.8	10.9	17.1	7.2	5.4
Anglo	6.7	4.2	6.5	4.9	2.3	2.8
Latino	4.0	2.6	6.4	3.1	1.8	2.9

This large discrepancy between African Americans and other ethnic populations is somewhat moderated by the case fatality rates shown in Figure 1-22. The "case fatality rate" measures the death rate among a cohort diagnosed with AIDS during a certain calendar year and tracked to determine year of death. When a cohort of those in care are tracked, African Americans do better, suggesting that once in care, they have similar outcomes to other ethnic populations.

Figure 1-22 % Fatality Rate - Deceased by Year of Diagnosis



	1997	1998	1999	2000	2001	2002
Af Am	25.0%	32.7%	19.4%	13.9%	14.3%	8.3%
Latino	27.3%	5.6%	15.0%	36.4%	5.9%	0.0%
Anglo	24.3%	25.3%	22.0%	21.9%	3.7%	7.7%

Physical And Emotional Health

While there is no trend data, it would be expected that a successful continuum of care would continue to keep persons in good physical health, including those with AIDS. Overall, based on improvement in both physical and emotional health, the care system is making an impact. Well over half of PLWH/A report that their physical and emotional health are the same or better. HIV symptomatic populations report having the worst outcomes.

Figure 1-23 and Figure 1-24 report the current and perceived change in physical health and emotional health. It is divided into three independent groups: 1) PLWH who are asymptomatic 2) PLWH who are symptomatic, and 3) those who report being diagnosed with AIDS (69% symptomatic and 31% asymptomatic. When available, physical and emotional health is compared to similar data collected in the San Francisco EMA.

Physical Health of PLWH With No Symptoms

- Over 60% of asymptomatic PLWH rate their physical health as good or excellent.
- Nearly half (47%) say that their physical health is better now as compared to when they first sought treatment and another 42% say their health is the same.

Physical Health of PLWH With Symptoms

- In contrast, far fewer symptomatic PLWH (39%) report that their health is good or excellent. About 52% report their physical health as fair.
- While about the same percentage of symptomatic PLWH as asymptomatic PLWH say their health is a little better now than when they first sought treatment. The biggest

difference between the asymptomatic and the symptomatic PLWH is that far more symptomatic PLWH (43%) say that their health is worse than before they sought treatment.

Physical Health of PLWA

- Not surprisingly, PLWA have a higher percentage than PLWH reporting poor health (16%). Still, about 40% say they have good to excellent health. Not surprisingly, they report the least improvement in health compared to those at other stages of infection since they started treatment (43%). In comparison to symptomatic PLWH, symptomatic PLWA are currently doing slightly better with 41% reporting good to excellent health compared to 39% of the symptomatic PLWH.
- Women, heterosexuals, and African Americans report the best physical health with about 20% reporting excellent health.

Emotional Health of PLWH With No Symptoms

The emotional health of PLWH is a little worse than their physical health. Symptomatic PLWH in particular report the worst emotional health of those in any stage of infection, but they say that their emotional health has gotten better since they started treatment.

- Nearly half of the asymptomatic PLWH in Sacramento report good to excellent emotional health, and 44% say it is better now than when they started treatment.

Emotional Health of PLWH With Symptoms

- Compared to both asymptomatic PLWH and PLWA, a larger percentage of symptomatic PLWH report poor (19%) or fair (52%) emotional health. This may be connected to concern of their recent diagnosis. But a majority (57%) reports better emotional health than their initial diagnosis.
- In contrast, about the same number of symptomatic PLWH say their emotional health is good or excellent, and significantly fewer say their emotional health is better now than when they first started treatment.

Emotional Health of PLWA

- About 47% of PLWA report excellent or good emotional health, and over 56% report an improvement in health since they started treatment.
- While more than half of PLWH/A report an improvement in their mental health, MSM/IDU (44%) report the poorest improvement in emotional health.

Figure 1-23 Quality of Life – Physical Health

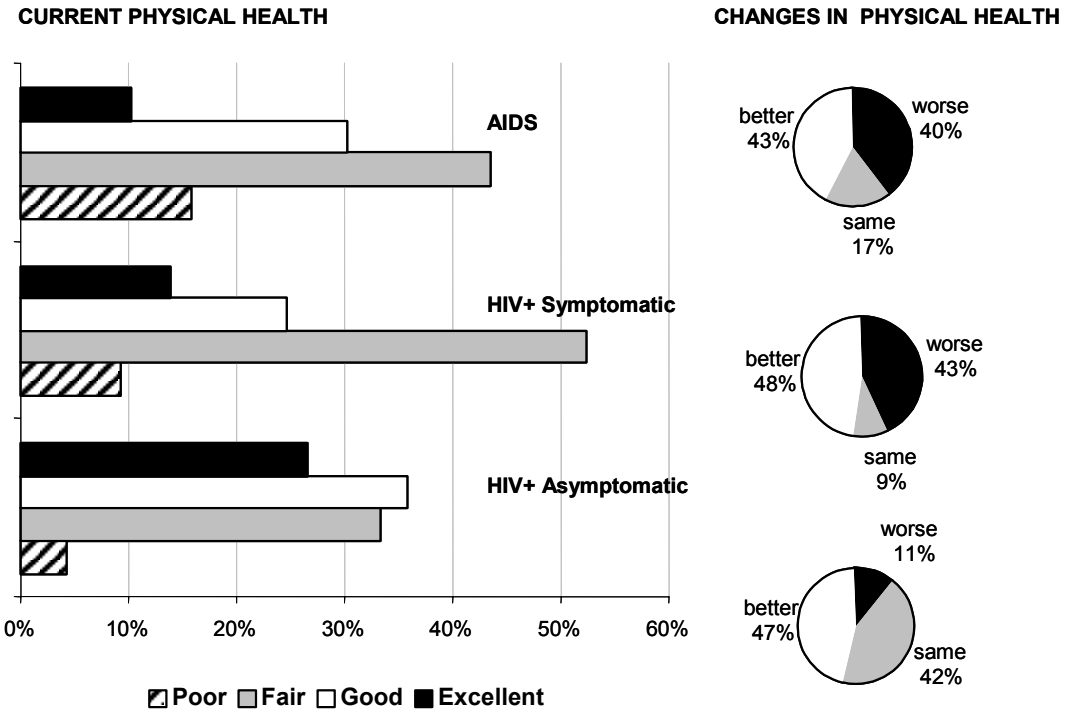
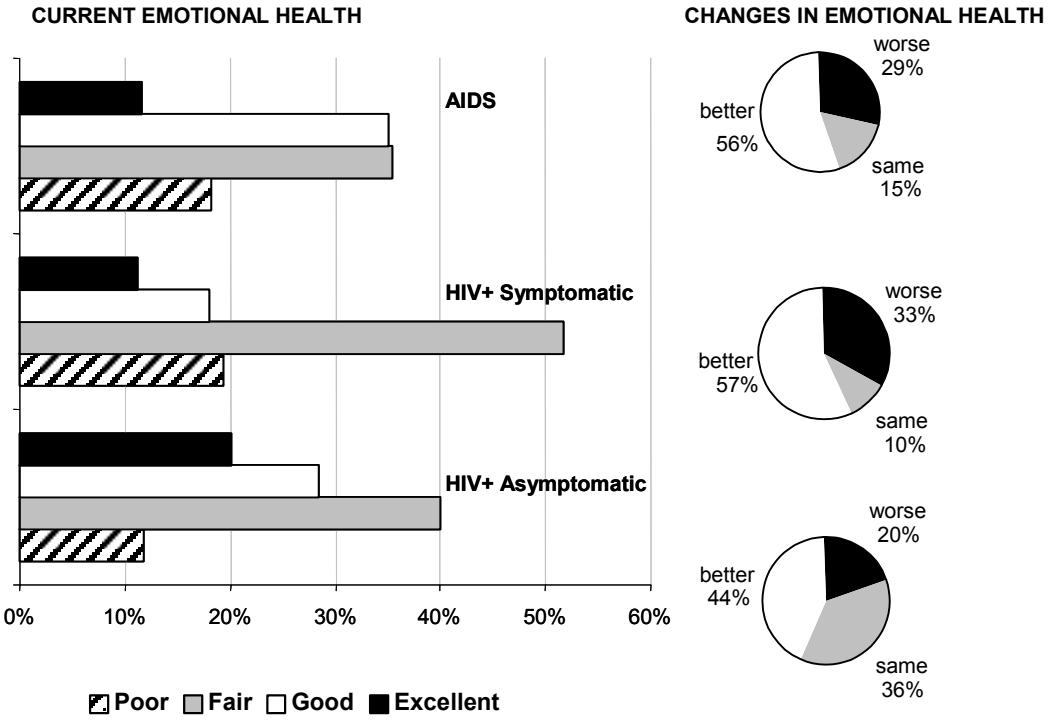


Figure 1-24 Quality of Life – Emotional Health



MEDICATION AND ADHERENCE

An objective of the care system is to increase adherence to medical regimens. Lack of adherence can limit the effectiveness of medication and create resistant strains of HIV. In the needs assessment survey of PLWH/A:

- Eighty-five percent (85%) of all PLWH/A report taking medicines to treat their HIV infection, and there is a linear relationship with stage of disease, starting with 67% of asymptomatic PLWH taking medication to 99% of symptomatic PLWA taking medication (Figure 1-25).
- PLWH/A with a longer history of HIV disease are more likely to have taken HIV medications. For instance, nearly 90% of men, MSM, and Anglos report having taken medications. On the other hand, women (70%) and heterosexuals (63%) are the least likely to have taken HIV medications – most likely as a function of their newer HIV status.
- Forty-two percent (42%) of PLWH/A report never skipping their medications, and at the other extreme, ten percent (10%) have stopped taking their medicines. Women are significantly more likely to stop their medication than men (Figure 1-26).
- Notably, symptomatic PLWA are more likely to skip taking their medication than asymptomatic PLWH/A or symptomatic PLWH.
- Among all groups, forgetting to take them (49%) is typically the major reason for skipping medication, with IDU (67%) and MSM/IDU (56%) being the most likely to forget (Figure 1-27).
- PLWH who are symptomatic and PLWA who are asymptomatic also have higher rates of forgetting than asymptomatic PLWH and symptomatic PLWA.
- The next two most common reasons cited for skipping doses were side effects of medications (39%) and the difficult medication schedules (27%). MSM/IDU (46%) and Anglos (44%) appear to have a greater problem with side effects than other groups. MSM/IDU (40%) also report the most trouble with the medication schedule.
- The three least cited reasons for skipping medications include not understanding the instructions (less than one percent), not wanting others to see taking medications (6%) and the feeling that medicines were no longer needed (6%).

Figure 1-25 Medication by Stage of Infection

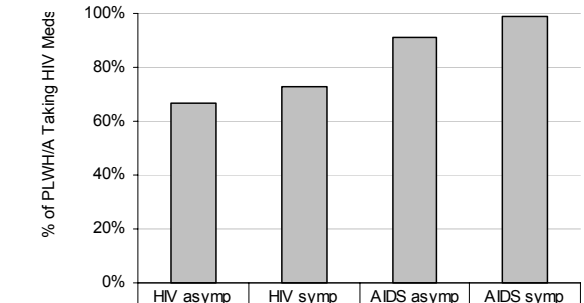
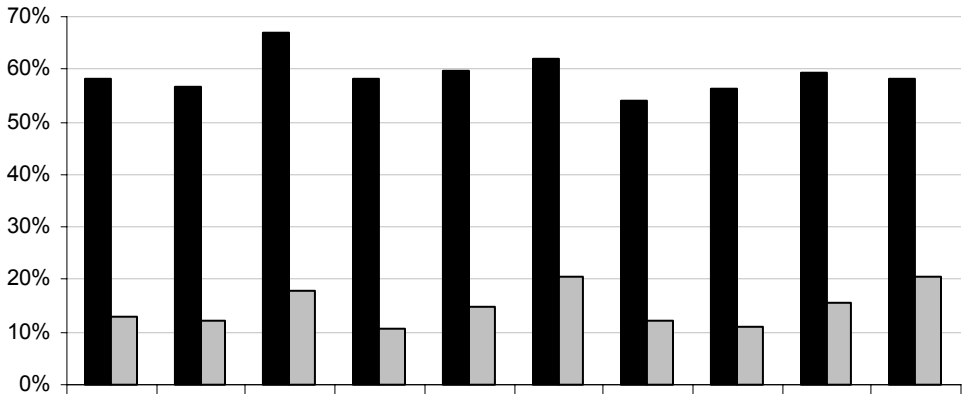
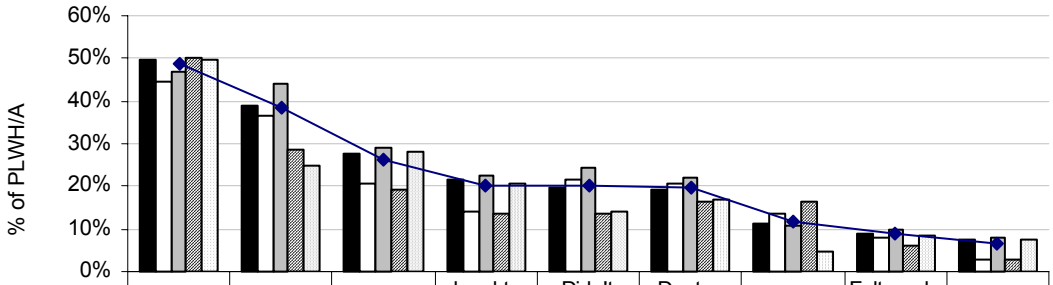


Figure 1-26 PLWH/A Who've Skipped Their Medications



	TOTAL	Male	Female	MSM	MSMIDU	IDU	Hetero	Anglo	African Am	Latino
Ever	58.3%	56.6%	67.1%	58.0%	59.8%	62.1%	53.9%	56.4%	59.3%	58.1%
Last week	13.0%	12.1%	17.8%	10.8%	14.9%	20.5%	12.2%	10.9%	15.4%	20.6%

Figure 1-27 Reasons for Skipping or Stopping Medications by Gender and Ethnicity



	Forgot	Side effects	Difficult sched	hard to coord. w/ food	Didn't want to take them	Doctor advised to stop	Homeless	Felt meds didn't work	Affordability
Male	49.8%	38.8%	27.7%	21.4%	19.9%	19.3%	11.1%	9.1%	7.3%
Female	44.6%	36.8%	20.4%	14.1%	21.4%	20.7%	13.7%	7.9%	2.6%
Anglo	46.9%	43.9%	29.2%	22.5%	24.5%	22.0%	10.9%	9.9%	8.0%
African Am	50.2%	28.6%	19.4%	13.8%	13.6%	16.3%	16.2%	6.1%	3.0%
Latino	49.9%	25.0%	28.3%	20.7%	14.0%	16.9%	4.7%	8.5%	7.6%
TOTAL	49.0%	38.5%	26.5%	20.2%	20.1%	19.6%	11.5%	8.9%	6.5%

CO-MORBIDITIES

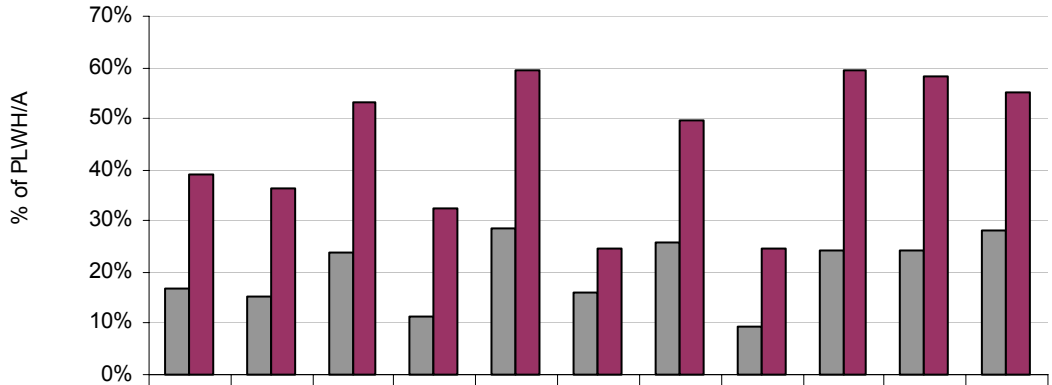
Effective treatment and prevention of HIV can mean treating different serious co-morbidities of PLWH/A. The co-morbidities of homelessness, mental illness, and STDs and drug use are discussed in this section.

Homelessness

Stable housing is often a prerequisite for a PLWH/A who is trying to adhere to a difficult medical regimen and improve their quality of life. Living in shelters with inconsistent access to food and proper nutrition, or sharing living spaces with strangers further aggravates the difficulty in adhering to medications. As shown in Figure 1-28:

- Nearly 17% of those interviewed currently report currently being homeless or living in transitional housing. Thirty-one percent (31%) of PLWH/A interviewed have been homeless in the past two years (not shown), and nearly 40% indicate unstable housing in the last two years.
- Men are less likely to be currently homeless or have a history of homelessness or living in transitional housing than women.
- African Americans are more likely to be currently homeless and have a history of homelessness and living in transitional housing than other ethnic groups.
- Recently incarcerated have the highest rate of homelessness and unstable housing (not shown).

Figure 1-28 Currently & History of Homelessness or Transitional Housing



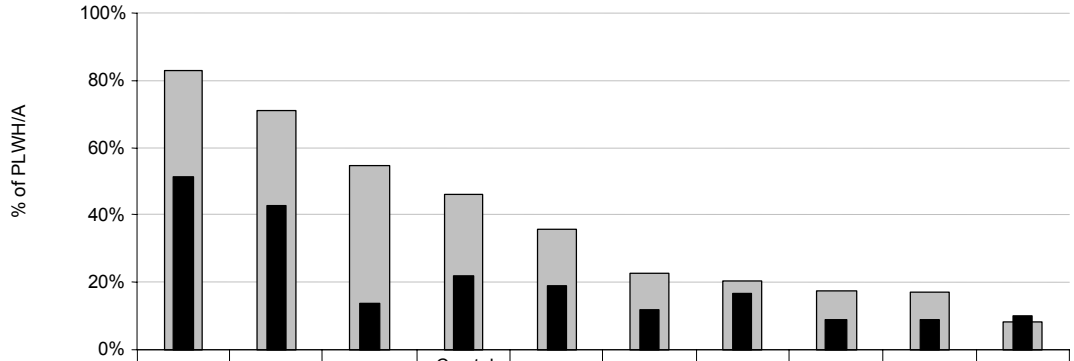
	Total	Male	Female	Anglo	African Am	Latino	API and other	MSM	MSM/ IDU	IDU	Hetero
Currently hmless	16.7%	15.1%	23.8%	11.3%	28.5%	16.1%	25.9%	9.2%	24.3%	24.4%	28.2%
Hist homeless	39.3%	36.3%	53.0%	32.6%	59.5%	24.8%	49.8%	24.7%	59.5%	58.1%	55.0%

Substance Use

Drug use is significantly correlated with symptomatic HIV, suggesting that those who use opiates such as heroin or crack and frequent users of marijuana and alcohol may not be seeking adequate prophylactic treatment and that drug use may be related to the manifestation of symptoms. Based on the survey, those self-medicating with crystal meth or speed show little impact on stage of infection, but heavy use of crystal meth or speed can be harmful by encouraging higher risk behaviors, having negative health consequences, and adding a considerable expense to persons already in or near the poverty level.

Figure 1-29 indicates Sacramento has relatively high drug use, particularly for opiates, crystal meth, and party drugs. Fifty-five percent (55%) of the PLWH/A report using crack/cocaine in the past with 14% of those who have used it in the past saying they used it in the last six months. Twenty-three percent (23%) report using heroin sometime in their life, and 12% of those have used it in the last 6 months.

Figure 1-29 Substance Use Among PLWH/A*



	Alcohol	Marijuana	Crack	Crystal meth	Poppers	Heroin	Pills	Speedball	Ecstasy	GHB
Ever Used (EU)	82.7%	71.0%	54.6%	46.2%	35.7%	22.9%	20.2%	17.5%	16.9%	8.2%
%EU who Currently Use	51.4%	42.6%	13.7%	21.9%	19.2%	11.9%	16.6%	9.2%	9.1%	9.9%

*The black bar represents the % of those who ever used and are currently users. For example, for GHB, 8.2% have ever used GHP, and of those 8.2%, 9.9% currently use it.

In addition:

- Recently incarcerated are among the most frequent abusers of drugs.
- "Party drugs" include poppers, ecstasy, and Gamma Hydroxybutyrate (GHB). More than one third (36%) of the PLWH/A report using poppers, with about 20% of those saying they used in the last six months. Party drugs are much more commonly used by men, Anglos and MSM with as much as three quarters of the MSM/IDU and 43% of the MSM reporting having used poppers in their lives. More than a quarter of MSM/IDU and about six percent (6%) of MSM have used GHB. A very small percentage of heterosexuals (3%) report using ecstasy compared to seventeen percent (17%) of all PLWH/A.

STDs

Sexually transmitted diseases (STDs) have a dual impact on PLWH/A and those at risk for HIV infection. Individuals with a history of STDs are likely to have a compromised immune system and are more likely to contract opportunistic infections (OIs). Also, manifestations of STDs such as open sores and genital ulcers make a person more vulnerable to HIV infection or re-infection. From an epidemiological perspective, a rise in STD rates, particularly gonorrhea and syphilis, indicate a rise in unprotected sexual intercourse that can lead to higher infection rates. Hepatitis, particularly hepatitis C, is associated with needle sharing and is an indication of risk of HIV infection among IDUs.

As expected, a history of STDs is a significant co-morbidity among PLWH/A. What is surprising, however, is that Latinos report one of the highest levels of STDs. This may be a function of the small sample size, but it does suggest that these high levels of STDs among Latinos be further investigated.

- Nearly one quarter of the PLWH/A report having been diagnosed with hepatitis C in the last year. Predictably, the incidence of hepatitis is significantly higher among IDUs (65%) and MSM/IDU (37%).
- Among ethnic communities, the incidence of hepatitis C is highest among Latinos (37%). The data shows that Latinos (23%) report a lower use of intravenous drugs than African Americans (35%) and Anglos (25%), suggesting that they are under-reporting IDU or have other routes of transmission.
- Next highest incidence of STDs is hepatitis A or B (23%). It is significantly higher among men (26%), Anglos (29%) and Latinos (23%). Among the risk groups, heterosexuals (8%) report the lowest incidence of hepatitis A or B.

Mental Illness

Mental illness covers a broad array of mental disabilities. Many people living with HIV and AIDS, particularly substance users, have had mental disabilities prior to becoming infected. For others, the diagnosis of HIV infection or its manifestations has led to mental health service needs. For many mental disabilities can negatively impact seeking and maintaining treatment.

For the purpose of this needs assessment mental illness was defined as having a self-reported diagnosis of anxiety, dementia, or depression. More than two thirds of PLWH/A (69%) reported having been diagnosed with one of these conditions.

- Depression has been diagnosed among 61% of PLWH/A in the past two years, and it is the most frequently diagnosed mental illness reported by PLWH/A. It tends to be highest among men (62%), Anglos (62%), symptomatic PLWA (71%), and MSM/IDU (72%).
- Asymptomatic PLWH (41%), heterosexuals (45%), women (58%), and African Americans (54%), recently incarcerated (58%) and PLWH/A with a history of homelessness (59%) report less than the average incidence of depression. While the lower incidence rates among these populations may suggest greater access to support

systems, it may also reflect a lower likelihood of seeking mental health professionals for a diagnosis.

- Forty–three percent (43%) of PLWH/A report a diagnosis of anxiety in the past two years. Anglos (51%) and MSM/IDU (53%) tend to have received a diagnosis of anxiety more than any of the other race and risk groups.
- There is a significant relationship between substance use and reported mental health problems. PLWH/A who report any type of drug use are also more likely to report substance use. Those using crack/cocaine and crystal meth are much more likely to report mental heath problems.

RESOURCES FOR SERVICES[4]

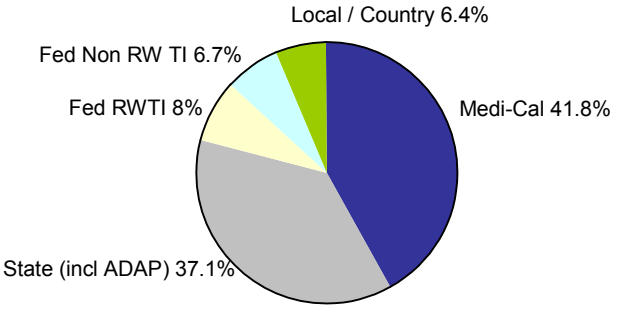
The purpose of this section is to show the relative importance of Ryan White Title I funded services in the overall funding of the continuum of care, and to provide some history about the mechanics of the disbursement of funding. This information is particularly useful in the priorities and allocation process when one of the key elements is providing resources for key services that are inadequately funded elsewhere.

Funding Sources for HIV/AIDS Services

The Sacramento EMA had about $38.4 million in public funding for HIV/AIDS care in 2003. Based on the epidemiological estimate of 4,600 PLWH/A that would mean there is about $8,400 per capita for their care and secondary prevention. This is likely to be low as it does not include those with private insurance, and includes those who are not in-care. While the number served is greater than the approximately 1,700 in the SEMAS database, it will not be all PLWH/A. If the actual number served by the $38.4 million is closer to 2,000, it suggests that there is an actual average per capita expense of over $19,000.

Figure 1-30 shows the distribution of Federal funds, State funds (including ADAP), Federal Ryan White Title I funds, and Federal, non-Ryan White Title I funds. Medi-Cal accounts for over $16 million and is the largest single source of funding for the HIV/AIDS Services Continuum. State funds, including ADAP (the Ryan White Title II pass-through), accounts for $14.2 million. ADAP alone contributes 21% to the HIV/AIDS Continuum of services. Ryan White Title I funds represent about $3 million, or about 8% of all funding. Federal, non Ryan White Title I funds, including Titles II (non ADAP) and III, HOPWA and HUD account for 6.7% of the funding. Local and Country Funds, including special DHHS grants and CARES local funds account for about 6.4% of the funds.

Figure 1-30 Distribution of $38.4 Million HIV/AIDS Funding – 2003

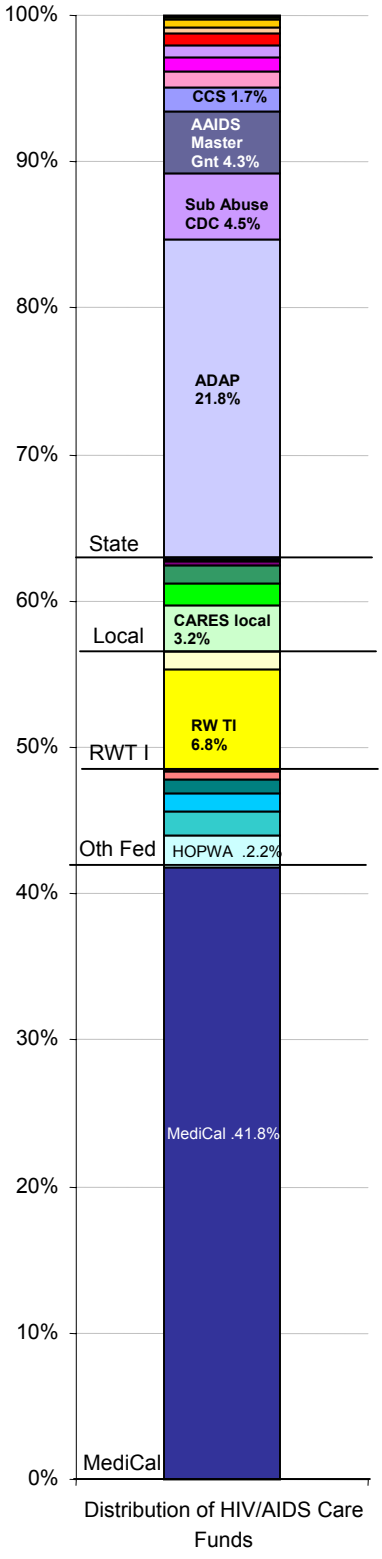


A more detailed accounting of these funds are shown in Figure 1-31. The bar graph on the right is a visual presentation of the distribution of funds and shows the magnitude of MediCal and ADAP in funding the system, and the relative contribution of Ryan White Title I funds.

[4] The information presented below was largely provided by the Grantee for Title I and through published material or grant applications. Information in this section was previously submitted to the Priorities and Allocation Committee and used as part of their deliberations. Ms. Carol Maytum assisted with the collection and presentation of the information in this section.

It further shows some emphasis on Early Intervention programs, and there are several smaller funding sources for education and information, including prevention.

Figure 1-31 Distribution of Funds in the HIV/AIDS Continuum of Services



HIPP	$20,000	0.1%
(Tobacco) Medical	$25,000	0.1%
Court Ordered AIDS Testing	$29,156	0.1%
(Viral Load Test Vouchers)	$37,500	0.1%
(Recent Release)	$181,193	0.5%
El Dorado (AIDS testing, prevention)	$191,235	0.5%
DHHS (PCRS)	$314,832	0.8%
Education (Breaking Barriers)	$326,600	0.9%
Harm Reduction-Outreach/Testing	$337,112	0.9%
EIP (CARES)	$412,855	1.1%
Ca. Child Services (UCD)	$644,590	1.7%
AAIDS Master Grant-no EIP	$1,647,942	4.3%
Substance Abuse (CDC)	$1,710,757	4.5%
ADAP (through RWTII)	$8,358,574	21.8%
State	**$14,237,346**	**37.1%**

Grantee Admin	$17,270	0.0%
Harm Reduction-Outreach/Testing	$10,000	0.0%
Case Mgmt	$54,571	0.1%
(Calif Endowment-outreach research)	$116,000	0.3%
Indigent & Mental	$472,000	1.2%
DHHS	$553,753	1.4%
(CARES - local)	$1,229,033	3.2%
Local /County	**$2,452,627**	**6.4%**

Grantee Admin, Prog Suppt	$487,110	1.3%
RWTI	$2,604,532	6.8%
Federal Ryan White Title I	**$3,091,642**	**8.0%**

Grantee Admin	$61,927	0.2%
HUD	$219,495	0.6%
RW Title III	$365,134	1.0%
DHHS	$472,373	1.2%
RW Titles II	$599,473	1.6%
HOPWA	$850,500	2.2%
Federal Non-Ryan White Title I	**$2,568,902**	**6.7**
MediCal	**$16,068,581**	**41.8%**

History of Ryan White Funding

This plan focuses on the use of the Ryan White Title I funds, and how they can best be configured to complement other funding sources to fill service needs and any gaps in services, and to overcome any barriers to services.

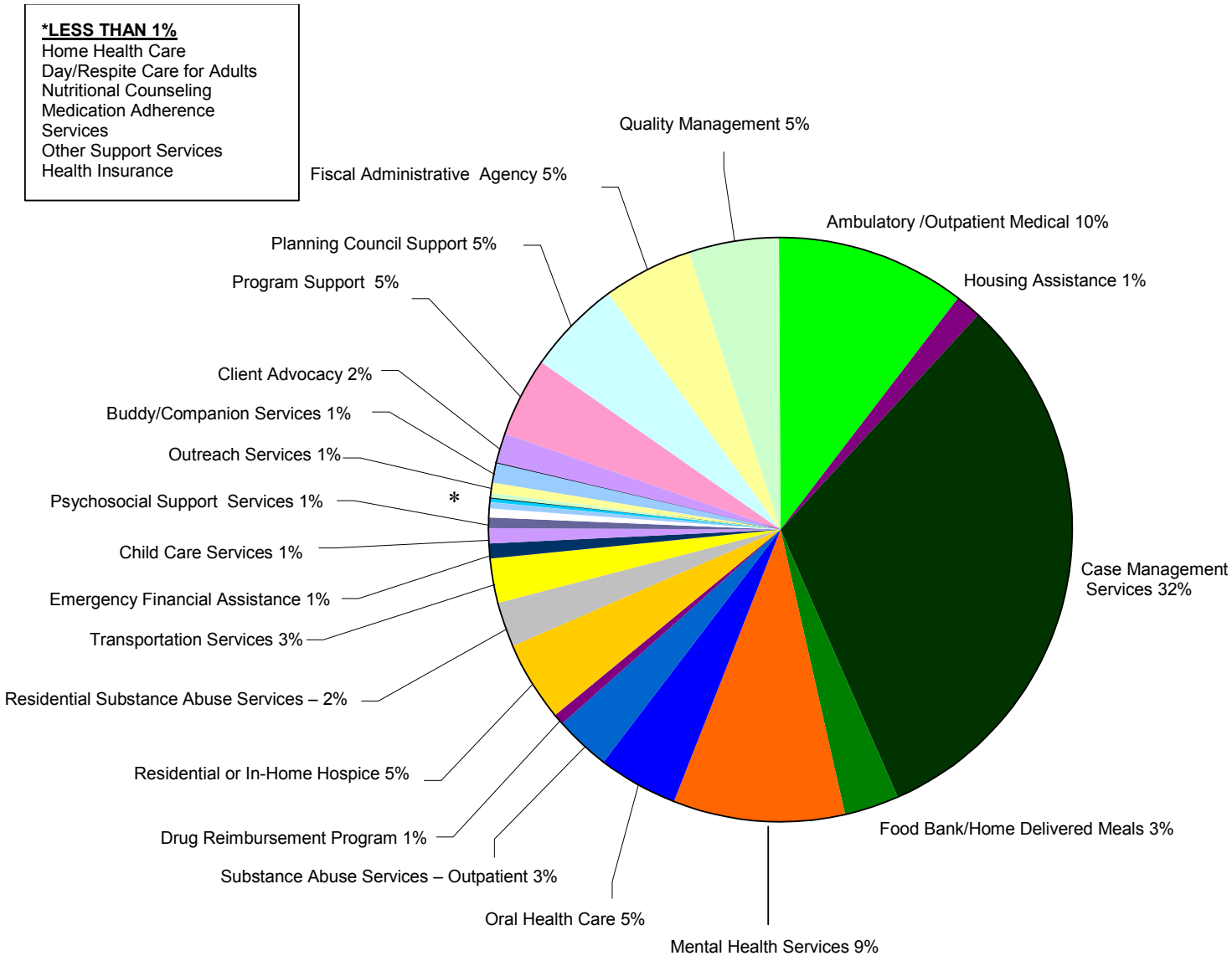
On June 18, 1996, the Director of the Department of Health and Human Services (DHHS) accepted funding from the United States Department of Health and Human Services (USDHHS) for the Ryan White CARE Act (RWCA) Title I and Title II Grant. On April 25, 1997, the State Department of Health Services (DHS), in concurrence with the Rural Counties' Department Directors, Health Officers, and respective Boards of Supervisors designated Sacramento County to act as fiscal agent for El Dorado and Placer Counties for Title II funding. Sacramento County's designation as the "Fiscal Agent" authorizes the Department to subcontract with various vendors to provide planning council staff support, program support and direct services to the community. The USDHHS grant conditions limit the administrative expenditures for the Fiscal Agent and Quality Management to 10% the amount awarded.

The responsibility for planning and distributing the funds rests with the Sacramento HIV Health Services Planning Council, a volunteer body that represents the community of PLWH/A. The HIV Health Services Planning Council is a 30-member community advisory body with the primary responsibility for assessment of need for direct medical psychosocial and support services for persons living with HIV/AIDS in El Dorado, Placer and Sacramento Counties. Additionally, the Council must establish appropriate service priorities and allocate approximately $3.5 million in federal grant funding, as provided under Titles I and II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, to providers of HIV/AIDS services within the region of continuum of care.

Council support is subcontracted to the Community Services Planning Council, a not-for-profit organization in Sacramento. Through monthly meetings and various subcommittee meetings the Council establishes priorities and allocations for the Title I funds and has the responsibility to set service standards and provide directives to providers for the appropriate use of the funds. More detail about the organizational structure of the Council can be found on http://www.communitycouncil.org.

Within Title I, the planned 2003 allocation of the projected $2.7 million in RWTI funds for each service is shown in Figure 1-32. By far, case management has the largest allocation, 32% ($943,263). It is followed by outpatient medical care with an allocation of 10% ($311,389) and mental health services, with an allocation of 9%. Notably, almost $600,000 is added to the outpatient medical care category from Ryan White Title II funds. After that dental care and residential or in-home hospice care were each allocated 5%. Food, transportation, and outpatient substance abuse were each allocated 3%

Figure 1-32 Ryan White Title I Allocations



Priorities and Allocations

The priority setting and resource allocation processes take place annually and traditionally over a period of months. The processes involve community meetings, trainings and data review sessions. The Priorities and Allocation Committee (PAC) leads the priority setting and allocation determination process. The Fiscal Agent is engaged throughout the process as they are responsible for the monitoring of expenditures throughout each fiscal year. As necessary, the PAC establishes ad hoc committees inclusive of consumers and community members to ensure the contribution of diverse perspectives.

Epidemiological data, service utilization data, needs assessment data, community input and CARE Act requirements should guide both the priority setting process and the resource allocation process. Analysis of service utilization based on units of service rather than solely unduplicated client counts is a key information component. This allows for a more detailed understanding of utilization patterns and a closer estimate of the costs associated with various services.

Based on this process and recommended continuum of HIV services, priorities were recommended for 2004-5 that are shown in Table 5. The logic behind these new priorities was to cluster groups of core services and wrap-around services. The priorities recognize the greatest need of outpatient care and gaps in services in oral health, emergency financial assistance, food, and housing.

Table 5 2004-05 Priorities

1	**Ambulatory/Outpatient Medical Care**
2	**Case Management Services**
	Case Management Childcare
	Minority AIDS Initiative
	Office-based Services
	Field/In-Home Services
3	**Oral Health Care**
4	**Emergency Financial Assistance**
	Food Vouchers
	Utility Assistance
	Other Critical Need
	Drug Reimbursement (Non-ADAP)
	ADAP Co-Pay Assistance
5	**Mental Health Services**
6	**Housing Assistance**
7	**Substance Abuse Services – Residential**
8	**Transportation Services**
9	**Substance Abuse Services - Outpatient**
10	**Food Bank/Home-Delivered Meals**
	Food Bank
	Meals
	Nutritional Supplements
11	**Psychosocial Support Services**
	HIV Support Group(s)
	Nutritional Counseling (non-licensed)
	Acupuncture/Chiropractic/Massage Services
	Acupuncture Services (substance abuse)
12	**Residential or In-Home Hospice Care**
13	**Child Care Services**
14	**Treatment Adherence Services**
	Pediatric Services
15	**Health Insurance Continuation**

Allocations

Based on these priorities, allocations were derived which supported the existing distribution of funds, with minor increase to allow for inflation.

Before allocations are determined for any service category, the PAC agrees to use percentages to determine the allocations to categories so that when the award is received from HRSA, allocations will be adjusted according to the percentage. The rationale for this decision is that the process used for the original allocation is a sound, data driven process and the Planning Council should not duplicate its work when the actual award amount is received. Allocations for services should be determined by using a formula that considered the following factors for each service category:

1. Number of unduplicated clients in the previous year (FY2002).
2. Increase in clients accessing services from FY2001 to FY2002.
3. Projected number of clients to be served in upcoming fiscal year FY2004.
4. Average number of units of service or encounters per client in FY2002.
5. Total expenditures in the previous year (FY2002).
6. Average cost per unit of service or encounter (based on total expenditure).

Once the final award from HRSA, or DHS has been received the Fiscal Agent re-calculates the available allocations within each service priority. The available allocations are published in the Fiscal Agent's Request for Proposals (RFP) process that solicits providers of HIV services once every three years. The procurement process solicits a variety on information, including financial information on the "unit cost of service". At the end of the procurement process the Provider and Fiscal Agent negotiate a reimbursement rate. Therefore, from the provider's perspective, understanding their operating cost and full cost (and other payment sources) is a critical element to a successful negotiation.

These allocations are shown in Table 6. This table is based on a worksheet that permits the PAC to change parameters for expected unduplicated counts of clients, unit costs, or average number of unit costs, and therefore model and project different scenarios.

Table 6 Priorities and Allocation - Projected 2004-05

Fiscal Year 2001 – 2002	Expended 2003-4	UOS	UDC	av # units	Exp / UOS	System Change UDC	2004-05 Proj System Change in UDC	Proj Unit Cost	Proj Average Units	2004-05 Est New UDC	Est New Units	Est New Cost	Percent Allo-cation
Service Category: Ambulatory Care													
Service Type													
20 min visit w/HCP*	$769,950	5,310	757	7.01	$145.00	-0.4%	0.0%	$149.35	7.01	757	5310	$793,049	28.53%
20 min specialty care	$17,368	171	27	6.33	$101.57		0.0%	$104.62	6.38	27	172	$18,009	0.65%
1 medication adherence session	$6,757	188	27	6.96	$35.94	-10.0%	0.0%	$37.02	6.96	27	188	$6,960	0.25%
Cost per client					1013		Totals	144.27	6.78	784	5670	$818,018	24.93%
1 vendor paid alter/comp therapy dollar	$53,448	48,589	111	437.74	$1.10	-26.0%	0.0%	$1.10	330.12	111	50050	$55,055	1.98%
1 acupuncture visit	$9,994	443	27	16.41	$22.56	-74.0%	0.0%	$23.24	16.41	27	443	$10,290	0.37%
Total Alternative Therapy													
							Totals	1.29415306	365.89	138	50493	$65,345	1.99%
Service Category: Oral Health Care (Dental)													
Annual Expenditures:													
Service Type	-	-	-	-									
1 dental visit	$155,963	1,514	305	4.96	$103.00	11.7%	0.0%	$106.10	4.96	341	1692	$179,479	5.47%
Service Category: Home Health Care: $0													
Service Category: Mental Health Counseling													
Annual Expenditures:													
Service Type	-	-	-	-									
1 hour adult psychological - ind.	$105,315	1,716	299	5.74	$61.37	-19.6%	0.0%	$61.37	5.74	299	1716	$105,315	3.79%
1 hour child psychological - ind.	$2,290	34	4	8.42	$68.00	-20.0%	0.0%	$68.00	8.42	4	34	$2,290	0.08%
1 hour ind. Family	$8,722	197	1	197.00	$44.27	0.0%	0.0%	$44.27	197.00	1	197	$8,722	0.31%
30 min.'s ind. Psychiatric (adult)	$121,204	1,616	255	6.34	$75.00	-10.8%	0.0%	$75.00	6.34	255	1616	$121,204	4.36%
30 min.'s ind. Psychiatric (child)	$990	12	1	12.00	$82.50	#VALUE!	0.0%	$82.50	12.00	1	12	$990	0.04%

Fiscal Year 2001 – 2002	Expended 2003-4	UOS	UDC	av # units	Exp / UOS	System Change UDC	2004-05 Proj System Change in UDC	Proj Unit Cost	Proj Average Units	2004-05 Est New UDC	Est New Units	Est New Cost	Percent Allo-cation
Each adult attending group	$1,680	56	11	5.09	$30.00	-26.7%	0.0%	$30.00	5.09	11	56	$1,680	0.06%
Each child attending group	$30	1	1	1.00	$30.00	0.0%	0.0%	$30.00	1.00	1	1	$30	0.00%
Totals			**509.00**					**55.8771**	9.99	509	5085	$284,154	8.66%
Cost per client					542								
Service Category: Outpatient Case Management													
Annual Expenditures:													
Service Type													
15 min face 2 face encounter	$414,557	25,581	777	32.92	$16.21	-2.5%	0.0%	$16.21	32.92	777	25581	$414,557	14.91%
15 min other encounter	$169,974	9,584	303	31.63	$17.74	-49.6%	0.0%	$17.74	31.63	303	9584	$169,974	6.12%
15 min CBC/MAI face2 face	$67,507	3,645	24	151.88	$18.52	-84.8%	0.0%	$18.52	151.88	24	3645	$67,507	2.43%
15 min CBC/MAI other	$46,275	2,177	23	94.65	$21.26	-58.2%	0.0%	$21.26	94.65	23	2177	$46,275	1.66%
Totals								19	43.45	954	41451	$787,576	24.00%
Cost per client													
Service Category: Residential Hospice													
Annual Expenditures:													
Service Type													
24 hours of hospice care	$141,837	1,747	18	97.06	$81.19	0.0%	0.0%	$83.63	103.41	18	1861	$155,669	4.74%
Totals													
Cost per client													
Service Category: Substance Abuse Treatment-residential													
Annual Expenditures:													
Service Type													
1 hour residential treatment	$56,063	21,156	26	813.69	$2.65	-18.8%	0.0%	$2.73	813.69	22	25805	$70,434	2.53%
1 hour residential treatment-detox	$28,209	4,872	19	256.42	$5.79	-32.1%	0.0%	$5.96	256.42	19	4872	$29,055	1.05%

Fiscal Year 2001 – 2002	Expended 2003-4	UOS	UDC	av # units	Exp / UOS	System Change UDC	2004-05 Proj System Change in UDC	Proj Unit Cost	Proj Average Units	2004-05 Est New UDC	Est New Units	Est New Cost	Percent Allo-cation
								3.34	727.00	41	29815	$99,494	3.03%
Totals	-	-	-	-									
Service Category: Substance Abuse Treatment-Outpatient													
Service Type	-	-	-	-									
1 addiction assessment	$6,210	100	63	1.59	$62.10	-40.6%	0.0%	$62.10	1.59	63	100	$6,210	0.22%
1 physical assessment	$1,822	35	31	1.13	$52.06	-50.0%	0.0%	$52.06	1.13	31	35	$1,822	0.07%
1 hour outpatient counseling	$18,180	404	61	6.62	$45.00	-26.5%	0.0%	$45.00	6.62	61	404	$18,180	0.65%
1 hour /client /group counseling	$18,056	559	41	13.63	$32.30	-12.8%	0.0%	$32.30	13.63	41	559	$18,056	0.65%
1 hour family counseling	$135	3	1	3.00	$45.00	-66.7%	0.0%	$45.00	3.00	1	3	$135	0.00%
90 min's family group counseling/person	$7,533	233	17	13.71	$32.33	-15.0%	0.0%	$32.33	13.71	17	233	$7,533	0.27%
15 min's other staff encounter	$31,155	1,915	67	28.58	$16.27	-23.0%	0.0%	$16.27	28.58	67	1915	$31,155	1.12%
Totals								$26.87	34.00	95	3230	$86,793	2.64%
Service Category: Supportive Services													
Service Type	-	-	-	-									
Buddy Companion	-	-	-	-									
	-	-	-	-									
1 hour emotional support	$13,377	637	49	13.00	$21.00	11.4%	0.0%	$21.00	13.00	49	637	$13,377	0.48%
1 hour volunteer support	$20,408	1,029	91	11.31	$19.83	-49.4%	0.0%	$19.83	11.31	91	1029	$20,408	0.73%
Total Buddy/Companion								0	0.00	0	0	$0	0.00%
Housing													
1 vendor rent dollar	$19,789	17,990	72	249.86	$1.10	-13.3%	0.0%	$1.10	249.86	72	17990	$19,789	0.71%
1 vendor lodging dollar	$13,355	12,141	31	391.65	$1.10	-45.6%	0.0%	$1.10	391.65	31	12141	$13,355	0.48%
Total Housing								1.1	314.00	99	31055	$34,160	1.04%

Fiscal Year 2001 – 2002	Expended 2003-4	UOS	UDC	av # units	Exp / UOS	System Change UDC	2004-05 Proj System Change in UDC	Proj Unit Cost	Proj Average Units	2004-05 Est New UDC	Est New Units	Est New Cost	Percent Allo-cation
Food/Nutrition													
1 vendor food dollar													
1 vendor vitamin/herb dollar	$5,723	5,202	4	1300.50	$1.10	-50.0%	0.0%	$1.10	1300.50	4	5202	$5,723	0.21%
1 nutritional supplement pack	$6,864	156	31	5.03	$44.00	-18.4%	0.0%	$44.00	5.03	31	156	$6,864	0.25%
1 home delivered meal	$6,989	694	92	7.54	$10.07	-22.7%	0.0%	$10.07	7.54	92	694	$6,989	0.25%
1 food bag	$6,652	732	97	7.55	$9.09	-31.2%	0.0%	$9.09	7.55	97	732	$6,652	0.24%
Total Food/Nutrition								3.98	24.00	220	5315	$21,153	0.64%
Emergency Financial Assistance													
	$55,184	50,168	506	99.15	$1.10	-6.8%	0.0%	$1.10	99.15	506	50168	$55,184	1.99%
1 vendor utility dollar	$34,827	31,661	206	153.69	$1.10	-2.4%	0.0%	$1.10	153.69	206	31661	$34,827	1.25%
1 other critical need dollar	$1,990	1,809	11	164.45	$1.10	-75.0%	0.0%	$1.10	164.45	11	1809	$1,990	0.07%
Total Emergency Financial								1.1	136.00	723	98338	$108,172	3.30%
Transportation													
1 one way trip	$35,340	3,516	157	22.39	$10.05	-32.6%	0.0%	$10.05	22.39	157	3516	$35,340	1.27%
1 vendor transportation dollar	$15,643	14,116	449	31.44	$1.11	28.3%	0.0%	$1.11	31.44	449	14116	$15,643	0.56%
Total Transportation								2.98	42.00	421	17632	$52,513	1.60%
Child/Respite Care													
1 vendor child care dollar	$47,169	47,169	23	2050.83	$1.00	-20.7%	0.0%	$1.10	613.90	31	19031	$20,935	0.64%
Total Child Care													
Treatment Adherence													
1 medication adherence session	$8,030	44	18	2.44	$182.50	-40.0%	0.0%	$187.97	7.05	18	127	$23,854	0.73%
Total Treatment Adherence													
Psychosocial Support Services													
1 nutritional counseling visit	$10,250	5,652	117	48.31	$1.81	41.0%	0.0%	$1.81	48.31	117	5652	$10,250	0.37%
1 hour individual support group	$8,386	136	62	2.19	$61.66	-20.5%	0.0%	$61.66	2.19	62	136	$8,386	0.30%

Fiscal Year 2001 – 2002	Expended 2003-4	UOS	UDC	av # units	Exp / UOS	System Change UDC	2004-05 Proj System Change in UDC	Proj Unit Cost	Proj Average Units	2004-05 Est New UDC	Est New Units	Est New Cost	Percent Allo-cation
Total PSSS								3.32	31.00	219	6878	$22,804	0.69%
Drug Reimbursement													
1 vendor paid medication dollar	$18,802	17,093	59	289.71	$1.10	-13.2%	0.0%	$1.10	298.00	59	17605	$19,366	0.59%
Total Drug Reimbursement													
Client Advocate													
15 min's face 2 face advocate encounter	$16,660	389	23	16.91	$42.83	-48.9%	0.0%	$42.83	16.91	23	389	$16,660	0.60%
15 min's other advocate encounter	$37,255	777	35	22.20	$47.95	-35.2%	0.0%	$47.95	22.20	35	777	$37,255	1.34%
Total Client Advocate								0	0.00	0	0	$0	0.00%
Outreach Services													
1 hour of outreach	$19,691	786	84	9.36	$25.05	211.1%	0.0%	$25.05	9.36	84	786	$19,691	0.71%
Total Outreach Services								0	0.00	0	0	$0	0.00%
												$2,779,484	84.70%
Totals	**$2,663,609**												
Cost per client													
El Dorado County												$219,865	6.70%
Placer County												$282,215	8.60%
Sub-Total Direct Service Allocations												$3,281,564	100.00%
Quality Management												$163,159	
Planning Council Support												$163,159	
Fiscal Agent-Administration												$222,065	
Program Support												$22,300	
GRAND TOTAL FY 04 ALLOCATIONS												**$3,852,247**	

As noted in the Table 6 above, there is a unit cost that when multiplied by the number of units of service expected, results in the overall funding levels. While the client database system is designed to establish unit costs, and most services are paid on a unit cost basis there are notable exceptions, such as outpatient medical care for adults.
The reasons for this are complex, but the end result is that the reimbursement for medical care is based on a cost-reimbursement basis with most of the discretion of cost left with the provider. This system lacks the checks and balances inherent in the unit-costing structure. Moving to a more transparent unit-cost system for all services would add transparency to the system.

Other Sources of Funding

At this time there is not a good understanding of other sources of existing funding. For example, the VA is likely to add about 3% to 5% to the resources for outpatient care, and the impact of private (non MediCal / Medicare) is unknown. The contribution to care of drug trial and pharmaceutical compassionate drug distribution programs are not known. When planning for services, there is a need to determine the contribution of other sources of care.

There is also no coordinated Council plan in place to exploit other funding sources, including other Ryan White Titles. There are applications for Title IV (for CARES) and Title III (CARES) and SPNS applications, but efforts are not tracked or coordinated.

NEEDS, UNMET NEEDS, GAPS

2003 Needs Assessment Methodology

A brief summary of the methodology is found below. A more completed description of the development of survey, focus group, and key informant instruments, sampling, fielding and analysis can be found in the 2003 Needs Assessment Report (June 2003).

Three data collection methods were used by PCH for the Sacramento EMA HIV/AIDS Care Needs Assessment:

1. Secondary analysis of existing needs assessments and epidemiological information in order to estimate incidence and prevalence of HIV and AIDS, develop a sampling plan, and obtain mortality and morbidity data as outcome measures for the continuum of care.
2. A consumer survey was conducted among 383 PLWH/A to determine their HIV/AIDS care needs, unmet needs, barriers, and relevant behaviors, such as adherence to medical regimens, drug use, and quality of life.
3. A series of eight focus groups among target populations permitted in-depth discussion of needs and barriers to services that allow a greater depth of analysis by providing support and exceptions to quantitative findings from the survey. In addition, one-on-one interviews were conducted with parents or guardians of HIV positive children and youth. As part of the process several discussions were held with providers.

A Project Advisory Group (PAG) was formed to provide oversight to the needs assessment process and feedback on survey and focus group tools and draft reports. Decisions regarding content and length were approved by the PAG and they continued to be consulted throughout the project. The names of those on the task force are shown in Attachment 1.

Consumer Survey

Questionnaire

The consumer survey was an interviewer-assisted questionnaire, with trained interviewers available at all sites where the survey was administered to provide guidance and assistance to participants.

The survey instrument was designed and approved on March 14, 2003. The process included a draft submitted by PCH and several rounds of revisions based on comments and specifications of the HHSPC and PAG. The survey was available in English and Spanish.

The survey measured key demographics, insurance and benefits, level of care, stage of infection, medication and adherence, and quality of life, and the awareness, current need, demand, and utilization of services. At the end of each major service category, PLWH/A had an opportunity to say what problems s/he had in obtaining the services.

Following the measurement of service need, PLWH/A ranked different barriers to care. The barriers assessed were based on prior needs assessments conducted by the research team using a multidimensional schema discussed in the Barriers Section in the Needs Assessment. The final questions in the survey measured drug-use and residency status.

Sample Design

The recruitment strategies for the consumer survey were based on a stratified quota sample based on race and risk group. It purposely oversampled specific subpopulations in order to have adequate sample sizes for females, heterosexuals, Latinos and other difficult-to-reach populations. Because the oversampled subpopulations were known, they were weighted back to their populations-proportionate-to-size in the analysis of all PLWH/A.

Survey Analysis

The survey data permits the analysis of needs, unmet needs, and barriers among different key populations. It also permits the estimates of co-morbidities including homelessness, substance use, STDs, mental illness, and tuberculosis among PLWH/A. The survey included measures of quality of life and adherence to medication as additional outcomes of the care system.

For the total sample analysis, oversampled subpopulations are weighed back to their proportion in the estimated HIV population. When subpopulations are compared, the weighted sample is used. However, when special populations are analyzed unweighted data is used to take full advantage of the oversamples.

The survey was analyzed using the statistical package Statistical Program for Social Sciences (SPSS). Analysis of the data was done by the "total sample" and key demographic, geographic, and stage of infection subpopulations. These are shown along with the unweighted sample size, and weighted and unweighted sample proportions in Table 1-7:

Table 1-7 Analysis Populations

Analysis Subpopulation	Unweighted N	Unweighted %	Weighted %
1. Total	383	100%	100%
2. Gender			
2.1 Male	278	73%	82%
2.2 Female	102	27%	18%
2.3 Transgender	3	1%	0%
3. Mode of Transmission			
3.1 MSM	132	35%	55%
3.2 MSM/IDU	68	18%	11%
3.3 IDU	100	26%	16%
3.4 Heterosexual	82	21%	18%
4. Race			
4.1 African American	159	42%	26%
4.2 Anglo	152	40%	61%
4.4 Latino	59	15%	11%
4.5 API and other ethnicities, including Native Americans	13	3%	3%
5. Medical Visit			
5.1 Within last six months (< 6 mos.)	354	94%	95%
5.2 Six months or longer (>= 6 mos.)	21	6%	5%
6. Stage of Infection			
6.1 HIV, asymptomatic	104	28%	23%
6.2 HIV, symptomatic	77	20%	19%
6.3 AIDS, asymptomatic	65	17%	18%
6.4 AIDS, symptomatic	131	35%	40%

Focus Groups and Key Informant Interviews

The purpose of the focus groups and key informant interviews was to gain greater insight into the perception of needs, gaps, and barriers of selected key populations. They supplement the quantitative findings of the consumer survey and, for populations where sample sizes are too small such as immigrants and migrants, they provide the main information for the report. The key informant interviews for the parents or guardians of children living with HIV/AIDS addresses a key population not included in the survey.

Eight focus groups among MSM, MSM of color, recently incarcerated men, women with children and adolescents with HIV, heterosexuals, recently incarcerated women, rural men and women, immigrants/migrants. Seven key informant interviews (1-1) were conducted among parents of children living with HIV/AIDS, adolescents, and the staff of providers. Parents and adolescents were obtained through referrals from a provider who contacted clients to determine their interest in participating in the survey.

Qualitative Analysis

Focus groups were audio taped, transcribed, and entered into a database. PCH staff coded comments by basic demographics and the service and/or barrier they referred to using a

systematic coding scheme (for greater detail see 2003 Needs Assessment Report), and team members sorted these comments based on services and barriers and they were selected for inclusion in the report based on the comment's ability to substantiate and add depth to the quantitative findings or show a view of consumers that is contradictory or different from the quantitative findings.

Service Categorization

Consumers were asked to rank their awareness, need, demand, and utilization for forty-two services, representing twenty-three service categories shown Table 1-8. The twenty-three service categories are shown in order of the Council's 2003 service priorities.

Table 1-8 Service Categories 2003 Priorities

2003 Priority	Service
1	**Ambulatory Outpatient Medical Care** Outpatient medical care Medical Specialist Complementary care
2	**Housing Assistance** Housing info Rental asst Supportive housing
3	**Case Management Services** CM help w/ benefits Benefits counseling Intake session Vocational referrals
4	**Food Bank / Home Delivered Meals** Food bank Food vouchers Delivered meals Nutrition supplement
5	**Mental Health Services** MH 1-1 Family counseling Bereavement counseling
6	**Oral Health Care** Dental care
7	**Substance Abuse Services - Outpatient** Subst abuse counseling Subst abuse assessment Subst abuse 1-1 counseling Subst abuse Grp Subst abuse family counseling Subst abuse peer group
8	**Drug Reimbursement** Medication Reimbursement
9	**Residential or In-home Hospice Care** Residential Hospice Care
10	**Substance Abuse Services - Residential** Sub Abuse Serv – Residential
11	**Transportation Services** Transportation Taxi vouchers
12	**Emergency Financial Assistance** Financial asst
13	**Child Care Services** Child care
14	**Psychosocial Support Services** MH group Peer counseling
15	**Medication Adherence Services** Adherence support
16	**Other Support Services**
17	**Nutrition Counseling** Nutrition counseling
18	**Home Health Care** Home health care
19	**Health Insurance** Insurance Asst
20	**Outreach Services**
21	**Buddy/Companion Services** Buddy emotional support Buddy household tasks Buddy advocate
22	**Day/Respite Care for Adults** Adult day care
23	**Client Advocacy** Client Advocacy

Top Needs: Council and PLWH/A

Each year the Council ranks services by priority as part of the Ryan White Title I application. The Figure 1-33 graphs services in the order of the 2003 Service priorities of the Council. The Council rankings reflect several criteria such as the consumer's perceived need, epidemiological trends, and other data. The numbers on top of some bars represent the ranking of the top twelve sub-services by consumers and the bars represent the percentage of PLWH/A who report they needed the service in the past year.

Consumer rankings, represented by the bars, are the percentage who says they needed the service in the past year. In general, consumer rankings match the Council's priority rankings. However there are significant differences. The Council ranks housing 2nd, but the consumers place it relatively lower on their list of needed services. Given reports of high levels of homelessness and difficulty finding stable housing other factors then the consumers' perceived need is reflected in the Council's ranking. Another difference is the approach to case management. Consumers understand that their access to services is often through their case manager, and it is not surprising that they rank it among their most needed service. That is followed by food and outpatient care. The Council perceives case management as a means to access service, so ranked it lower than direct medical services. From the consumers' point of view, however, because they perceive case managers as the gatekeepers to care, it is logical that their need for it would be very high.

Figure 1-33 further shows that:

- Three of the top ten highest priorities are in the case management category, and two of the top ten are in outpatient medical care and food. The top two most needed services[5] are not within health care: 1) case management and 2) food vouchers. Notably in 2003, case management received the greatest RWTI allocation.
- Outpatient care is the top rank of the Council and is needed by the third largest number of PLWH/A.
- Dental care is among the top services needed by PLWH/A.
- Taxi vouchers and transportation are important, but in the second tier needs by both PLWH/A and the Council.
- Notably, the perceived need by PLWH/A for substance abuse treatment is relatively low even among drug users. While ranked higher among IDUs, it is not a top need, with far more saying they need outpatient medical care, food pantry, rental assistance, and case management. It was perceived as more important by the Council, and that is justified by the high non-IDU drug use and strong relation to poor adherence and high service needs.
- Nearly 54% of PLWH/A reported they needed one-on-one mental health counseling. Still it was not among the top services needed by all PLWH/A, and the other mental health services, family counseling and bereavement counseling, were needed by under 20% of PLWH/A. However, the Council is likely to have responded to the very high

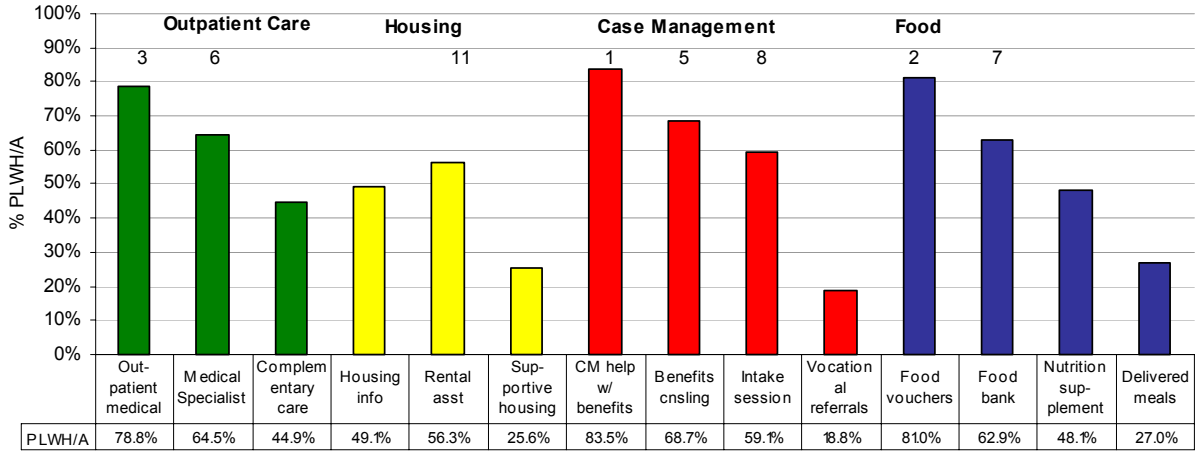
[5] "Most needed" refers to aggregate ranking of consumers who say they needed each service; it is not the report of individual rankings or sorting of services.

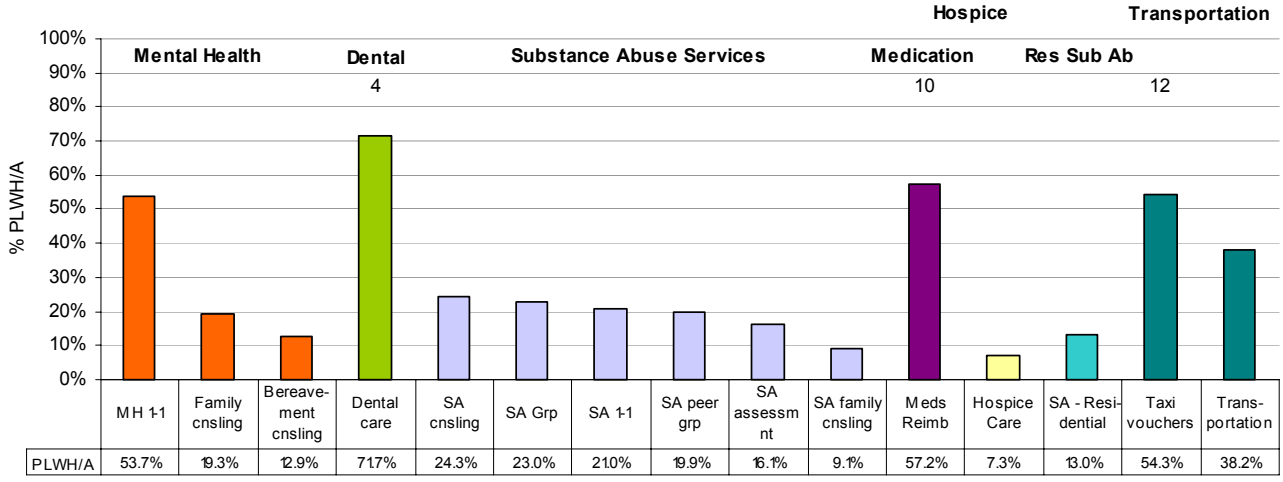
incidence of depression, anxiety, and other emotional problems reported by PLWH/A, in giving mental health services a ranking of 5 out of 21 services.

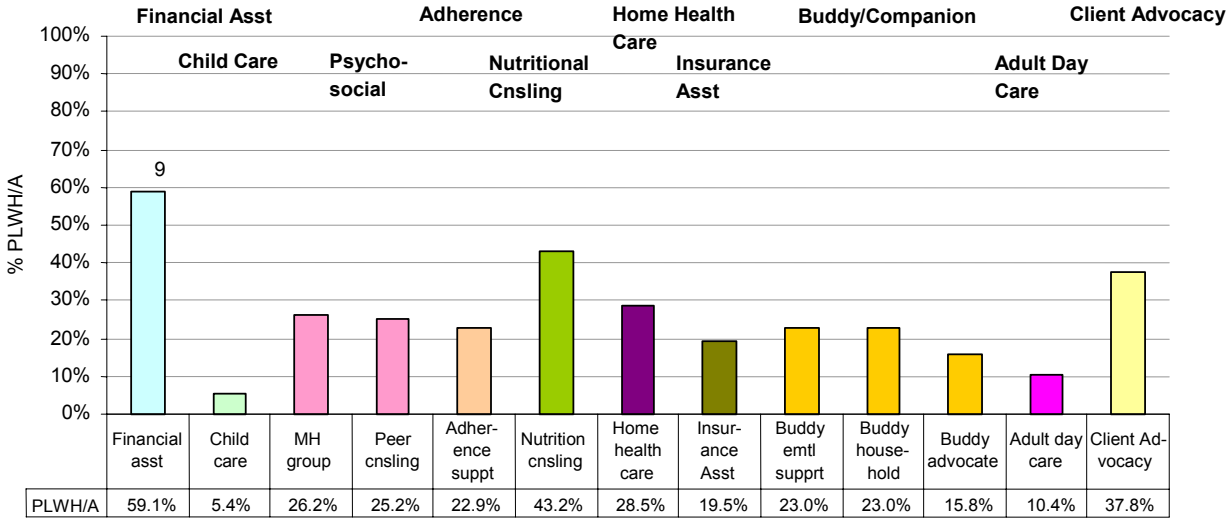
In a subgroup analysis:

- Men perceive a greater need for medical care, and women perceive a greater need for support services. For example, among the top perceived needs, women report a much greater need than men for transportation and mental health services. For the most part, men and women have about the same rankings for other top services.
- Most of the largest differences in perceived need between men and women are among the services with lower overall need. As might be expected there is a greater perceived need among women for childcare. However, there is also a greater perceived need for bereavement counseling, adult day-care and respite care, and emotional support from buddies.
- Anglos and then Latinos perceive a higher need for medical services, including dental care. Anglos perceive a higher need than Latinos or African Americans for mental health services and complementary care.
- African Americans perceive a higher need for most support services, particularly substance abuse services, including assessment and group sessions, and transportation services. Reflecting the disproportionate number of African American women infected, they also have a higher need for childcare and family counseling.

Figure 1-33 Ranked Service Needs







Service Demand and Utilization

Participants in the survey reported whether they had asked for each of the 42 services in the past year, and whether they received the service:

- With the exception of outpatient medical care, perceived need is higher than either the reported demand or utilization for each service.
- Demand is usually greater than utilization, with the exception of outpatient medical care, intake, and adherence support, where they are about the same.
- The demand for services follows reported need, with the exception of food vouchers and financial assistance where PLWH/A are considerably less likely to ask for them than other top ranked services.
- Among services with less perceived need, PLWH/A are considerably less likely to ask for nutritional supplements, counseling, complementary care, and insurance assistance.

Service Gaps

This report highlights three gap measures: 1) what services are needed by PLWH/A but not asked for, 2) what services are asked but not received, and 3) what services are known, but not asked for. In the first instance the reason may reflect the consumer knowledge that they are not eligible, that the service is not available in the continuum of care, or it may indicate a lack of knowledge.

Figure 1-34 focuses on services where there was a large difference between PLWH/A who have needed but not asked for, and asked for but not received services. It is ranked by the "need-asked" for gap. The need-ask gap reflects an expectation on the part of the consumer that the service is available, but that the system was unable to provide it. The "aware-ask" gap shows that consumers say they need but do not report asking for the service.

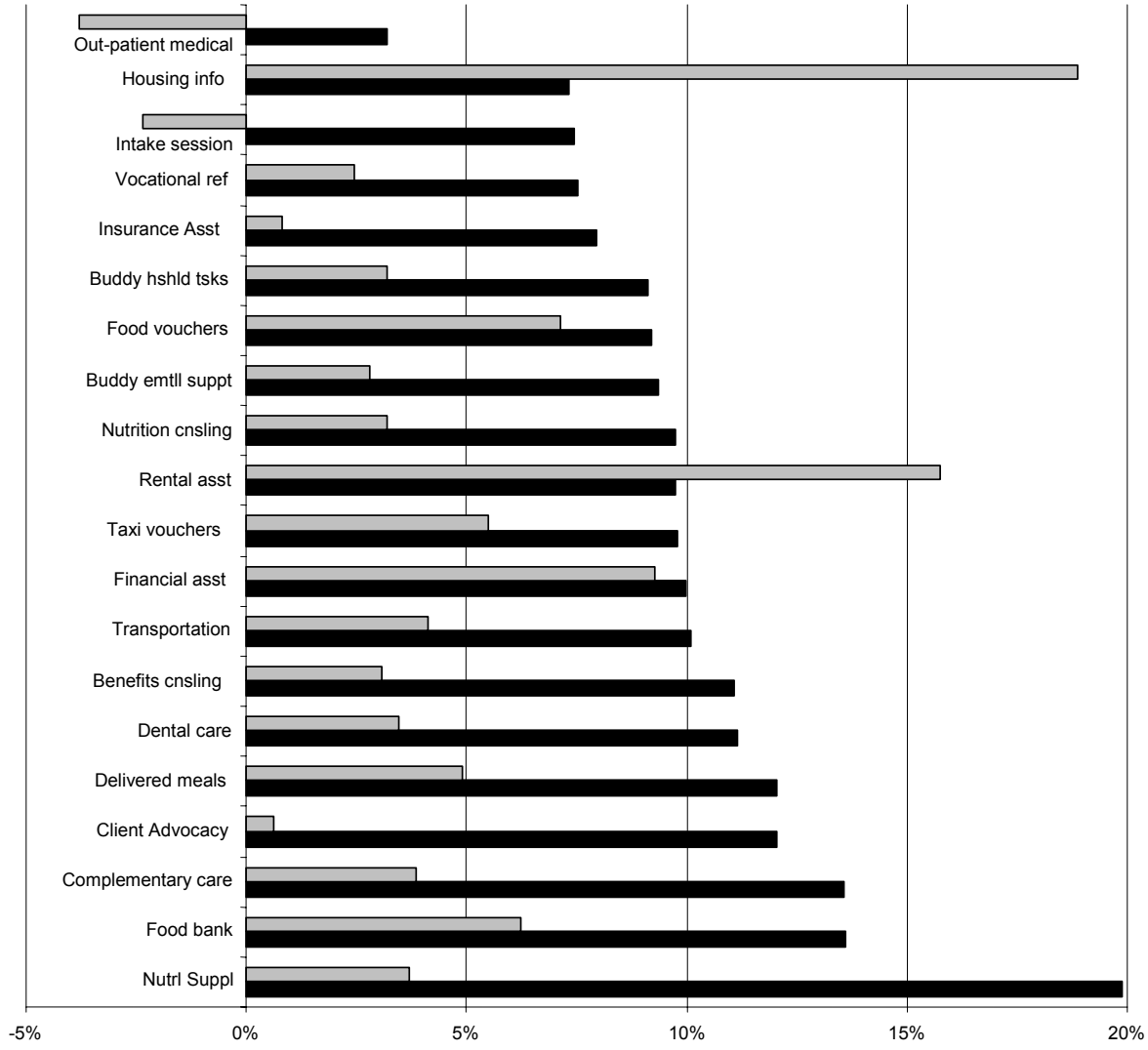
- For the most part, consumers know what services they are eligible for. The biggest "need – ask" gap is for food services, particularly nutritional supplements, and food bank and delivered meals.
- Other services with relatively large need-ask gaps are complementary care, client advocacy, benefits counseling, dental care, transportation, financial assistance and rental assistance.
- For the "ask – receive" gap (services consumers ask for but do not receive), housing has by far the largest gap. More consumers ask for but do not receive housing information and rental assistance, and financial assistance. After that food vouchers and food bank have a greater than 5% gap.
- The largest "know-ask" gaps are for substance abuse and mental health counseling. As noted earlier, even among IDUs, the perceived need for substance abuse services is low, and this provides further evidence that the barrier is not lack of knowledge.
- Many PLWH/A who perceive a need for complementary care, do not ask for it. However, once asked for, they are fairly likely to receive it.

- There is over a 10% gap between those consumers who perceive a need but do not ask for client advocacy, benefit counseling, dental care, and transportation. In each of these instances, once consumers ask for the service most report receiving them.
- The opposite pattern is found for housing services. There is a substantial gap between those who ask for but do not receive housing information and rental assistance, but a smaller gap between those who need it and ask for it.
- Four percent (4%) of PLWH/A received outpatient medical care without asking for it, whereas three percent (3%) of them expressed a need for outpatient medical care but did not ask for it. One explanation for this discrepancy is the fact that most PLWH/A automatically seek out medical care with the knowledge they are eligible for service.

Consumers sometimes may be aware of a service, but do not ask for it.

- Case management is ranked as the most needed service, yet 18% of PLWH/A who were aware of it did not ask for it.
- The two services with the highest "need-ask" gap are nutritional supplements and food bank services. For nutritional supplements, 48% say they need it and 28% say they asked for it. For food bank services, 63% of PLWH/A indicated that the food bank is a need but only 49% have asked for it. Complementary care, client advocacy, delivered meals, and dental care and benefit counseling have similar "need-ask" gaps.
- Certain services such as dental care and financial assistance for housing, utilities, and/or insurance premiums, although known and needed by PLWH/A, were not asked for by PLWH/A. This is likely due to eligibility constraints.

Figure 1-34 Service Gaps*



	Nutrl Suppl	Food bank	Compl emen ary	Client Advoc acy	Deliv- ered meals	Dental care	Bene- fits cnslin	Trans portat on	Financ ial asst	Taxi vou- chers	Rental asst	Nutrit on cnslin	Buddy emtll suppt	Food vouch ers	Buddy hshld tsks	Insur- ance Asst	Vocati onal ref	Intake session	Hous- ing info	Out- patien medi
Ask - Receive	3.7%	6.2%	3.9%	0.6%	4.9%	3.5%	3.1	4.1	9.3%	5.5%	15.8	3.2%	2.8%	7.1	3.2%	0.8%	2.4%	-2.4%	18.9	-3.8%
Need - Ask	19.9	13.6	13.6	12.0	12.0	11.1	11.1	10.1	10.0	9.8%	9.8%	9.7%	9.4%	9.2%	9.1	7.9%	7.5%	7.5%	7.3%	3.2%

*Services with insignificant or no perceived gaps include case management help w/ benefits, supportive housing, mental health group, Peer counseling, family counseling, medication reimbursement, home health, medical specialist, buddy advocate, Adult day care, mental health one-on-one, bereavement counseling, adherence support, substance abuse group, Residential Hospice, substance abuse counseling, substance abuse residential, Child care, substance abuse 1-1counseling, substance abuse family counseling, substance abuse assessment, substance abuse peer group.

BARRIERS

PLWH/A were asked to rank problems on a scale ranging from "not a problem" to a "very big problem". They ranked thirty potential problems. In Table 1-9, two analyses are presented. First is the percent who have a problem. Second, is the size of the problem. The barriers are classified into the more general categories of "organizational", "structural, or "individual" barriers. Individual barriers are those that the PLWH/A attribute to themselves and they can hope to control it. Organizational barriers tend to be rooted in the practices and attitudes of the providers such as their procedures or the attitudes and sensitivity of their staff. Structural barriers tend to be those that are controlled through the legislative and administrative dictates of the government or other regulatory bodies.

Existence of a Barrier

As seen in Table 1-9, the largest percentage of PLWH/A report individual barriers. Over 60% of PLWH/A said that not knowing about treatment and their own state-of-mind were barriers. The size of these barriers was moderate.

- Over 55% said that not knowing who to ask for services was a barrier. Among those, it was a moderately high barrier.
- About 46% said that the lack of knowledge of needed services was a barrier, and for them it was a moderately high barrier.
- Among structural barriers, over 50% of PLWH/A have some problem with "waiting for appointments or to see someone" and transportation. Between 40% and 50% have a problem with navigating the care system, the amount of red-tape, rules and regulations, including eligibility rules, and availability of a specialist.
- On average, among structural rules and regulation barriers, none were ranked as a big barrier. Yet, for those having a problem with the lack of adequate insurance, cost, eligibility, and rules and regulations represented moderate barriers.
- For the 50% of PLWH/A who noted that transportation was a problem, over forty percent (40%) said it was a big problem. The need for transportation was consistently voiced in the focus groups.
- Fifty percent (50%) of PLWH/A said that waiting and navigating the system was a problem, and for them, over a third said it was a big problem.
- Among organizational barriers, sensitivity of the organization, feeling like a number, and provider expertise are reported as a barrier by over 50% of PLWH/A. Among those naming these barriers, provider sensitivity is reported to be a moderate barrier. This topic was frequently discussed in the focus groups. A number of participants noted that they received excellent care from staff, particularly from physicians. However, it should be noted that there were a number of negative comments about case managers in the focus groups.
- Lack of referrals and fear of losing confidentiality were also perceived as moderately high among those naming them as barriers.

- Forty percent (40%) of PLWH/A named discrimination by "the persons or organizations providing services" as a barrier and ranked it as a relatively high barrier. Sixteen percent (16%) of those with a problem said it was a big problem. In focus groups, person of color and IDUs were most likely to mention discrimination.

Severity of a Problem

Although the highest average barrier was rated as a moderate barrier, different populations reported considerably higher barriers. Important differences are highlighted below.

- Overall, males were more likely to report barriers than females, but among women who reported barriers they rated them as slightly bigger than men. Men were significantly more likely to report structural problems than women, particularly red tape, rules and regulations, eligibility, and navigating the system. They were also more likely to report individual-level problems than women, including knowledge about service treatment, their own state-of-mind and physical health.
- Among risk groups, IDUs tended to report more problems than other risk groups, particularly individual and organizational barriers. MSM are more likely to report structural barriers particularly waiting for an appointment, red tape, and rules and regulations. Heterosexuals are less likely to report barriers than other risk groups.
- For those reporting barriers, MSM/IDU tend to report bigger barriers, particularly related to problems with the justice system (along with IDUs), confidentiality, insurance, and transportation. IDUs tend to report that getting along with their provider is a bigger barrier than for other risk groups.
- African Americans, while less likely to mention barriers, generally reported higher barriers than other ethnic populations when they were mentioned, particularly regarding individual and organizational barriers.

Table 1-9 Types of Barriers

STRUCTURAL 0= Not a Problem, 1=Very small, 2=Small, 3=Moderate, 4=Big, 5=Very big	% WITH PROBLEM	% WITH BIG PROBLEM	AVERAGE BARRIER SCORE
Rules and Regulations			
1. The amount of time I had to wait to get an appointment or to see someone.	63.3%	35.8%	3.0
2. My ability to find my way through the system.	50.1%	35.2%	2.9
3. There was too much paperwork or red tape.	48.7%	32.4%	2.8
4. There are too many rules and regulations.	45.9%	35.6%	3.0
5. I was not eligible for the service.	42.0%	32.9%	3.0
6. My lack of, or inadequate, insurance coverage.	38.8%	38.1%	3.1
7. I can't afford one or more of the services.	41.8%	36.4%	3.1
Access			
8. There was no specialist who could provide the care I needed.	42.5%	26.9%	2.8
9. No transportation.	50.0%	42.2%	3.2
10. I have been denied or have been afraid to seek services due to a criminal justice matter.	23.8%	32.7%	2.8
11. I have been terminated or suspended from seeking services.	20.5%	26.3%	2.5
12. No childcare.	16.6%	18.2%	2.1
ORGANIZATIONAL			
Provider Sensitivity			
13. Sensitivity of the organization and person providing services to me regarding my issues and concerns.	51.8%	35.1%	3.1
14. The organization providing the service made me feel like a number.	52.5%	29.1%	2.8
15. The people providing services to me are not helpful.	43.4%	24.2%	2.6
16. Fear of my HIV or AIDS status being found out by others – lack of confidentiality.	42.4%	39.4%	2.9
17. Discrimination I experienced by the persons or organization providing the services.	43.0%	34.2%	2.8
18. Fear that I would be reported to immigration or other authorities.	16.0%	23.8%	2.3
Provider Expertise			
19. Experience or expertise of the person providing services to me.	51.2%	26.5%	2.8
20. The organization did not provide the right referrals to the services I need.	41.9%	32.4%	2.9
21. I do not get along with the people providing services.	39.1%	22.3%	2.5
INDIVIDUAL			
Knowledge			
22. Not knowing that a service or treatment was available to me.	61.2%	38.5%	3.1
23. Not knowing the location of the service(s).	56.3%	34.6%	2.9
24. Not knowing who to ask for help.	55.7%	43.2%	3.2
25. Not knowing what medical services I need to treat my HIV infection or AIDS.	45.9%	38.0%	3.0
26. Not understanding instructions for obtaining service or treatment.	51.0%	25.8%	2.6
27. My ability to communicate or interact with the service provider.	35.9%	18.1%	2.4
Well-Being			
28. My state of mind or mental ability to deal with the treatment.	55.8%	35.6%	3.0
29. My physical health has not allowed me to get to the place where the service is provided.	52.7%	24.0%	2.6
30. I do not believe HIV/AIDS is a problem for me that requires assistance (denial).	61.2%	34.2%	3.0

SERVICE AND BARRIER TEMPLATES

This next section provides thumbnail representations of each service and is particularly useful for making decisions about priorities and allocations. Readers may go to the service of interest (page numbers are in the Table of Contents) and quickly review the unit of measurement and eligibility for a specific service.

Each service is shown using the same page layout. At the top of each template is the name of the service followed by the total estimated PLWH/A. The estimate of 3,360 PLWH/A is used throughout these templates based on the epidemiological projections noted earlier.

The next measure is the unit of service that is reported in the SEMAS system or used by the council for priorities and allocations. Following the unit of service is a description of any system-wide eligibility criteria for receiving the service. Notably, different providers may have their own additional eligibility criteria. This information is useful in understanding the continuum of care and specifically what services are provided. In future needs assessments, in order to gauge the need for the service and availability of the service, more system wide eligibility criteria might be considered.

The box titled "Funding 2002-2003" is a summary of the founding sources and amounts reported during fiscal year 2002 –2003. The adjacent box, "EXPENDED AND PROJECTED," presents the total units of service provided during 2002-2003 and the amounts projected through 2004 –2005. Because 2003-2004 information is not available, and allocation decisions have to be made for 2004-2005, those making decisions have only 2002-2003 data available. Again, some of this information was not available for the specified year and therefore spaces are left blank.

Notably, this information is generally available at the overall service category level and not at the sub service level. Given the limited amount of information available at the sub-service level regarding units of service funded, provided, and projected it is not possible to present a full description of the service delivery system nor calculate its capacity. However, in all instances spaces are left for this information, so these templates can be completed as information becomes available.

Below these top boxes are three graphs, and to their right a summary of the gaps measure. The graphs show the level of awareness, perceive need, reported demand, and reported utilization of different key populations of PLWH/A. The top graph shows these measures for sex/gender and ethnic/race groups. The second graph shows the four measures by risk group and the third graph shows them by stage of infection, homeless, and recently incarcerated populations.

The boxes to the right of the graphs display summary gap measures based on the survey. . The "need-ask gap" is the difference between the percentage who perceive they need the service and the percentage who actually demand the service. The larger the "need-ask" gap the more likely the person was to need a service and not ask for it. This may be because the

consumer is aware that they are not eligible for the service or it may reflect a frustration in trying to receive a service.

The “ask-receive gap” is the difference between the percentage of PLWH/A who asked for the service and received it. It is a useful in determining how well the system processes PLWH/A who ask for services and how well PLWH/A understand the eligibility criteria.

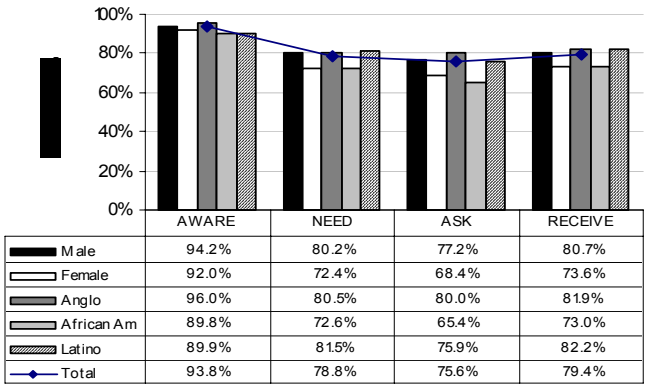
Following the gap tables there is a box with the summary of the top barriers reported for each subservice.

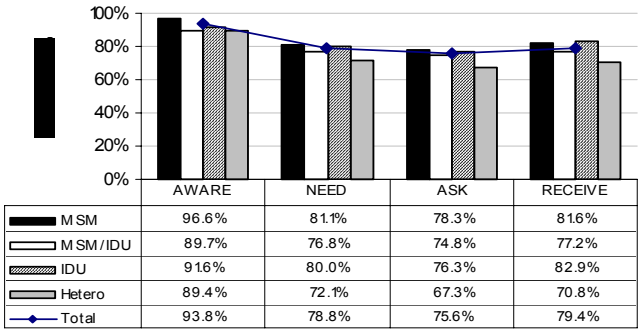
Finally, at the right bottom corner of each template there is box highlighting specific notes and considerations for each sub-service. This space is left for readers to add notes and observations that may be useful of them in assessing the service needs, gaps, and barriers.

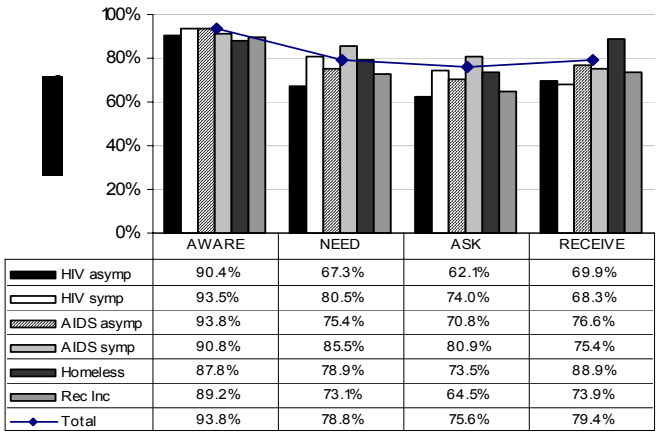
Outpatient Medical Care

Service Unit and Eligibility	
Total PLWH/A:	3,360
Unit:	20 minute visit
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	5,310	
RW Care Title II		Number unduplicated	757	
Other		Average Used	7	
Total Allocated		Expenditure	$769,950	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	3.2%	-3.8%
Male	3.1%	-3.5%
Female	4.0%	-5.2%
MSM	2.8%	-3.4%
MSMIDU	2.0%	-2.4%
IDU	3.7%	-6.5%
Hetero	4.7%	-3.5%
Anglo	0.5%	-1.9%
African Am	7.2%	-7.6%
Latino	5.6%	-6.3%
HIV asymp	5.2%	62.1%
HIV symp	6.5%	74.0%
AIDS asymp	4.6%	70.8%
AIDS symp	4.6%	80.9%
Homeless	5.4%	73.5%
Recently Incarcerated	8.6%	64.5%

Consumer Rank 3 out of 42

Barriers

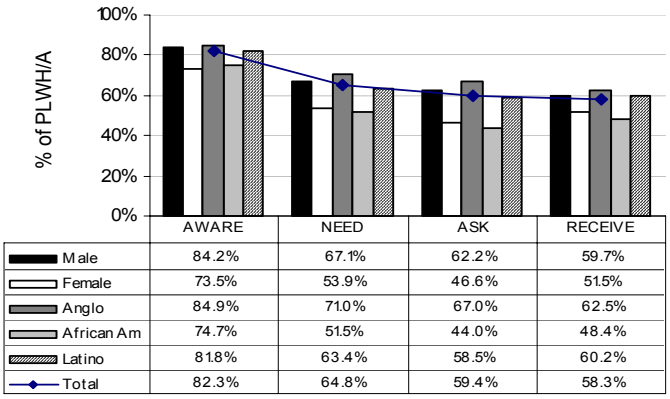
- Not knowing about service
- Not provided proper referrals
- Length of time for an appointment
- Individual physical or mental health
- Cost of service/ inadequate insurance

Notes

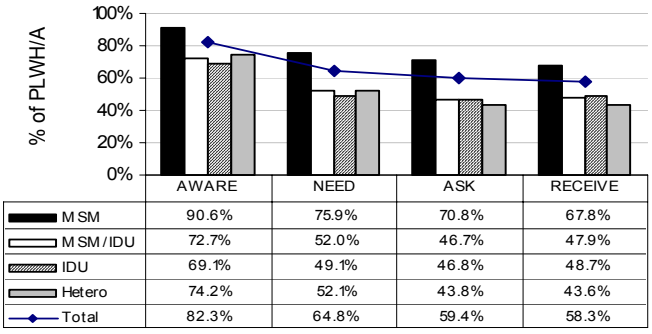
Medical Specialist

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	20 minute visit
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

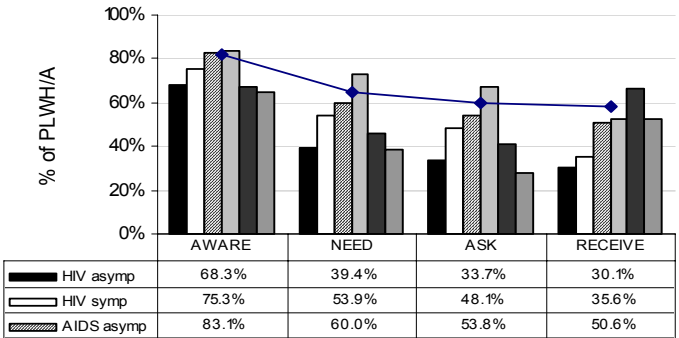
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	171	
RW Care Title II		Number unduplicated	27	
Other		Average Used	6	
Total Allocated		Expenditure	$17,368	



	AWARE	NEED	ASK	RECEIVE
Male	84.2%	67.1%	62.2%	59.7%
Female	73.5%	53.9%	46.6%	51.5%
Anglo	84.9%	71.0%	67.0%	62.5%
African Am	74.7%	51.5%	44.0%	48.4%
Latino	81.8%	63.4%	58.5%	60.2%
Total	82.3%	64.8%	59.4%	58.3%



	AWARE	NEED	ASK	RECEIVE
MSM	90.6%	75.9%	70.8%	67.8%
MSM/IDU	72.7%	52.0%	46.7%	47.9%
IDU	69.1%	49.1%	46.8%	48.7%
Hetero	74.2%	52.1%	43.8%	43.6%
Total	82.3%	64.8%	59.4%	58.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	68.3%	39.4%	33.7%	30.1%
HIV symp	75.3%	53.9%	48.1%	35.6%
AIDS asymp	83.1%	60.0%	53.8%	50.6%
AIDS symp	83.2%	73.1%	67.4%	52.3%
Homeless	67.3%	46.3%	41.1%	66.7%
Rec Inc	64.5%	38.7%	28.0%	52.2%
Total	82.3%	64.8%	59.4%	58.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	5.3%	1.2%
Male	4.9%	2.5%
Female	7.3%	-4.9%
MSM	5.1%	2.9%
MSMIDU	5.2%	-1.2%
IDU	2.3%	-1.9%
Hetero	8.3%	0.1%
Anglo	4.0%	4.5%
African Am	7.5%	-4.5%
Latino	4.9%	-1.7%
HIV asymp	5.8%	3.5%
HIV symp	5.9%	12.5%
AIDS asymp	6.2%	3.2%
AIDS symp	5.6%	15.1%
Homeless	5.2%	-25.6%
Recently Incarcerated	10.8%	-24.2%

Consumer Rank	6 out of 42

Barriers

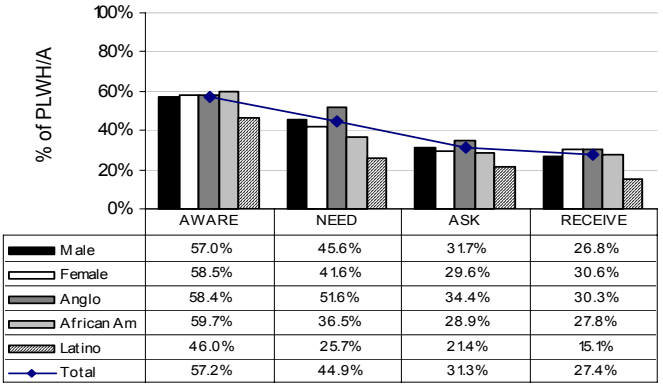
- Not knowing about service
- Not provided proper referrals

Notes

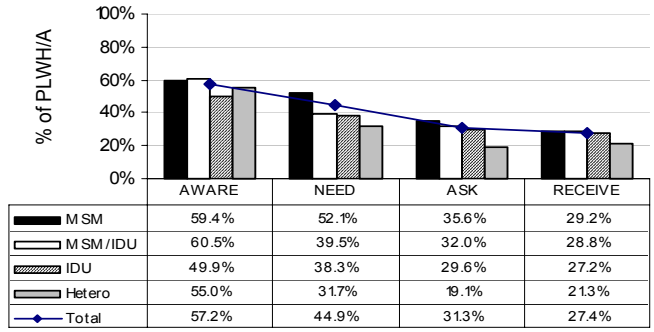
Complementary Care

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	vendor paid therapy dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; Distribution among maximum number of clients; First come, first serve with limited availability; Limitations may be established.

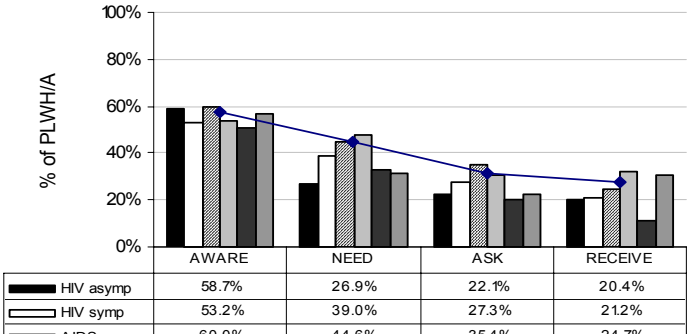
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$47,296	Number duplicated	49,032	37,087
RW Care Title II		Number unduplicated	138	138
Other		Average Used	355	269
Total Allocated		Expenditure	$63,442	$50,602



	AWARE	NEED	ASK	RECEIVE
Male	57.0%	45.6%	31.7%	26.8%
Female	58.5%	41.6%	29.6%	30.6%
Anglo	58.4%	51.6%	34.4%	30.3%
African Am	59.7%	36.5%	28.9%	27.8%
Latino	46.0%	25.7%	21.4%	15.1%
Total	57.2%	44.9%	31.3%	27.4%



	AWARE	NEED	ASK	RECEIVE
MSM	59.4%	52.1%	35.6%	29.2%
MSM/IDU	60.5%	39.5%	32.0%	28.8%
IDU	49.9%	38.3%	29.6%	27.2%
Hetero	55.0%	31.7%	19.1%	21.3%
Total	57.2%	44.9%	31.3%	27.4%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	58.7%	26.9%	22.1%	20.4%
HIV symp	53.2%	39.0%	27.3%	21.2%
AIDS asymp	60.0%	44.6%	35.4%	24.7%
AIDS symp	53.8%	48.1%	30.8%	32.3%
Homeless	51.0%	32.7%	20.4%	11.1%
Rec Inc	57.0%	31.2%	22.6%	30.4%
Total	57.2%	44.9%	31.3%	27.4%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	13.6%	3.9%
Male	13.9%	4.9%
Female	11.9%	-1.0%
MSM	16.4%	6.4%
MSMIDU	7.5%	3.2%
IDU	8.7%	2.4%
Hetero	12.6%	-2.2%
Anglo	17.2%	4.1%
African Am	7.7%	1.1%
Latino	4.3%	6.3%
HIV asymp	4.8%	1.7%
HIV symp	11.7%	6.1%
AIDS asymp	9.2%	10.7%
AIDS symp	17.3%	-1.5%
Homeless	12.2%	9.3%
Recently Incarcerated	8.6%	-7.9%

Consumer Rank 16 out of 42

Barriers

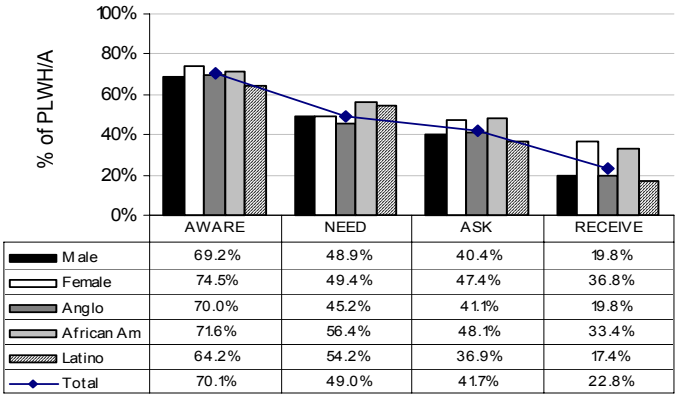
- Not knowing about service
- Length of time for an appointment
- Red tape
- Lack of funding for service
- Variable need

Notes

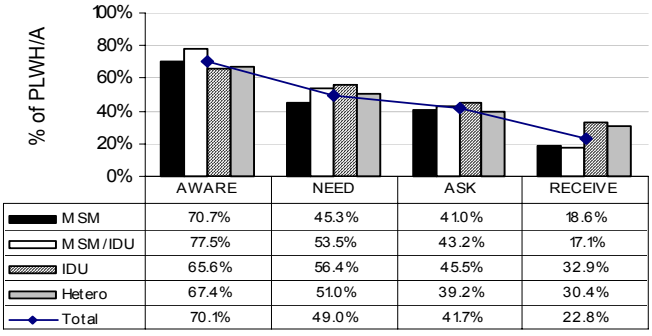
Housing Information

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

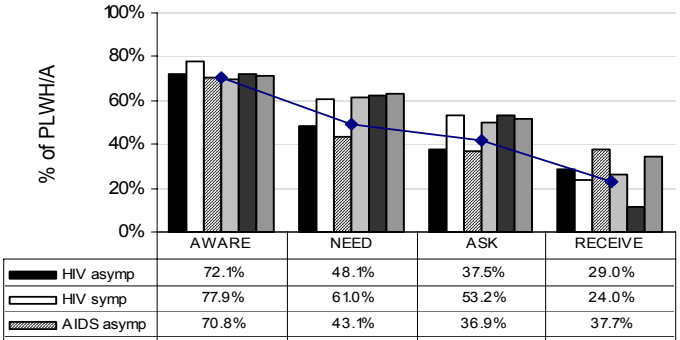
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	69.2%	48.9%	40.4%	19.8%
Female	74.5%	49.4%	47.4%	36.8%
Anglo	70.0%	45.2%	41.1%	19.8%
African Am	71.6%	56.4%	48.1%	33.4%
Latino	64.2%	54.2%	36.9%	17.4%
Total	70.1%	49.0%	41.7%	22.8%



	AWARE	NEED	ASK	RECEIVE
MSM	70.7%	45.3%	41.0%	18.6%
MSM/IDU	77.5%	53.5%	43.2%	17.1%
IDU	65.6%	56.4%	45.5%	32.9%
Hetero	67.4%	51.0%	39.2%	30.4%
Total	70.1%	49.0%	41.7%	22.8%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	72.1%	48.1%	37.5%	29.0%
HIV symp	77.9%	61.0%	53.2%	24.0%
AIDS asymp	70.8%	43.1%	36.9%	37.7%
AIDS symp	69.5%	61.1%	50.4%	26.2%
Homeless	72.1%	62.6%	53.1%	11.1%
Rec Inc	71.0%	63.4%	51.6%	34.8%
Total	70.1%	49.0%	41.7%	22.8%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	7.3%	18.9%
Male	8.5%	20.6%
Female	2.0%	10.6%
MSM	4.2%	22.4%
MSMIDU	10.3%	26.1%
IDU	10.9%	12.6%
Hetero	11.8%	8.8%
Anglo	4.1%	21.3%
African Am	8.3%	14.7%
Latino	17.3%	19.5%
HIV asymp	10.6%	8.5%
HIV symp	7.8%	29.2%
AIDS asymp	6.2%	-0.7%
AIDS symp	10.7%	24.2%
Homeless	9.5%	42.0%
Recently Incarcerated	11.8%	16.8%

Consumer Rank 14 out of 42

Barriers

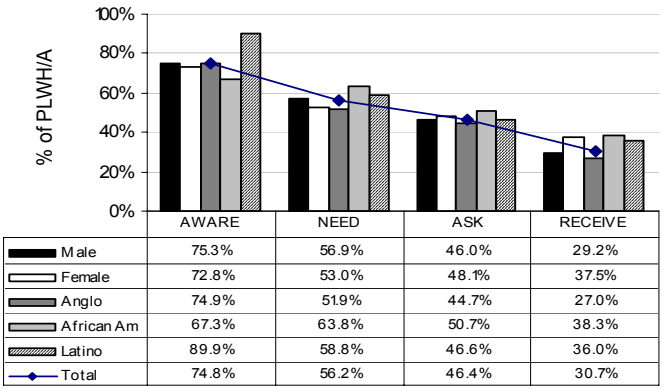
- Not knowing about service
- Long waiting list for housing
- Service is unavailable – cannot find housing
- Service providers not helpful
- Eligibility criteria – e.g., citizenship, income
- Individual, physical or mental health

Notes

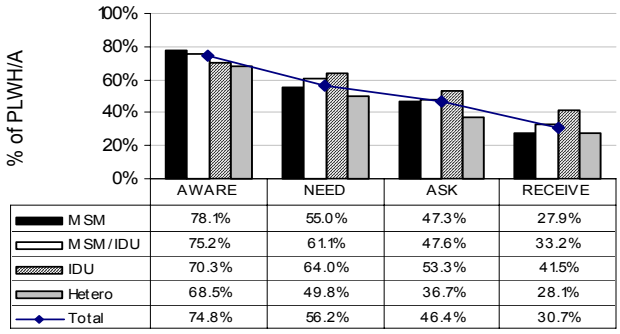
Rental Assistance

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Vendor rent dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

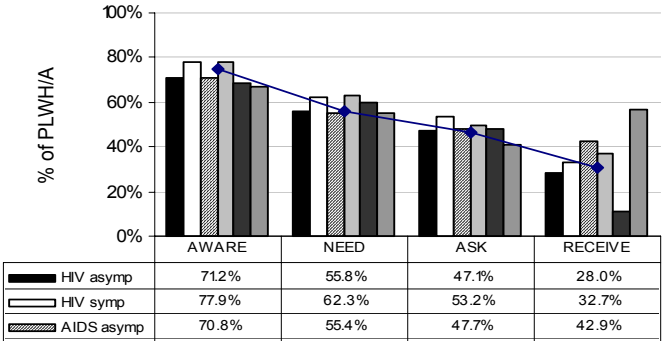
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	$17,990	
RW Care Title II		Number unduplicated	72	
Other		Average Used	250	
Total Allocated		Expenditure	$19,789	



	AWARE	NEED	ASK	RECEIVE
Male	75.3%	56.9%	46.0%	29.2%
Female	72.8%	53.0%	48.1%	37.5%
Anglo	74.9%	51.9%	44.7%	27.0%
African Am	67.3%	63.8%	50.7%	38.3%
Latino	89.9%	58.8%	46.6%	36.0%
Total	74.8%	56.2%	46.4%	30.7%



	AWARE	NEED	ASK	RECEIVE
MSM	78.1%	55.0%	47.3%	27.9%
MSM/IDU	75.2%	61.1%	47.6%	33.2%
IDU	70.3%	64.0%	53.3%	41.5%
Hetero	68.5%	49.8%	36.7%	28.1%
Total	74.8%	56.2%	46.4%	30.7%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	71.2%	55.8%	47.1%	28.0%
HIV symp	77.9%	62.3%	53.2%	32.7%
AIDS asymp	70.8%	55.4%	47.7%	42.9%
AIDS symp	77.9%	63.4%	49.6%	36.9%
Homeless	68.7%	59.9%	48.3%	11.1%
Rec Inc	66.7%	54.8%	40.9%	56.5%
Total	74.8%	56.2%	46.4%	30.7%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.8%	15.8%
Male	10.8%	16.9%
Female	4.9%	10.6%
MSM	7.7%	19.4%
MSMIDU	13.4%	14.5%
IDU	10.7%	11.8%
Hetero	13.0%	8.7%
Anglo	7.2%	17.8%
African Am	13.1%	12.4%
Latino	12.2%	10.6%
HIV asymp	8.7%	19.2%
HIV symp	9.1%	20.6%
AIDS asymp	7.7%	4.8%
AIDS symp	13.7%	12.7%
Homeless	11.6%	37.2%
Recently Incarcerated	14.0%	-15.7%

Consumer Rank 11 out of 42

Barriers

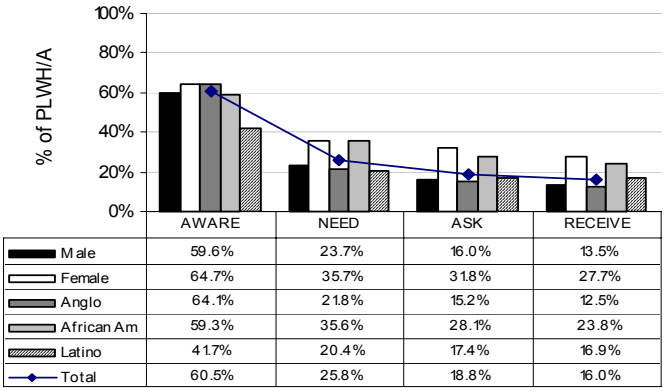
- Not knowing about service
- Insufficient funding available for service
- Eligibility criteria, e.g., income restrictions

Notes

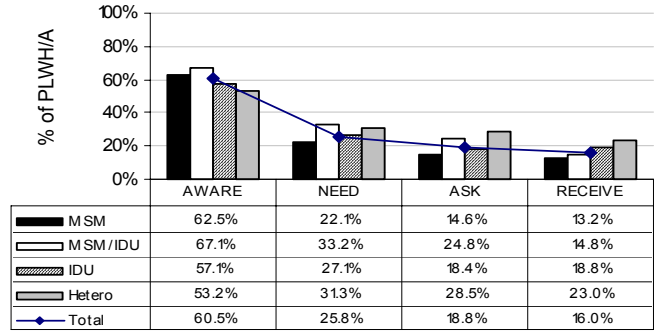
Supportive Housing

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Vendor lodging dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

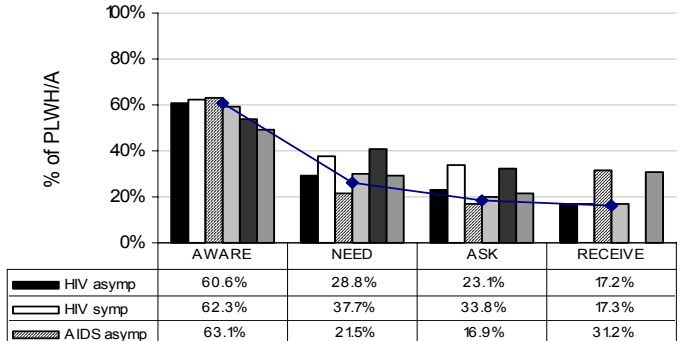
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	12,141	
RW Care Title II		Number unduplicated	31	
Other		Average Used	392	
Total Allocated		Expenditure	$13,355	



	AWARE	NEED	ASK	RECEIVE
Male	59.6%	23.7%	16.0%	13.5%
Female	64.7%	35.7%	31.8%	27.7%
Anglo	64.1%	21.8%	15.2%	12.5%
African Am	59.3%	35.6%	28.1%	23.8%
Latino	41.7%	20.4%	17.4%	16.9%
Total	60.5%	25.8%	18.8%	16.0%



	AWARE	NEED	ASK	RECEIVE
MSM	62.5%	22.1%	14.6%	13.2%
MSM/IDU	67.1%	33.2%	24.8%	14.8%
IDU	57.1%	27.1%	18.4%	18.8%
Hetero	53.2%	31.3%	28.5%	23.0%
Total	60.5%	25.8%	18.8%	16.0%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	60.6%	28.8%	23.1%	17.2%
HIV symp	62.3%	37.7%	33.8%	17.3%
AIDS asymp	63.1%	21.5%	16.9%	31.2%
AIDS symp	59.5%	29.8%	19.8%	16.9%
Homeless	53.7%	40.8%	32.0%	0.0%
Rec Inc	49.5%	29.0%	21.5%	30.4%
Total	60.5%	25.8%	18.8%	16.0%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	7.0%	2.8%
Male	7.7%	2.5%
Female	3.9%	4.2%
MSM	7.6%	1.4%
MSMIDU	8.4%	10.0%
IDU	8.8%	-0.5%
Hetero	2.8%	5.5%
Anglo	6.7%	2.7%
African Am	7.6%	4.3%
Latino	3.0%	0.5%
HIV asymp	5.8%	5.9%
HIV symp	3.9%	16.5%
AIDS asymp	4.6%	-14.2%
AIDS symp	9.9%	2.9%
Homeless	8.8%	32.0%
Recently Incarcerated	7.5%	-8.9%

Consumer Rank	23 out of 42

Barriers

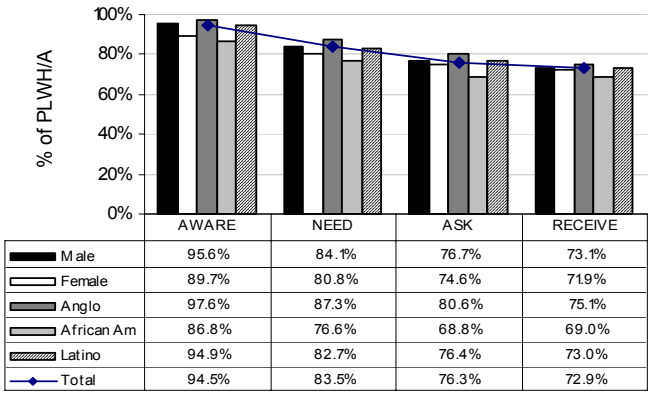
- Not knowing about service
- Not interested in this type of housing

Notes

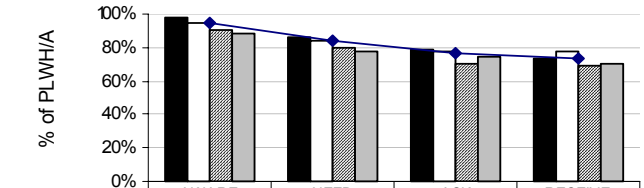
Case Management

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	15 minute interval
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

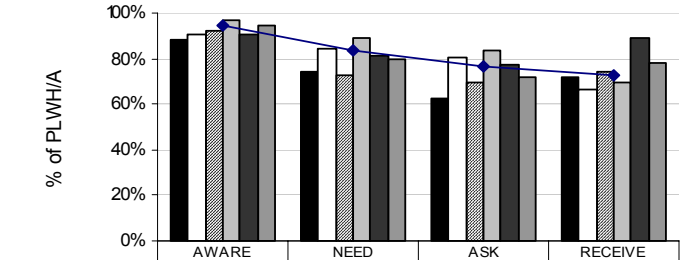
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	40,987	
RW Care Title II		Number unduplicated	879	
Other		Average Used	78	
Total Allocated		Expenditure	$698,313	



	AWARE	NEED	ASK	RECEIVE
Male	95.6%	84.1%	76.7%	73.1%
Female	89.7%	80.8%	74.6%	71.9%
Anglo	97.6%	87.3%	80.6%	75.1%
African Am	86.8%	76.6%	68.8%	69.0%
Latino	94.9%	82.7%	76.4%	73.0%
Total	94.5%	83.5%	76.3%	72.9%



	AWARE	NEED	ASK	RECEIVE
MSM	97.7%	86.3%	78.4%	73.8%
MSM/IDU	94.8%	84.3%	77.1%	77.6%
IDU	90.5%	79.5%	70.5%	69.2%
Hetero	88.1%	77.9%	74.3%	70.1%
Total	94.5%	83.5%	76.3%	72.9%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	88.3%	74.0%	62.5%	72.0%
HIV symp	90.9%	84.4%	80.5%	66.3%
AIDS asymp	92.3%	72.3%	69.2%	74.0%
AIDS symp	96.9%	89.3%	84.0%	69.2%
Homeless	90.4%	81.6%	77.6%	88.9%
Rec Inc	94.6%	79.6%	72.0%	78.3%
Total	94.5%	83.5%	76.3%	72.9%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	7.2%	3.4%
Male	7.5%	3.6%
Female	6.1%	2.7%
MSM	7.9%	4.6%
MSMIDU	7.2%	-0.5%
IDU	8.9%	1.3%
Hetero	3.6%	4.2%
Anglo	6.7%	5.5%
African Am	7.9%	-0.3%
Latino	6.3%	3.4%
HIV asymp	11.5%	-9.5%
HIV symp	3.9%	14.2%
AIDS asymp	3.1%	-4.8%
AIDS symp	5.3%	14.7%
Homeless	4.1%	-11.3%
Recently Incarcerated	7.5%	-6.2%

Consumer Rank 1 out of 42

Barriers

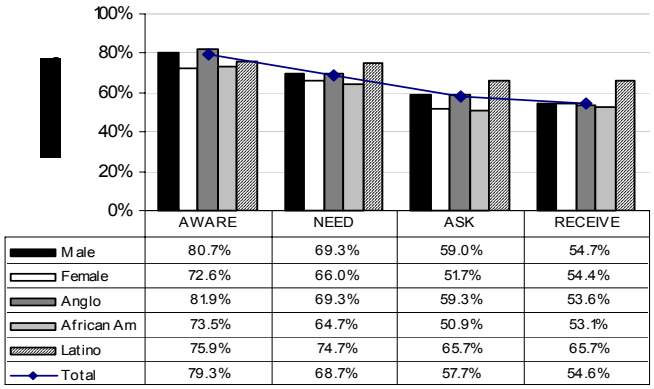
- Case managers are not helpful, they are rude or insensitive
- Eligibility criteria, i.e., income restrictions
- Not enough funding for needed benefits, e.g., bus passes, food vouchers
- Staff turnover – lack of continuity
- Hard to navigate system
- Not knowing about service

Notes

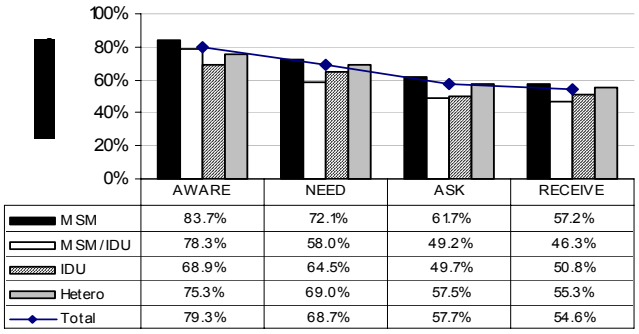
Benefits Counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

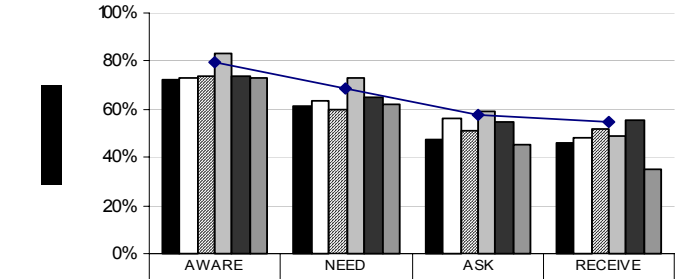
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	80.7%	69.3%	59.0%	54.7%
Female	72.6%	66.0%	51.7%	54.4%
Anglo	81.9%	69.3%	59.3%	53.6%
African Am	73.5%	64.7%	50.9%	53.1%
Latino	75.9%	74.7%	65.7%	65.7%
Total	79.3%	68.7%	57.7%	54.6%



	AWARE	NEED	ASK	RECEIVE
MSM	83.7%	72.1%	61.7%	57.2%
MSM/IDU	78.3%	58.0%	49.2%	46.3%
IDU	68.9%	64.5%	49.7%	50.8%
Hetero	75.3%	69.0%	57.5%	55.3%
Total	79.3%	68.7%	57.7%	54.6%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	72.1%	61.5%	47.1%	46.2%
HIV symp	72.7%	63.6%	55.8%	48.1%
AIDS asymp	73.4%	60.0%	50.8%	51.9%
AIDS symp	83.2%	73.3%	58.8%	49.2%
Homeless	73.5%	65.3%	55.1%	55.6%
Rec Inc	73.1%	62.4%	45.2%	34.8%
Total	79.3%	68.7%	57.7%	54.6%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	11.1%	3.1%
Male	10.4%	4.3%
Female	14.3%	-2.6%
MSM	10.3%	4.6%
MSMIDU	8.8%	2.9%
IDU	14.8%	-1.1%
Hetero	11.5%	2.2%
Anglo	10.0%	5.7%
African Am	13.8%	-2.1%
Latino	9.0%	0.0%
HIV asymp	14.4%	0.9%
HIV symp	7.8%	7.8%
AIDS asymp	9.2%	-1.2%
AIDS symp	14.5%	9.5%
Homeless	10.2%	-0.5%
Recently Incarcerated	17.2%	10.4%

Consumer Rank 5 out of 42

Barriers

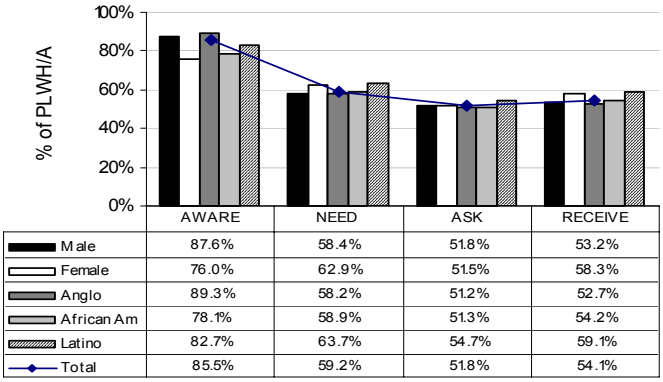
- Not knowing about service
- Counselors do not volunteer information

Notes

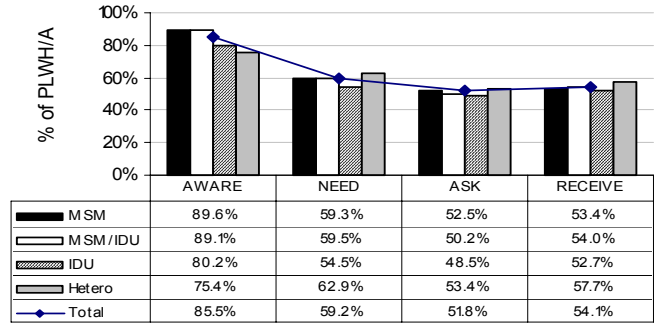
Intake Session

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

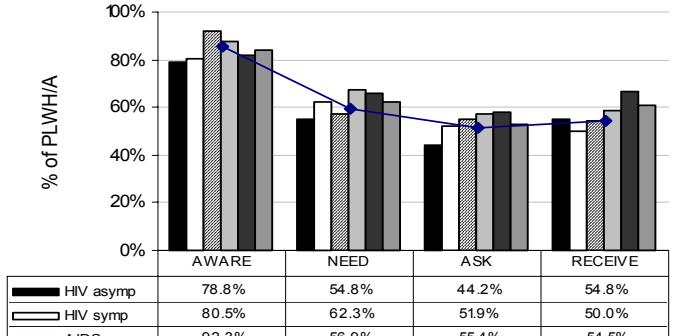
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	87.6%	58.4%	51.8%	53.2%
Female	76.0%	62.9%	51.5%	58.3%
Anglo	89.3%	58.2%	51.2%	52.7%
African Am	78.1%	58.9%	51.3%	54.2%
Latino	82.7%	63.7%	54.7%	59.1%
Total	85.5%	59.2%	51.8%	54.1%



	AWARE	NEED	ASK	RECEIVE
MSM	89.6%	59.3%	52.5%	53.4%
MSM/IDU	89.1%	59.5%	50.2%	54.0%
IDU	80.2%	54.5%	48.5%	52.7%
Hetero	75.4%	62.9%	53.4%	57.7%
Total	85.5%	59.2%	51.8%	54.1%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	78.8%	54.8%	44.2%	54.8%
HIV symp	80.5%	62.3%	51.9%	50.0%
AIDS asymp	92.3%	56.9%	55.4%	54.5%
AIDS symp	87.8%	67.2%	57.3%	58.5%
Homeless	81.6%	66.0%	57.8%	66.7%
Rec Inc	83.9%	62.4%	52.7%	60.9%
Total	85.5%	59.2%	51.8%	54.1%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	7.5%	-2.4%
Male	6.6%	-1.4%
Female	11.4%	-6.8%
MSM	6.8%	-0.9%
MSMIDU	9.3%	-3.8%
IDU	6.0%	-4.1%
Hetero	9.6%	-4.4%
Anglo	7.1%	-1.5%
African Am	7.6%	-2.9%
Latino	9.0%	-4.3%
HIV asymp	10.6%	-10.6%
HIV symp	10.4%	1.9%
AIDS asymp	1.5%	0.8%
AIDS symp	9.9%	-1.2%
Homeless	8.2%	-8.8%
Recently Incarcerated	9.7%	-8.2%

Consumer Rank	8 out of 42

Barriers

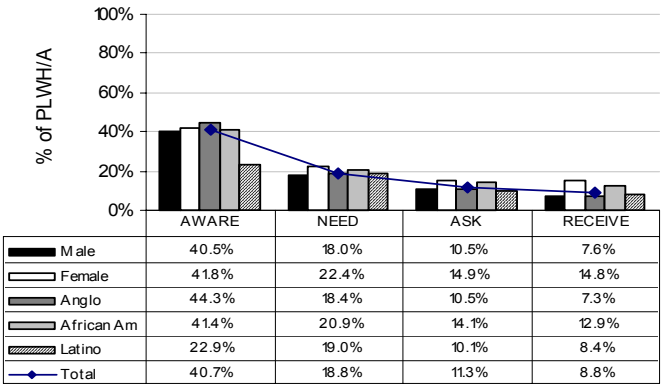
- Not knowing about service
- Not provided proper referrals

Notes

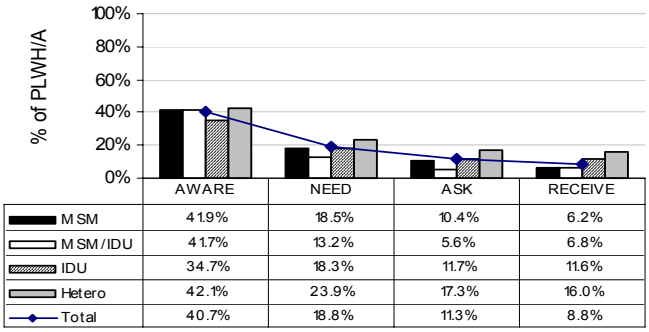
Vocational Referrals

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

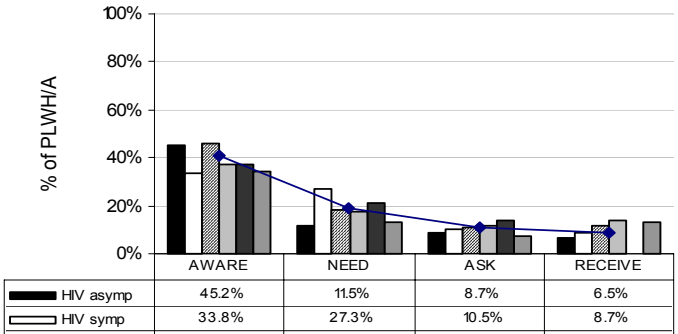
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	40.5%	18.0%	10.5%	7.6%
Female	41.8%	22.4%	14.9%	14.8%
Anglo	44.3%	18.4%	10.5%	7.3%
African Am	41.4%	20.9%	14.1%	12.9%
Latino	22.9%	19.0%	10.1%	8.4%
Total	40.7%	18.8%	11.3%	8.8%



	AWARE	NEED	ASK	RECEIVE
MSM	41.9%	18.5%	10.4%	6.2%
MSM/IDU	41.7%	13.2%	5.6%	6.8%
IDU	34.7%	18.3%	11.7%	11.6%
Hetero	42.1%	23.9%	17.3%	16.0%
Total	40.7%	18.8%	11.3%	8.8%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	45.2%	11.5%	8.7%	6.5%
HIV symp	33.8%	27.3%	10.5%	8.7%
AIDS asymp	46.2%	18.5%	10.8%	11.7%
AIDS symp	37.4%	17.6%	11.5%	13.8%
Homeless	37.4%	21.1%	13.7%	0.0%
Rec Inc	34.4%	12.9%	7.5%	13.0%
Total	40.7%	18.8%	11.3%	8.8%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	7.5%	2.4%
Male	7.5%	2.9%
Female	7.5%	0.2%
MSM	8.1%	4.2%
MSMIDU	7.6%	-1.2%
IDU	6.6%	0.2%
Hetero	6.6%	1.3%
Anglo	7.9%	3.2%
African Am	6.9%	1.2%
Latino	8.9%	1.6%
HIV asymp	2.9%	2.2%
HIV symp	16.7%	1.9%
AIDS asymp	7.7%	-0.9%
AIDS symp	6.1%	-2.4%
Homeless	7.4%	13.7%
Recently Incarcerated	5.4%	-5.5%

Consumer Rank	34 out of 42

Barriers

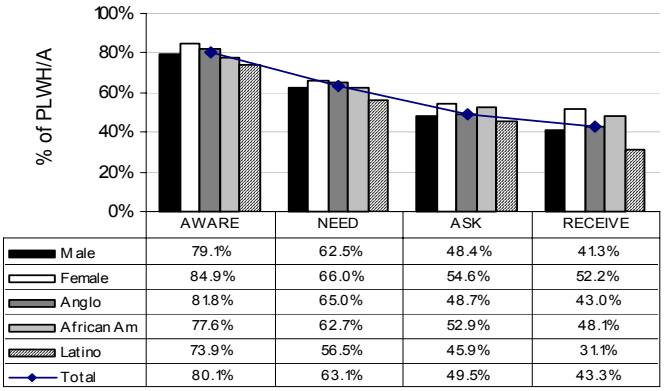
- Not knowing about service
- Do not need service
- Physical health – disabled

Notes

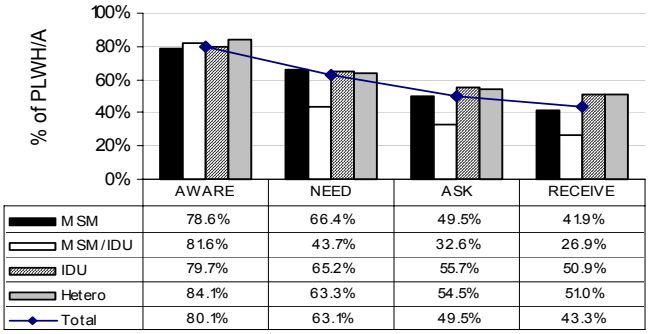
Food bank

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 food bag
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; To be distributed among the maximum number of most at-risk clients.

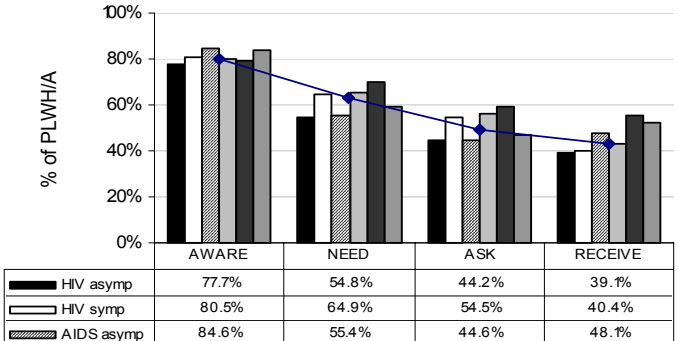
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	732	
RW Care Title II		Number unduplicated	97	
Other		Average Used	8	
Total Allocated		Expenditure	$6,652	



	AWARE	NEED	ASK	RECEIVE
Male	79.1%	62.5%	48.4%	41.3%
Female	84.9%	66.0%	54.6%	52.2%
Anglo	81.8%	65.0%	48.7%	43.0%
African Am	77.6%	62.7%	52.9%	48.1%
Latino	73.9%	56.5%	45.9%	31.1%
Total	80.1%	63.1%	49.5%	43.3%



	AWARE	NEED	ASK	RECEIVE
MSM	78.6%	66.4%	49.5%	41.9%
MSM/IDU	81.6%	43.7%	32.6%	26.9%
IDU	79.7%	65.2%	55.7%	50.9%
Hetero	84.1%	63.3%	54.5%	51.0%
Total	80.1%	63.1%	49.5%	43.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	77.7%	54.8%	44.2%	39.1%
HIV symp	80.5%	64.9%	54.5%	40.4%
AIDS asymp	84.6%	55.4%	44.6%	48.1%
AIDS symp	80.2%	65.6%	56.2%	43.1%
Homeless	79.6%	70.1%	59.6%	55.6%
Rec Inc	83.9%	59.1%	46.7%	52.2%
Total	80.1%	63.1%	49.5%	43.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	13.6%	6.2%
Male	14.1%	7.1%
Female	11.4%	2.4%
MSM	16.9%	7.7%
MSMIDU	11.1%	5.7%
IDU	9.5%	4.8%
Hetero	8.8%	3.5%
Anglo	16.4%	5.6%
African Am	9.8%	4.8%
Latino	10.6%	14.8%
HIV asymp	10.6%	5.1%
HIV symp	10.4%	14.2%
AIDS asymp	10.8%	-3.4%
AIDS symp	9.5%	13.1%
Homeless	10.5%	4.0%
Recently Incarcerated	12.4%	-5.4%

Consumer Rank 7 out of 42

Barriers

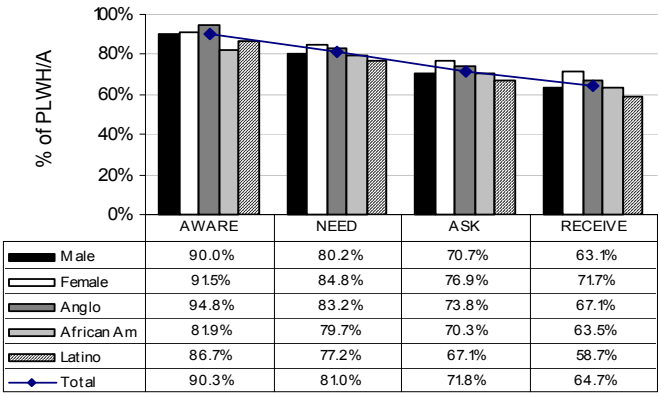
- Not knowing about service
- Transportation to food bank
- Lack of funding for service
- Poor quality of food
- Eligibility criteria

Notes

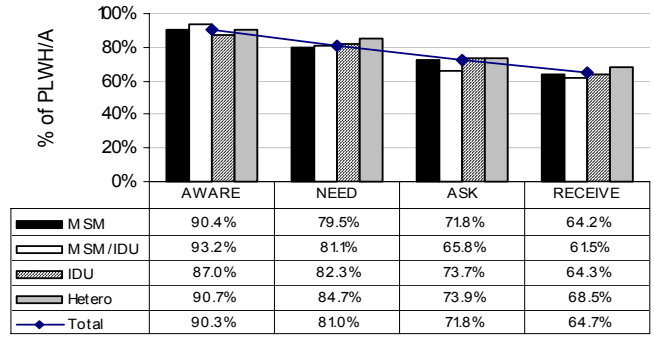
Food vouchers

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; To be distributed among the maximum number of most at-risk clients; No purchase of alcohol, tobacco, or game of chance.

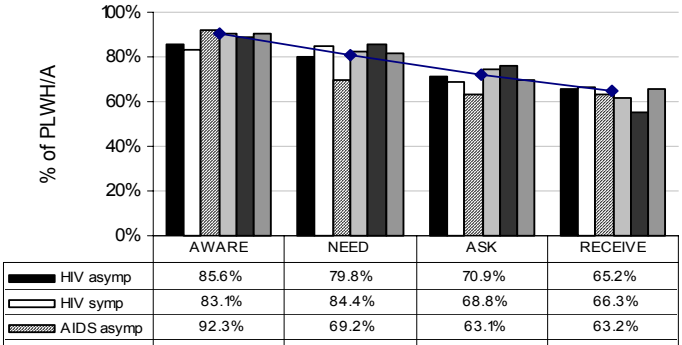
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	90.0%	80.2%	70.7%	63.1%
Female	91.5%	84.8%	76.9%	71.7%
Anglo	94.8%	83.2%	73.8%	67.1%
African Am	81.9%	79.7%	70.3%	63.5%
Latino	86.7%	77.2%	67.1%	58.7%
Total	90.3%	81.0%	71.8%	64.7%



	AWARE	NEED	ASK	RECEIVE
MSM	90.4%	79.5%	71.8%	64.2%
MSM/IDU	93.2%	81.1%	65.8%	61.5%
IDU	87.0%	82.3%	73.7%	64.3%
Hetero	90.7%	84.7%	73.9%	68.5%
Total	90.3%	81.0%	71.8%	64.7%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	85.6%	79.8%	70.9%	65.2%
HIV symp	83.1%	84.4%	68.8%	66.3%
AIDS asymp	92.3%	69.2%	63.1%	63.2%
AIDS symp	90.1%	82.3%	74.6%	61.5%
Homeless	88.4%	85.7%	76.0%	55.6%
Rec Inc	90.3%	81.7%	69.9%	65.2%
Total	90.3%	81.0%	71.8%	64.7%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.2%	7.1%
Male	9.5%	7.6%
Female	7.9%	5.2%
MSM	7.7%	7.6%
MSMIDU	15.3%	4.3%
IDU	8.5%	9.4%
Hetero	10.8%	5.4%
Anglo	9.4%	6.7%
African Am	9.3%	6.8%
Latino	10.1%	8.5%
HIV asymp	8.9%	5.7%
HIV symp	15.6%	2.5%
AIDS asymp	6.2%	-0.1%
AIDS symp	7.7%	13.1%
Homeless	9.7%	20.5%
Recently Incarcerated	11.8%	4.7%

Consumer Rank 2 out of 42

Barriers

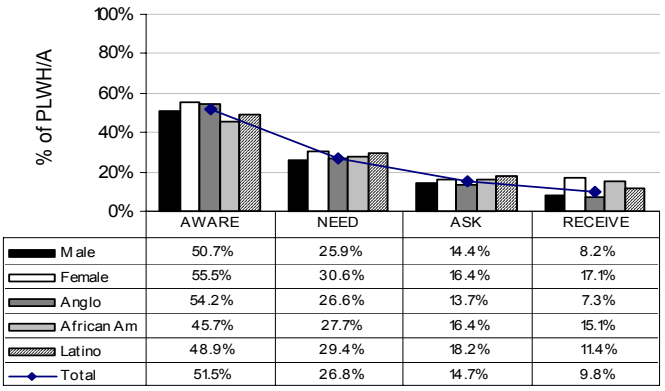
- Do not know where to go for the service
- Limited availability of food vouchers
- Not enough funding for service
- Too many rules and regulations

Notes

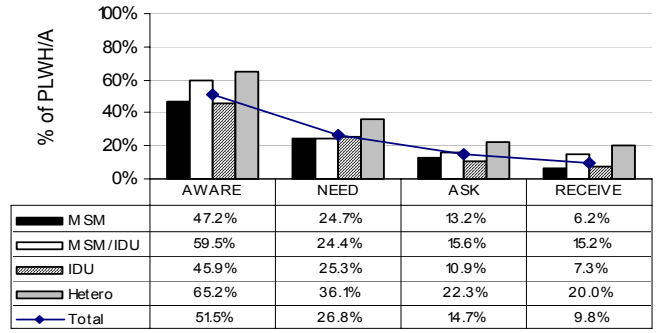
Delivered meals

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 home delivered meal
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; To be distributed among the maximum number of most at-risk clients.

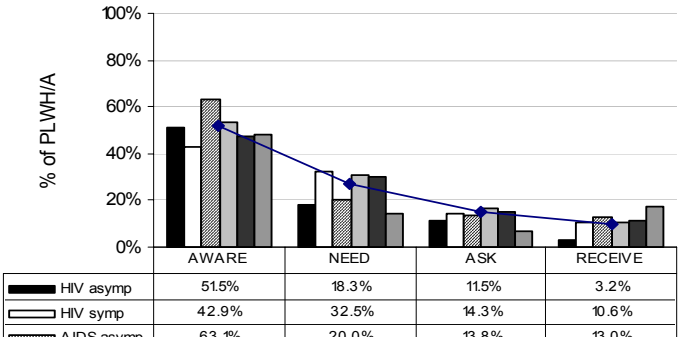
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	694	
RW Care Title II		Number unduplicated	92	
Other		Average Used	8	
Total Allocated		Expenditure	$6,989	



	AWARE	NEED	ASK	RECEIVE
Male	50.7%	25.9%	14.4%	8.2%
Female	55.5%	30.6%	16.4%	17.1%
Anglo	54.2%	26.6%	13.7%	7.3%
African Am	45.7%	27.7%	16.4%	15.1%
Latino	48.9%	29.4%	18.2%	11.4%
Total	51.5%	26.8%	14.7%	9.8%



	AWARE	NEED	ASK	RECEIVE
MSM	47.2%	24.7%	13.2%	6.2%
MSM/IDU	59.5%	24.4%	15.6%	15.2%
IDU	45.9%	25.3%	10.9%	7.3%
Hetero	65.2%	36.1%	22.3%	20.0%
Total	51.5%	26.8%	14.7%	9.8%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	51.5%	18.3%	11.5%	3.2%
HIV symp	42.9%	32.5%	14.3%	10.6%
AIDS asymp	63.1%	20.0%	13.8%	13.0%
AIDS symp	53.4%	30.5%	16.8%	10.8%
Homeless	47.3%	29.9%	15.0%	11.1%
Rec Inc	48.4%	14.0%	6.5%	17.4%
Total	51.5%	26.8%	14.7%	9.8%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	12.0%	4.9%
Male	11.6%	6.1%
Female	14.2%	-0.7%
MSM	11.4%	7.1%
MSMIDU	8.7%	0.4%
IDU	14.5%	3.6%
Hetero	13.7%	2.4%
Anglo	12.9%	6.4%
African Am	11.4%	1.3%
Latino	11.2%	6.8%
HIV asymp	6.7%	8.3%
HIV symp	18.2%	3.7%
AIDS asymp	6.2%	0.9%
AIDS symp	13.7%	6.0%
Homeless	15.0%	3.9%
Recently Incarcerated	7.5%	-10.9%

Consumer Rank	21 out of 42

Barriers

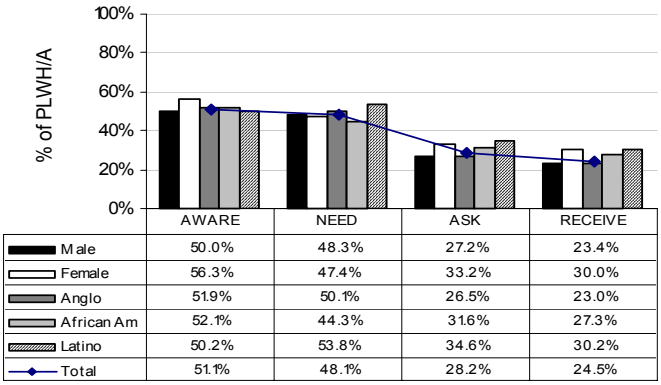
- Not knowing about service
- Not eligible
- Language barrier

Notes

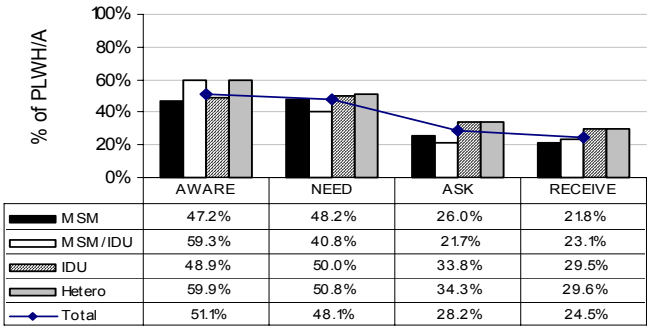
Nutrition Supplement

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 nutritional supplement pack
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; To be distributed among the maximum number of most at-risk clients

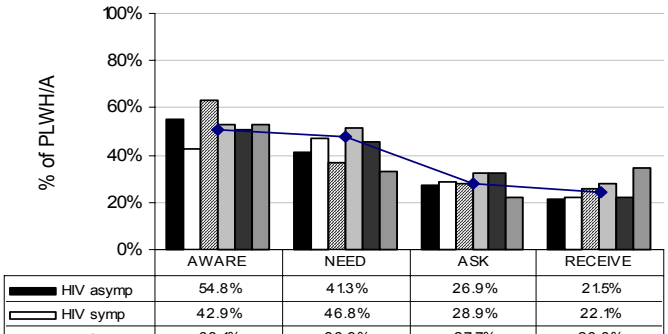
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	156	
RW Care Title II		Number unduplicated	31	
Other		Average Used	5	
Total Allocated		Expenditure	$6,864	



	AWARE	NEED	ASK	RECEIVE
Male	50.0%	48.3%	27.2%	23.4%
Female	56.3%	47.4%	33.2%	30.0%
Anglo	51.9%	50.1%	26.5%	23.0%
African Am	52.1%	44.3%	31.6%	27.3%
Latino	50.2%	53.8%	34.6%	30.2%
Total	51.1%	48.1%	28.2%	24.5%



	AWARE	NEED	ASK	RECEIVE
MSM	47.2%	48.2%	26.0%	21.8%
MSM/IDU	59.3%	40.8%	21.7%	23.1%
IDU	48.9%	50.0%	33.8%	29.5%
Hetero	59.9%	50.8%	34.3%	29.6%
Total	51.1%	48.1%	28.2%	24.5%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	54.8%	41.3%	26.9%	21.5%
HIV symp	42.9%	46.8%	28.9%	22.1%
AIDS asymp	63.1%	36.9%	27.7%	26.0%
AIDS symp	52.7%	51.1%	32.3%	27.7%
Homeless	51.0%	45.6%	32.2%	22.2%
Rec Inc	52.7%	33.3%	21.7%	34.8%
Total	51.1%	48.1%	28.2%	24.5%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	19.9%	3.7%
Male	21.1%	3.8%
Female	14.2%	3.2%
MSM	22.2%	4.2%
MSMIDU	19.1%	-1.4%
IDU	16.2%	4.3%
Hetero	16.5%	4.7%
Anglo	23.6%	3.5%
African Am	12.6%	4.3%
Latino	19.2%	4.4%
HIV asymp	14.4%	5.4%
HIV symp	17.8%	6.8%
AIDS asymp	9.2%	1.7%
AIDS symp	18.8%	4.6%
Homeless	13.4%	10.0%
Recently Incarcerated	11.6%	-13.0%

Consumer Rank	14 out of 42

Barriers

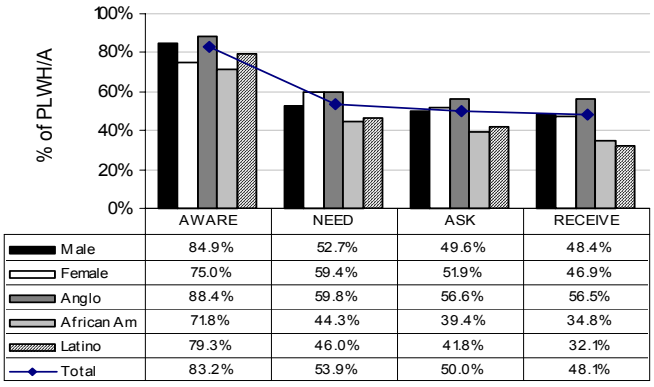
- Not knowing about service
- Not eligible – service not provided
- Quality of supplements

Notes

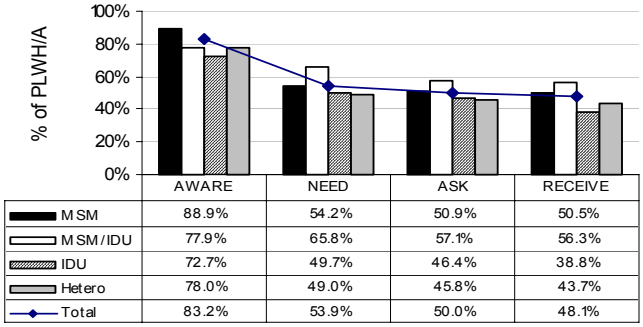
Mental Health One on One

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour (psychological)
Eligibility:	Diagnosis of HIV infection or family member of, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; RW to be used only as a last resort on a limited, goal-focused basis.

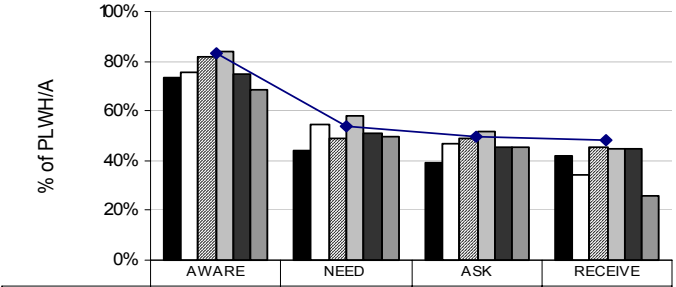
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	1,716	
RW Care Title II		Number unduplicated	299	
Other		Average Used	6	
Total Allocated		Expenditure	$105,315	



	AWARE	NEED	ASK	RECEIVE
Male	84.9%	52.7%	49.6%	48.4%
Female	75.0%	59.4%	51.9%	46.9%
Anglo	88.4%	59.8%	56.6%	56.5%
African Am	71.8%	44.3%	39.4%	34.8%
Latino	79.3%	46.0%	41.8%	32.1%
Total	83.2%	53.9%	50.0%	48.1%



	AWARE	NEED	ASK	RECEIVE
MSM	88.9%	54.2%	50.9%	50.5%
MSM/IDU	77.9%	65.8%	57.1%	56.3%
IDU	72.7%	49.7%	46.4%	38.8%
Hetero	78.0%	49.0%	45.8%	43.7%
Total	83.2%	53.9%	50.0%	48.1%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	73.1%	44.2%	39.4%	41.9%
HIV symp	75.3%	54.5%	46.8%	34.6%
AIDS asymp	81.5%	49.2%	49.2%	45.5%
AIDS symp	84.0%	57.7%	51.9%	44.6%
Homeless	74.8%	51.0%	45.6%	44.4%
Rec Inc	68.8%	49.5%	45.2%	26.1%
Total	83.2%	53.9%	50.0%	48.1%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	3.9%	1.8%
Male	3.1%	1.2%
Female	7.5%	4.9%
MSM	3.4%	0.3%
MSMIDU	8.7%	0.8%
IDU	3.3%	7.6%
Hetero	3.2%	2.1%
Anglo	3.2%	0.0%
African Am	4.9%	4.6%
Latino	4.2%	9.7%
HIV asymp	4.8%	-2.5%
HIV symp	7.8%	12.1%
AIDS asymp	0.0%	3.8%
AIDS symp	5.8%	7.3%
Homeless	5.4%	1.1%
Recently Incarcerated	4.3%	19.1%

Consumer Rank 13 out of 42

Barriers

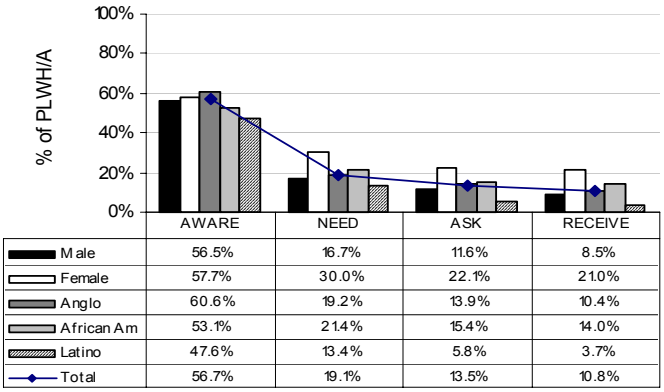
- Not knowing about service
- Length of time for appointment -overbooked
- No Spanish services available
- Red tape

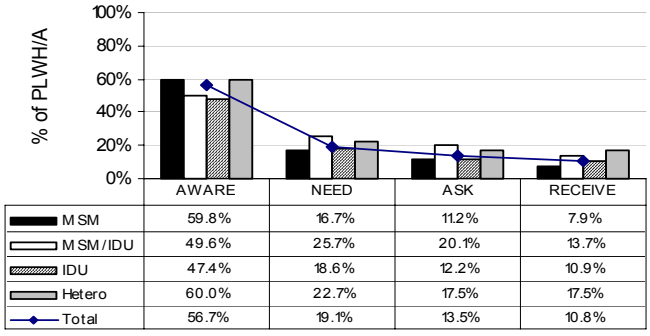
Notes

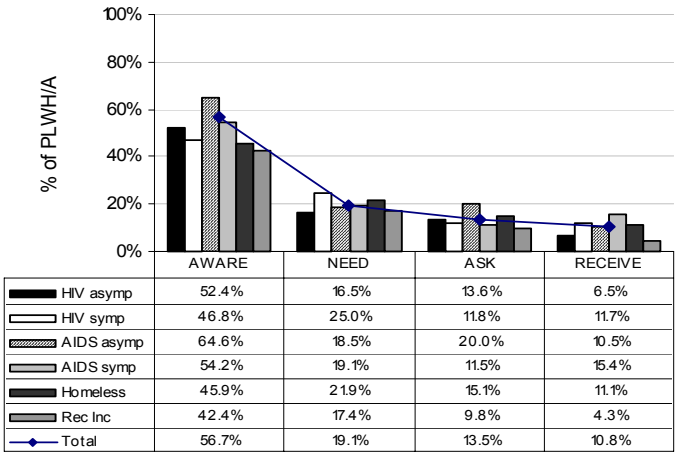
Family Counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour (family)
Eligibility:	Diagnosis of HIV infection or family member of, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; RW to be used only as a last resort on a limited, goal-focused basis.

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	197	
RW Care Title II		Number unduplicated	1	
Other		Average Used	197	
Total Allocated		Expenditure	$8,722	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	5.6%	2.7%
Male	5.1%	3.1%
Female	7.9%	1.1%
MSM	5.5%	3.3%
MSMIDU	5.6%	6.4%
IDU	6.4%	1.3%
Hetero	5.2%	0.0%
Anglo	5.3%	3.5%
African Am	6.0%	1.4%
Latino	7.6%	2.1%
HIV asymp	2.9%	7.1%
HIV symp	13.2%	0.2%
AIDS asymp	-1.5%	9.5%
AIDS symp	7.6%	-3.9%
Homeless	6.8%	4.0%
Recently Incarcerated	7.6%	5.4%

Consumer Rank	33 out of 42

Barriers

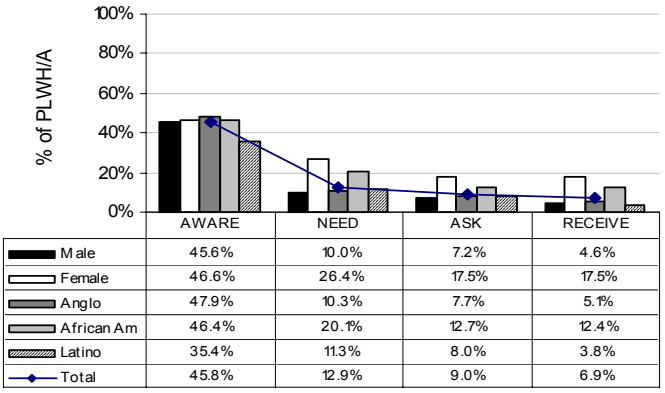
- Not knowing about service
- Hours of operation

Notes

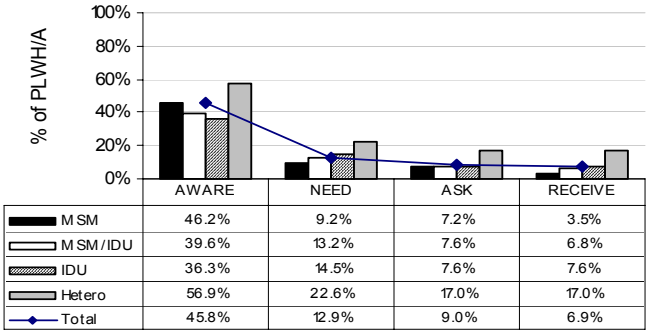
Bereavement counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection or family member of, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; RW to be used only as a last resort on a limited, goal-focused basis.

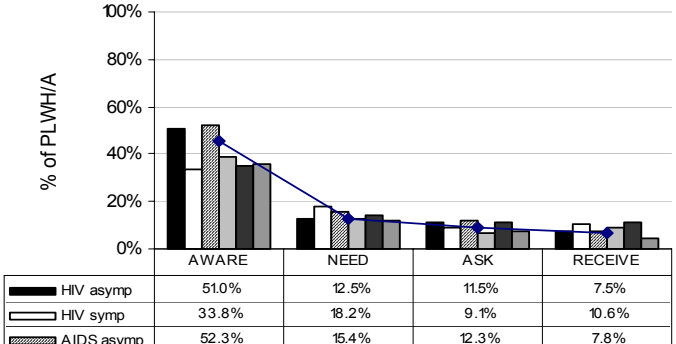
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	45.6%	10.0%	7.2%	4.6%
Female	46.6%	26.4%	17.5%	17.5%
Anglo	47.9%	10.3%	7.7%	5.1%
African Am	46.4%	20.1%	12.7%	12.4%
Latino	35.4%	11.3%	8.0%	3.8%
Total	45.8%	12.9%	9.0%	6.9%



	AWARE	NEED	ASK	RECEIVE
MSM	46.2%	9.2%	7.2%	3.5%
MSM/IDU	39.6%	13.2%	7.6%	6.8%
IDU	36.3%	14.5%	7.6%	7.6%
Hetero	56.9%	22.6%	17.0%	17.0%
Total	45.8%	12.9%	9.0%	6.9%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	51.0%	12.5%	11.5%	7.5%
HIV symp	33.8%	18.2%	9.1%	10.6%
AIDS asymp	52.3%	15.4%	12.3%	7.8%
AIDS symp	38.9%	13.0%	6.9%	9.2%
Homeless	35.4%	14.3%	10.9%	11.1%
Rec Inc	35.5%	11.8%	7.5%	4.3%
Total	45.8%	12.9%	9.0%	6.9%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	3.9%	2.1%
Male	2.8%	2.6%
Female	8.9%	0.0%
MSM	2.1%	3.7%
MSMIDU	5.6%	0.8%
IDU	7.0%	0.0%
Hetero	5.5%	0.0%
Anglo	2.6%	2.6%
African Am	7.4%	0.3%
Latino	3.3%	4.2%
HIV asymp	1.0%	4.0%
HIV symp	9.1%	-1.5%
AIDS asymp	3.1%	4.5%
AIDS symp	6.1%	-2.4%
Homeless	3.4%	-0.2%
Recently Incarcerated	4.3%	3.2%

Consumer Rank	38 out of 42

Barriers

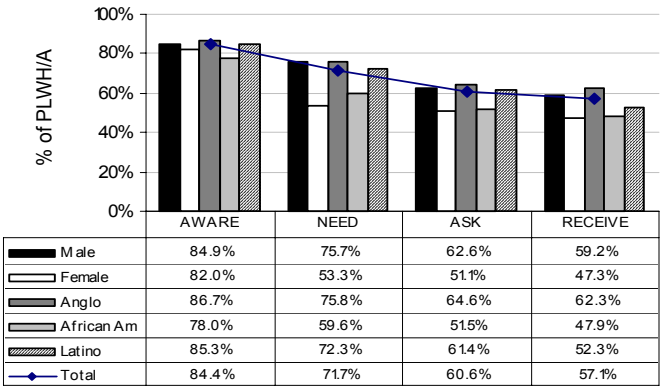
- Not knowing about service

Notes

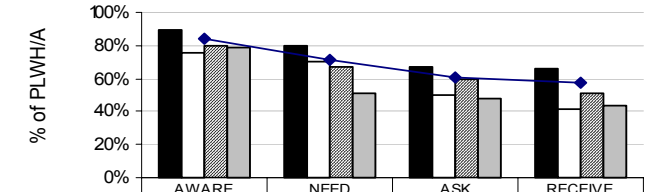
Dental Care

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Encounter
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

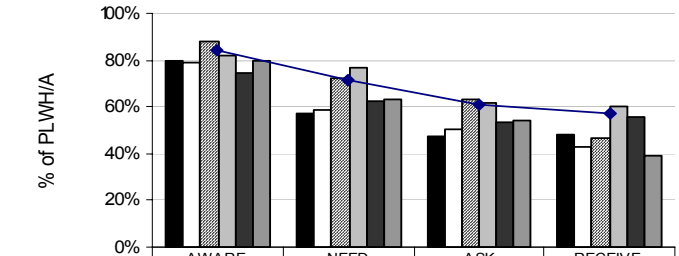
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$166,171	Number duplicated	1,514	1692
RW Care Title II		Number unduplicated	305	341
Other		Average Used	5	5
Total Allocated		Expenditure	$155,963	$179,479



	AWARE	NEED	ASK	RECEIVE
Male	84.9%	75.7%	62.6%	59.2%
Female	82.0%	53.3%	51.1%	47.3%
Anglo	86.7%	75.8%	64.6%	62.3%
African Am	78.0%	59.6%	51.5%	47.9%
Latino	85.3%	72.3%	61.4%	52.3%
Total	84.4%	71.7%	60.6%	57.1%



	AWARE	NEED	ASK	RECEIVE
MSM	89.1%	80.2%	67.1%	66.4%
MSM/IDU	76.0%	69.7%	50.3%	41.8%
IDU	80.2%	67.0%	59.6%	50.7%
Hetero	78.6%	51.1%	47.9%	43.8%
Total	84.4%	71.7%	60.6%	57.1%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	79.6%	57.3%	47.1%	48.4%
HIV symp	79.2%	58.4%	50.6%	42.6%
AIDS asymp	87.7%	72.3%	63.1%	46.8%
AIDS symp	82.2%	76.9%	62.0%	60.0%
Homeless	74.7%	62.3%	53.1%	55.6%
Rec Inc	79.6%	63.4%	53.8%	39.1%
Total	84.4%	71.7%	60.6%	57.1%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	11.1%	3.5%
Male	13.0%	3.4%
Female	2.2%	3.8%
MSM	13.0%	0.8%
MSMIDU	19.4%	8.5%
IDU	7.4%	8.9%
Hetero	3.2%	4.1%
Anglo	11.2%	2.4%
African Am	8.0%	3.6%
Latino	10.9%	9.1%
HIV asymp	10.2%	-1.3%
HIV symp	7.8%	8.1%
AIDS asymp	9.2%	16.3%
AIDS symp	14.9%	2.0%
Homeless	9.2%	-2.5%
Recently Incarcerated	9.7%	14.6%

Consumer Rank 4 out of 42

Barriers

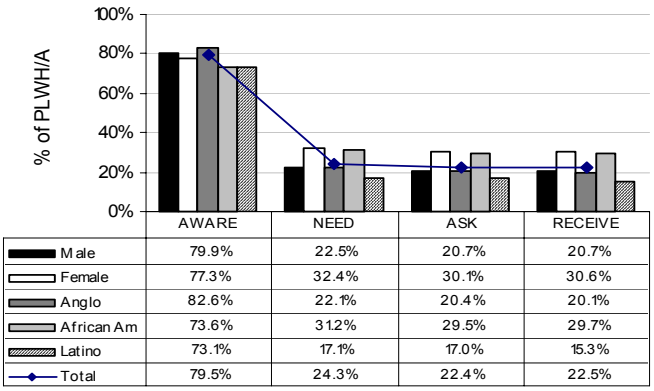
- Length of time for an appointment
- Insufficient coverage
- Transportation
- Not knowing about service

Notes

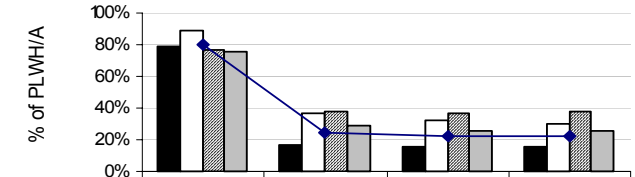
Substance abuse counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour outpatient counseling
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

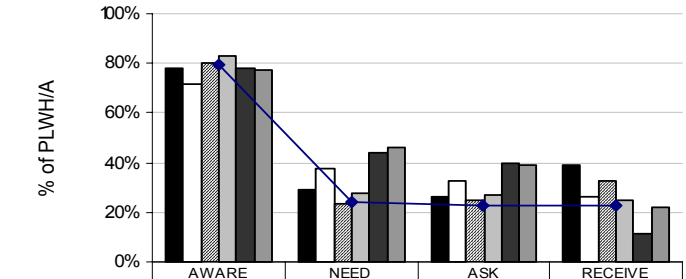
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	404	
RW Care Title II		Number unduplicated	61	
Other		Average Used	7	
Total Allocated		Expenditure	$18,180	



	AWARE	NEED	ASK	RECEIVE
Male	79.9%	22.5%	20.7%	20.7%
Female	77.3%	32.4%	30.1%	30.6%
Anglo	82.6%	22.1%	20.4%	20.1%
African Am	73.6%	31.2%	29.5%	29.7%
Latino	73.1%	17.1%	17.0%	15.3%
Total	79.5%	24.3%	22.4%	22.5%



	AWARE	NEED	ASK	RECEIVE
MSM	79.4%	16.7%	15.5%	15.6%
MSM/IDU	88.5%	36.8%	32.0%	30.0%
IDU	76.9%	37.3%	36.3%	37.9%
Hetero	76.0%	28.5%	25.5%	25.5%
Total	79.5%	24.3%	22.4%	22.5%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	77.7%	29.1%	26.2%	38.7%
HIV symp	71.4%	37.7%	32.5%	26.2%
AIDS asymp	80.0%	23.1%	24.6%	32.5%
AIDS symp	83.1%	27.5%	26.7%	24.6%
Homeless	78.2%	44.2%	39.5%	11.1%
Rec Inc	77.4%	46.2%	38.7%	21.7%
Total	79.5%	24.3%	22.4%	22.5%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.9%	-0.1%
Male	1.8%	0.0%
Female	2.3%	-0.4%
MSM	1.2%	-0.1%
MSMIDU	4.8%	2.0%
IDU	1.0%	-1.6%
Hetero	3.0%	0.0%
Anglo	1.7%	0.3%
African Am	1.7%	-0.1%
Latino	0.1%	1.8%
HIV asymp	2.9%	-12.5%
HIV symp	5.2%	6.3%
AIDS asymp	-1.5%	-7.9%
AIDS symp	0.8%	2.1%
Homeless	4.8%	28.3%
Recently Incarcerated	7.5%	17.0%

Consumer Rank 25 out of 42

Barriers

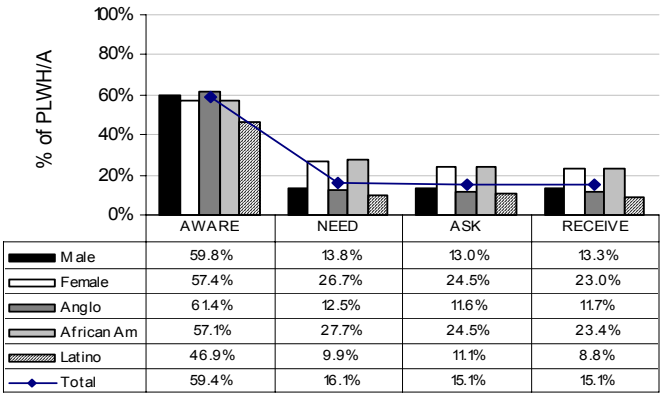
- Do not need service - sober
- Not knowing about service
- Limited availability of detox beds
- Discrimination toward PLWH/A
- Lack of trust, fear of loss of confidentiality

Notes

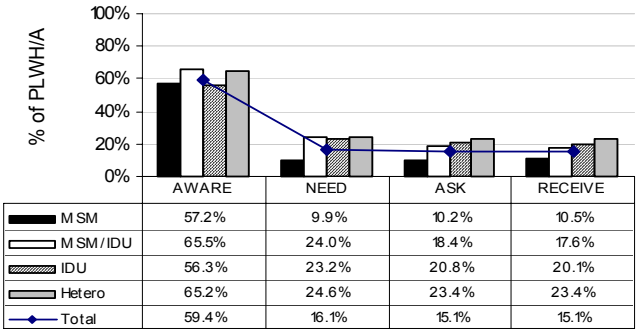
Substance abuse assessment

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 addiction assessment
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

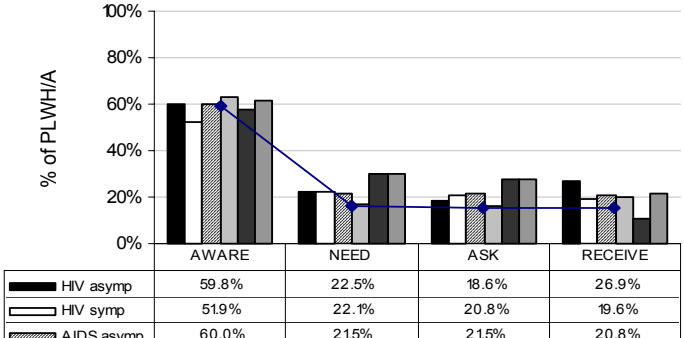
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	100	
RW Care Title II		Number unduplicated	63	
Other		Average Used	2	
Total Allocated		Expenditure	$6,210	



	AWARE	NEED	ASK	RECEIVE
Male	59.8%	13.8%	13.0%	13.3%
Female	57.4%	26.7%	24.5%	23.0%
Anglo	61.4%	12.5%	11.6%	11.7%
African Am	57.1%	27.7%	24.5%	23.4%
Latino	46.9%	9.9%	11.1%	8.8%
Total	59.4%	16.1%	15.1%	15.1%



	AWARE	NEED	ASK	RECEIVE
MSM	57.2%	9.9%	10.2%	10.5%
MSM/IDU	65.5%	24.0%	18.4%	17.6%
IDU	56.3%	23.2%	20.8%	20.1%
Hetero	65.2%	24.6%	23.4%	23.4%
Total	59.4%	16.1%	15.1%	15.1%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	59.8%	22.5%	18.6%	26.9%
HIV symp	51.9%	22.1%	20.8%	19.6%
AIDS asymp	60.0%	21.5%	21.5%	20.8%
AIDS symp	63.4%	16.8%	16.0%	20.0%
Homeless	57.8%	29.9%	27.9%	11.1%
Rec Inc	61.3%	30.1%	28.0%	21.7%
Total	59.4%	16.1%	15.1%	15.1%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.0%	0.0%
Male	0.8%	-0.3%
Female	2.2%	1.5%
MSM	-0.3%	-0.3%
MSMIDU	5.7%	0.8%
IDU	2.4%	0.7%
Hetero	1.2%	0.0%
Anglo	0.9%	-0.1%
African Am	3.2%	1.1%
Latino	-1.3%	2.3%
HIV asymp	3.9%	-8.3%
HIV symp	1.3%	1.2%
AIDS asymp	0.0%	0.8%
AIDS symp	0.8%	-4.0%
Homeless	2.0%	16.8%
Recently Incarcerated	2.2%	6.2%

Consumer Rank	35 out of 42

Barriers

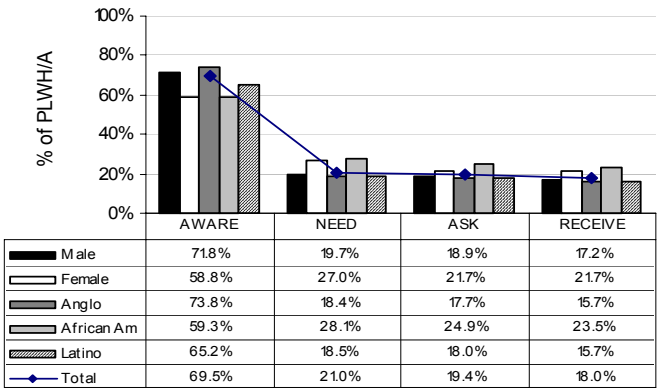
- Not knowing about service

Notes

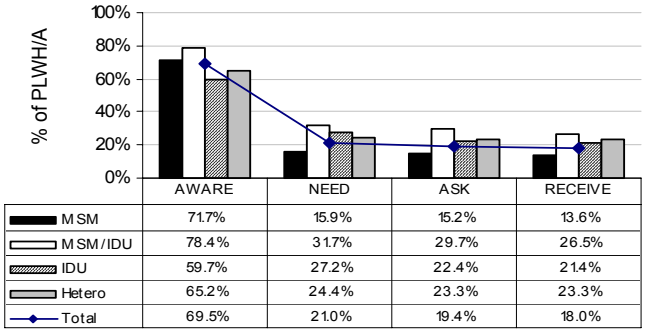
Substance abuse one-on-one counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; if unable to participate in federal, state, or local programs; provided funding is available for extension periods.

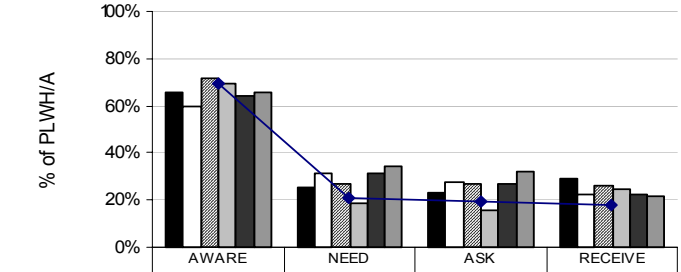
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	71.8%	19.7%	18.9%	17.2%
Female	58.8%	27.0%	21.7%	21.7%
Anglo	73.8%	18.4%	17.7%	15.7%
African Am	59.3%	28.1%	24.9%	23.5%
Latino	65.2%	18.5%	18.0%	15.7%
Total	69.5%	21.0%	19.4%	18.0%



	AWARE	NEED	ASK	RECEIVE
MSM	71.7%	15.9%	15.2%	13.6%
MSM/IDU	78.4%	31.7%	29.7%	26.5%
IDU	59.7%	27.2%	22.4%	21.4%
Hetero	65.2%	24.4%	23.3%	23.3%
Total	69.5%	21.0%	19.4%	18.0%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	66.0%	25.2%	23.3%	29.0%
HIV symp	59.7%	31.2%	27.3%	22.3%
AIDS asymp	71.9%	26.6%	26.6%	26.0%
AIDS symp	69.2%	18.5%	15.4%	25.0%
Homeless	63.9%	31.3%	27.2%	22.2%
Rec Inc	65.6%	34.4%	32.3%	21.7%
Total	69.5%	21.0%	19.4%	18.0%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.6%	1.4%
Male	0.7%	1.7%
Female	5.3%	0.0%
MSM	0.7%	1.6%
MSMIDU	2.1%	3.2%
IDU	4.7%	1.0%
Hetero	1.2%	0.0%
Anglo	0.7%	2.0%
African Am	3.2%	1.4%
Latino	0.5%	2.3%
HIV asymp	1.9%	-5.7%
HIV symp	3.9%	4.9%
AIDS asymp	0.0%	0.6%
AIDS symp	3.1%	-9.6%
Homeless	4.1%	5.0%
Recently Incarcerated	2.2%	10.5%

Consumer Rank 30 out of 42

Barriers

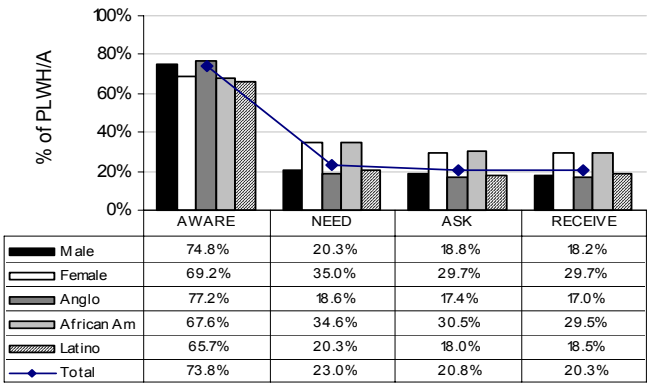
- Not knowing about service
- Not provided proper referrals
- Length of time for an appointment
- Individual physical or mental health
- Cost of service/ inadequate insurance

Notes

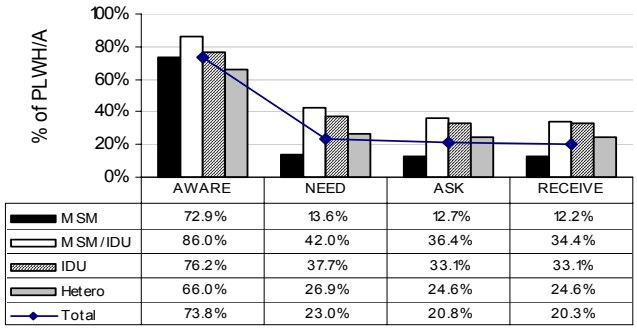
Substance Abuse Group

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; if unable to participate in federal, state, or local programs; provided funding is available for extension periods.

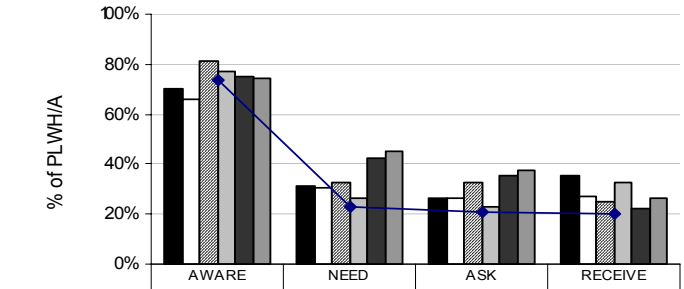
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	559	
RW Care Title II		Number unduplicated	41	
Other		Average Used	14	
Total Allocated		Expenditure	$18,056	



	AWARE	NEED	ASK	RECEIVE
Male	74.8%	20.3%	18.8%	18.2%
Female	69.2%	35.0%	29.7%	29.7%
Anglo	77.2%	18.6%	17.4%	17.0%
African Am	67.6%	34.6%	30.5%	29.5%
Latino	65.7%	20.3%	18.0%	18.5%
Total	73.8%	23.0%	20.8%	20.3%



	AWARE	NEED	ASK	RECEIVE
MSM	72.9%	13.6%	12.7%	12.2%
MSM/IDU	86.0%	42.0%	36.4%	34.4%
IDU	76.2%	37.7%	33.1%	33.1%
Hetero	66.0%	26.9%	24.6%	24.6%
Total	73.8%	23.0%	20.8%	20.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	69.9%	31.1%	26.2%	35.5%
HIV symp	66.2%	30.7%	26.7%	27.2%
AIDS asymp	81.3%	32.8%	32.8%	25.3%
AIDS symp	76.9%	26.2%	23.1%	32.8%
Homeless	75.0%	42.4%	35.4%	22.2%
Rec Inc	74.2%	45.2%	37.6%	26.1%
Total	73.8%	23.0%	20.8%	20.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask – Received
Total	2.2%	0.5%
Male	1.6%	0.6%
Female	5.3%	0.0%
MSM	0.8%	0.5%
MSMIDU	5.6%	2.0%
IDU	4.6%	0.0%
Hetero	2.3%	0.0%
Anglo	1.2%	0.5%
African Am	4.0%	1.0%
Latino	2.3%	-0.5%
HIV asymp	4.9%	-15.5%
HIV symp	4.0%	-0.6%
AIDS asymp	0.0%	4.6%
AIDS symp	3.1%	-9.4%
Homeless	6.9%	9.3%
Recently Incarcerated	7.5%	23.5%

Consumer Rank	26 out of 42

Barriers

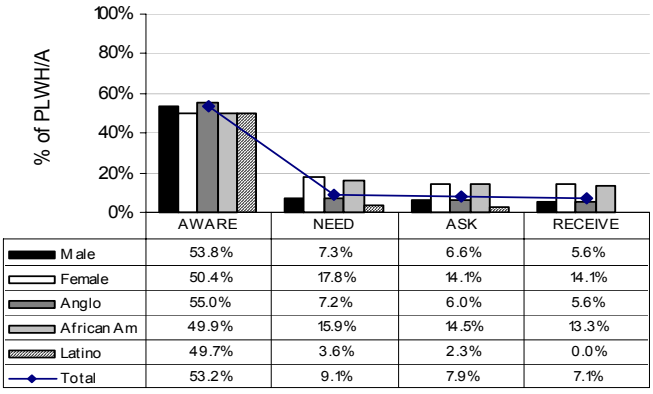
- Not knowing about service

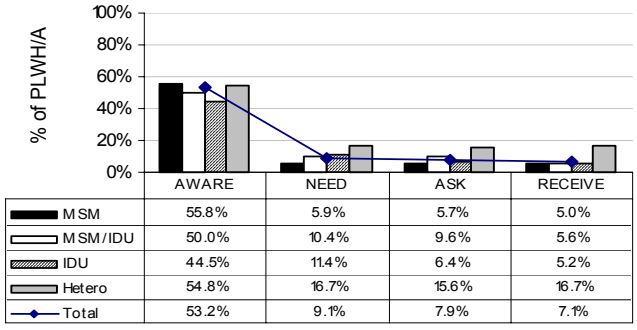
Notes

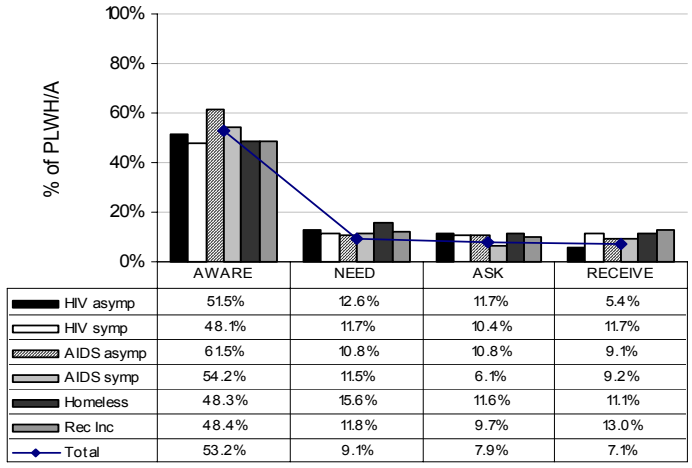
Substance abuse family counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; if unable to participate in federal, state, or local programs; provided funding is available for extension periods.

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	3	
RW Care Title II		Number unduplicated	1	
Other		Average Used	3	
Total Allocated		Expenditure	$135	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.2%	0.8%
Male	0.7%	1.0%
Female	3.8%	0.0%
MSM	0.2%	0.6%
MSMIDU	0.8%	4.0%
IDU	5.0%	1.3%
Hetero	1.2%	-1.2%
Anglo	1.2%	0.4%
African Am	1.3%	1.2%
Latino	1.3%	2.3%
HIV asymp	1.0%	6.3%
HIV symp	1.3%	-1.3%
AIDS asymp	0.0%	1.7%
AIDS symp	5.3%	-3.1%
Homeless	4.1%	0.5%
Recently Incarcerated	2.2%	-3.4%

Consumer Rank	40 out of 42

Barriers

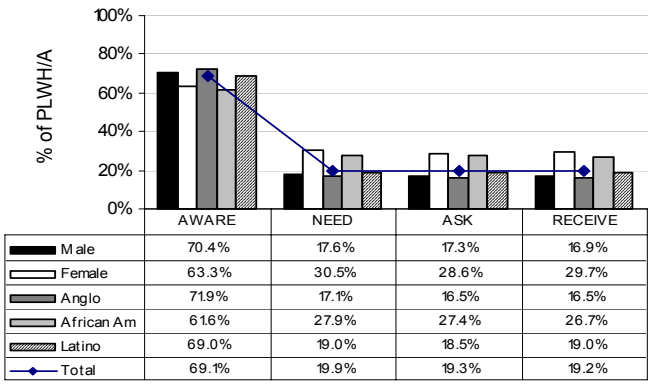
- Not knowing about service

Notes

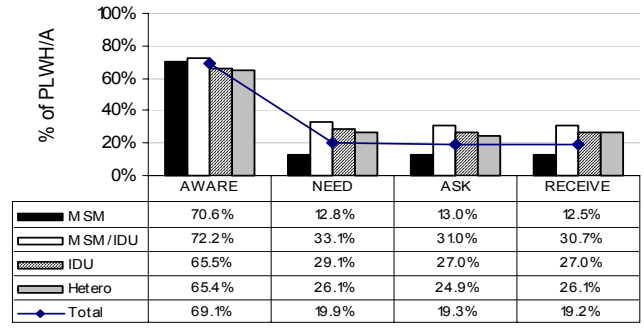
Substance Abuse peer group

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; if unable to participate in federal, state, or local programs; provided funding is available for extension periods.

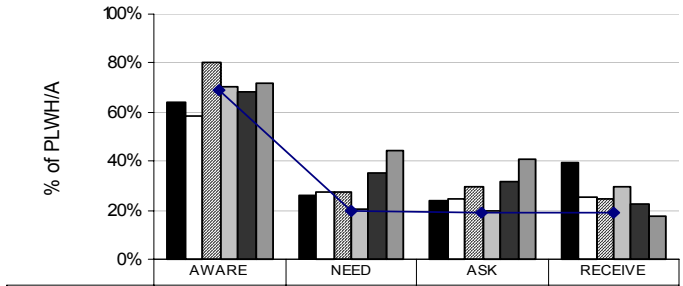
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	70.4%	17.6%	17.3%	16.9%
Female	63.3%	30.5%	28.6%	29.7%
Anglo	71.9%	17.1%	16.5%	16.5%
African Am	61.6%	27.9%	27.4%	26.7%
Latino	69.0%	19.0%	18.5%	19.0%
Total	69.1%	19.9%	19.3%	19.2%



	AWARE	NEED	ASK	RECEIVE
MSM	70.6%	12.8%	13.0%	12.5%
MSM/IDU	72.2%	33.1%	31.0%	30.7%
IDU	65.5%	29.1%	27.0%	27.0%
Hetero	65.4%	26.1%	24.9%	26.1%
Total	69.1%	19.9%	19.3%	19.2%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	64.1%	26.2%	24.3%	39.8%
HIV symp	58.4%	27.3%	24.7%	25.2%
AIDS asymp	80.0%	27.7%	29.2%	24.7%
AIDS symp	70.8%	20.6%	19.8%	29.2%
Homeless	68.5%	34.9%	31.5%	22.2%
Rec Inc	72.0%	44.1%	40.9%	17.4%
Total	69.1%	19.9%	19.3%	19.2%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	2.2%	0.1%
Male	1.6%	0.4%
Female	5.3%	-1.1%
MSM	0.8%	0.5%
MSMIDU	5.6%	0.4%
IDU	4.6%	0.0%
Hetero	2.3%	-1.2%
Anglo	1.2%	0.0%
African Am	4.0%	0.6%
Latino	2.3%	-0.5%
HIV asymp	1.9%	-15.5%
HIV symp	2.6%	-0.6%
AIDS asymp	-1.5%	4.6%
AIDS symp	0.8%	-9.4%
Homeless	3.4%	9.3%
Recently Incarcerated	3.2%	23.5%

Consumer Rank	31 out of 42

Barriers

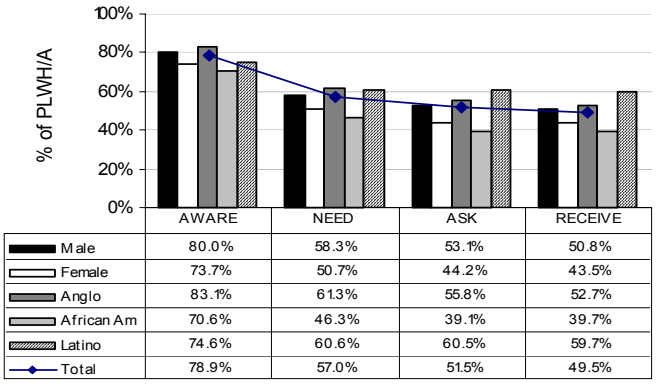
- Not knowing about service

Notes

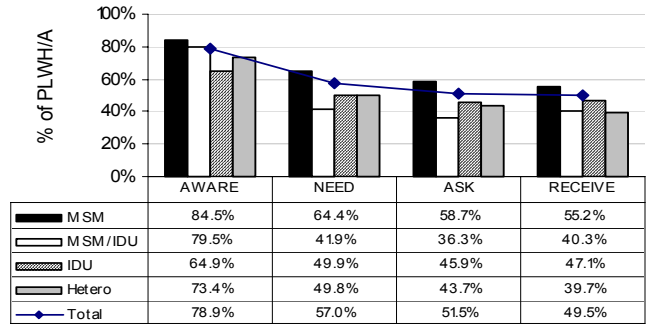
Medication Reimbursement

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 vendor paid medication dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

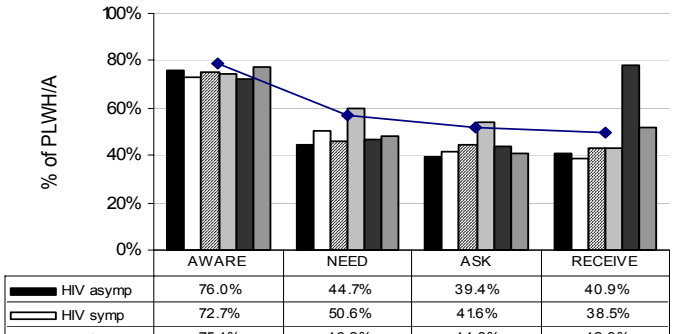
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$20,400	Number duplicated	17,093	17,604.4
RW Care Title II		Number unduplicated	59	59
Other		Average Used	290	298
Total Allocated		Expenditure	$18,802	$19,366



	AWARE	NEED	ASK	RECEIVE
Male	80.0%	58.3%	53.1%	50.8%
Female	73.7%	50.7%	44.2%	43.5%
Anglo	83.1%	61.3%	55.8%	52.7%
African Am	70.6%	46.3%	39.1%	39.7%
Latino	74.6%	60.6%	60.5%	59.7%
Total	78.9%	57.0%	51.5%	49.5%



	AWARE	NEED	ASK	RECEIVE
MSM	84.5%	64.4%	58.7%	55.2%
MSM/IDU	79.5%	41.9%	36.3%	40.3%
IDU	64.9%	49.9%	45.9%	47.1%
Hetero	73.4%	49.8%	43.7%	39.7%
Total	78.9%	57.0%	51.5%	49.5%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	76.0%	44.7%	39.4%	40.9%
HIV symp	72.7%	50.6%	41.6%	38.5%
AIDS asymp	75.4%	46.2%	44.6%	42.9%
AIDS symp	74.8%	59.5%	54.2%	43.1%
Homeless	72.1%	46.6%	43.5%	77.8%
Rec Inc	77.4%	48.4%	40.9%	52.2%
Total	78.9%	57.0%	51.5%	49.5%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask – Received
Total	5.5%	2.0%
Male	5.3%	2.3%
Female	6.5%	0.7%
MSM	5.7%	3.5%
MSMIDU	5.6%	-4.0%
IDU	4.1%	-1.3%
Hetero	6.0%	4.0%
Anglo	5.5%	3.1%
African Am	7.2%	-0.6%
Latino	0.1%	0.8%
HIV asymp	5.2%	-1.4%
HIV symp	9.1%	3.1%
AIDS asymp	1.5%	1.8%
AIDS symp	5.3%	11.1%
Homeless	3.0%	-34.2%
Recently Incarcerated	7.5%	-11.3%

Consumer Rank	10 out of 42

Barriers

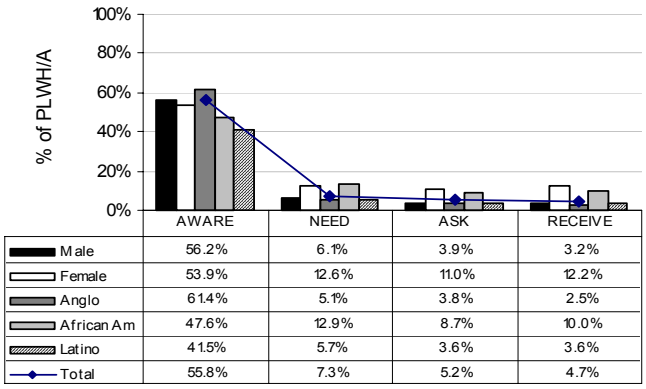
- Not knowing about service

Notes

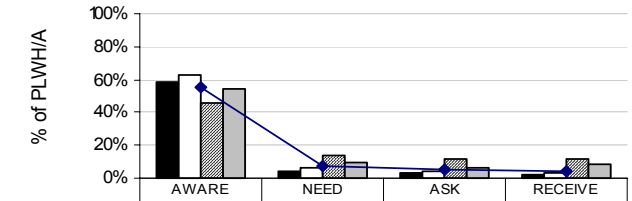
Residential Hospice Care

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	24 hours (1 day)
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

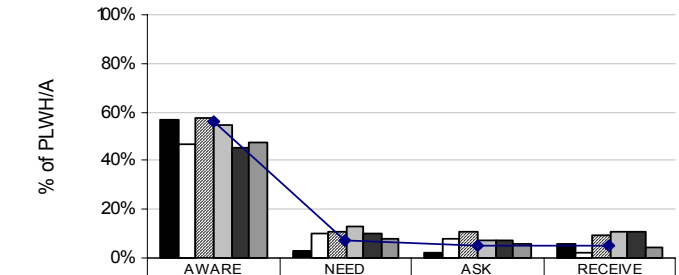
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$142,222	Number duplicated	1,747	1861
RW Care Title II		Number unduplicated	18	18
Other		Average Used	97	103
Total Allocated		Expenditure	$141,837	$155,669



	AWARE	NEED	ASK	RECEIVE
Male	56.2%	6.1%	3.9%	3.2%
Female	53.9%	12.6%	11.0%	12.2%
Anglo	61.4%	5.1%	3.8%	2.5%
African Am	47.6%	12.9%	8.7%	10.0%
Latino	41.5%	5.7%	3.6%	3.6%
Total	55.8%	7.3%	5.2%	4.7%



	AWARE	NEED	ASK	RECEIVE
MSM	58.0%	4.7%	3.1%	1.7%
MSM/IDU	62.4%	6.7%	4.3%	3.5%
IDU	45.2%	13.4%	11.6%	11.6%
Hetero	54.3%	10.0%	6.5%	8.9%
Total	55.8%	7.3%	5.2%	4.7%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	56.7%	2.9%	1.9%	5.4%
HIV symp	46.8%	10.4%	7.8%	1.9%
AIDS asymp	57.8%	10.9%	10.9%	9.1%
AIDS symp	55.0%	13.0%	6.9%	10.9%
Homeless	45.2%	10.3%	6.9%	11.1%
Rec Inc	47.8%	7.6%	5.4%	4.3%
Total	55.8%	7.3%	5.2%	4.7%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	2.1%	0.5%
Male	2.2%	0.8%
Female	1.5%	-1.1%
MSM	1.6%	1.4%
MSMIDU	2.4%	0.8%
IDU	1.7%	0.0%
Hetero	3.5%	-2.4%
Anglo	1.2%	1.3%
African Am	4.2%	-1.3%
Latino	2.1%	0.0%
HIV asymp	1.0%	-3.5%
HIV symp	2.6%	5.9%
AIDS asymp	0.0%	1.8%
AIDS symp	6.1%	-4.1%
Homeless	3.4%	-4.2%
Recently Incarcerated	2.2%	1.1%

Consumer Rank 41 out of 42

Barriers

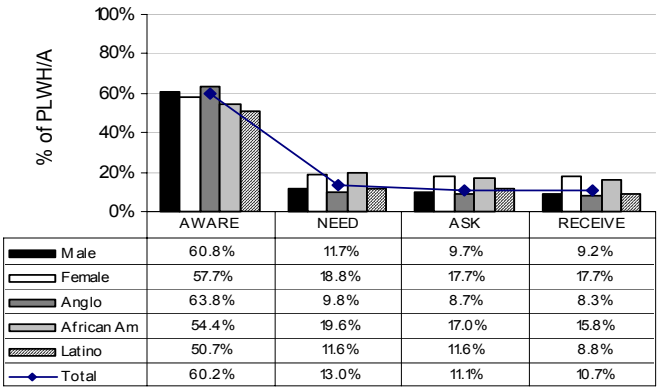
- Not knowing about service
- Service not available

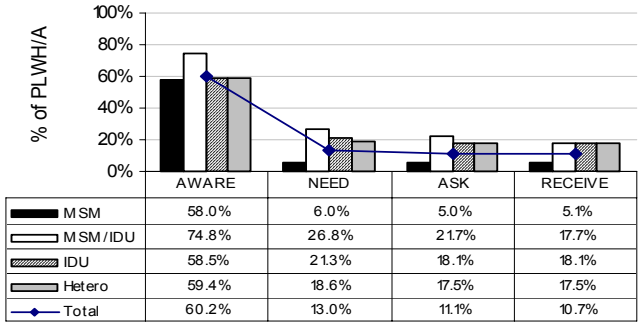
Notes

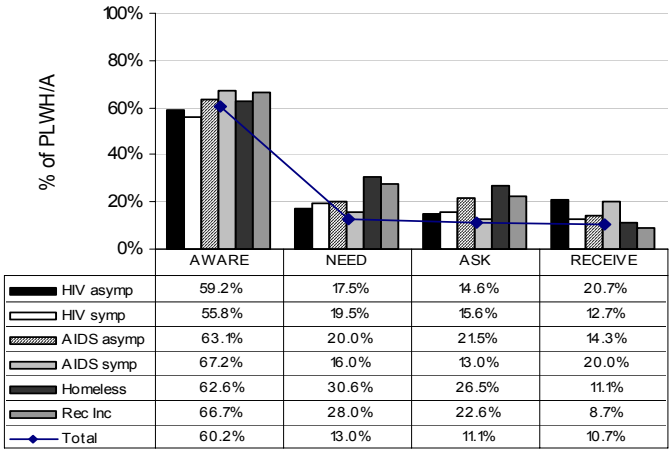
Substance abuse services- Residential

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$96,595	Number duplicated	26,028	29,815
RW Care Title II		Number unduplicated	41	41
Other		Average Used	635	727
Total Allocated		Expenditure	$84,272	$99,494







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.8%	0.4%
Male	2.0%	0.5%
Female	1.1%	0.0%
MSM	1.0%	-0.1%
MSMIDU	5.1%	4.0%
IDU	3.2%	0.0%
Hetero	1.2%	0.0%
Anglo	1.2%	0.4%
African Am	2.6%	1.2%
Latino	0.0%	2.8%
HIV asymp	2.9%	-6.1%
HIV symp	3.9%	2.8%
AIDS asymp	-1.5%	7.3%
AIDS symp	3.1%	-7.0%
Homeless	4.1%	15.4%
Recently Incarcerated	5.4%	13.9%

Consumer Rank	37 out of 42

Barriers

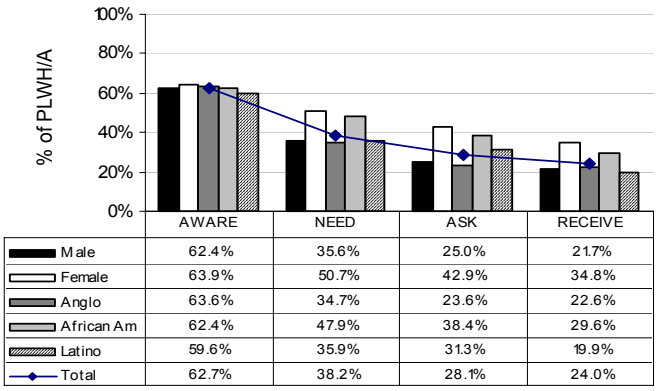
- Not knowing about service
- Not RW funded
- Not enough beds available for detox

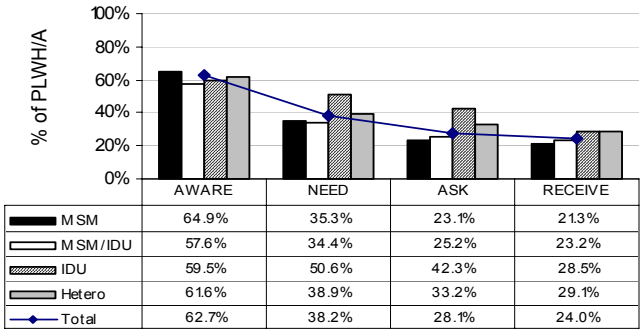
Notes

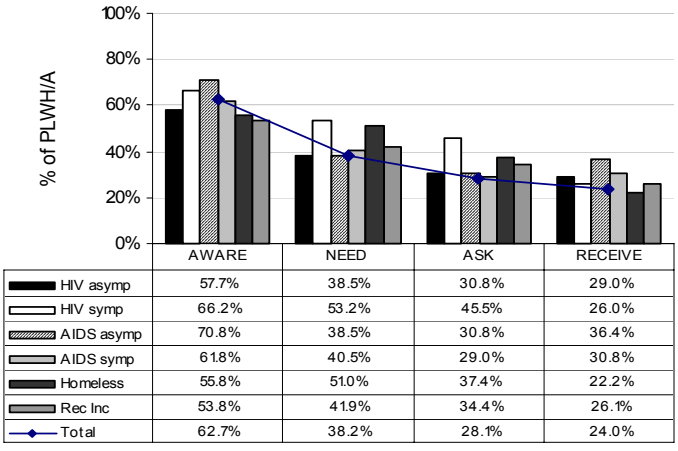
Transportation

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 one-way trip
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	3,516	
RW Care Title II		Number unduplicated	157	
Other		Average Used	22	
Total Allocated		Expenditure	$35,340	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	10.1%	4.1%
Male	10.6%	3.2%
Female	7.8%	8.1%
MSM	12.2%	1.8%
MSMIDU	9.2%	2.1%
IDU	8.4%	13.8%
Hetero	5.7%	4.1%
Anglo	11.1%	1.0%
African Am	9.5%	8.9%
Latino	4.7%	11.3%
HIV asymp	7.7%	1.7%
HIV symp	7.8%	19.5%
AIDS asymp	7.7%	-5.6%
AIDS symp	11.5%	-1.8%
Homeless	13.6%	15.2%
Recently Incarcerated	7.5%	8.3%

Consumer Rank 18 out of 42

Barriers

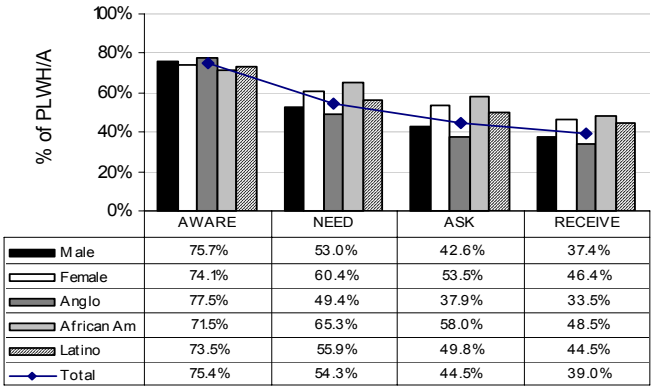
- Not knowing about service
- Unreliable transportation service – no show

Notes

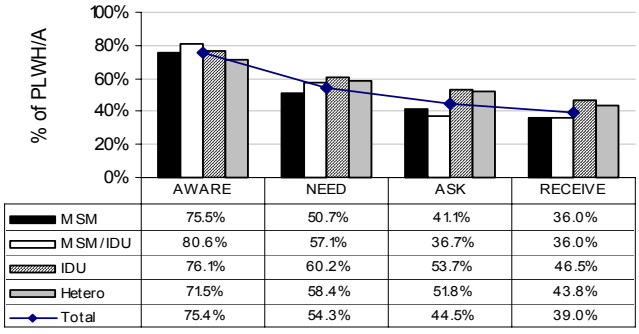
Taxi vouchers

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 vendor transportation dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific, only to be used if health condition does not permit use of public trans and experiencing time-related unavoidable emergency and no other service is available.

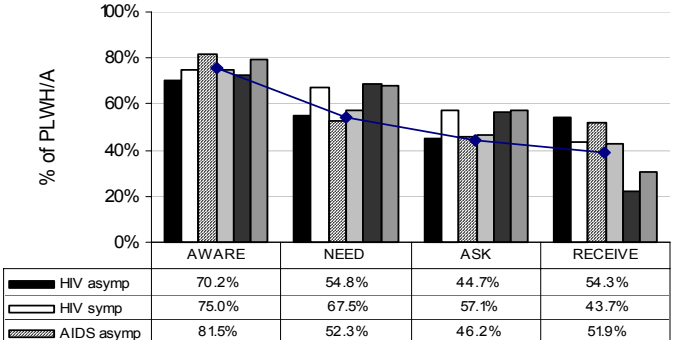
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	14,116	
RW Care Title II		Number unduplicated	449	
Other		Average Used	31	
Total Allocated		Expenditure	$15,643	



	AWARE	NEED	ASK	RECEIVE
Male	75.7%	53.0%	42.6%	37.4%
Female	74.1%	60.4%	53.5%	46.4%
Anglo	77.5%	49.4%	37.9%	33.5%
African Am	71.5%	65.3%	58.0%	48.5%
Latino	73.5%	55.9%	49.8%	44.5%
Total	75.4%	54.3%	44.5%	39.0%



	AWARE	NEED	ASK	RECEIVE
MSM	75.5%	50.7%	41.1%	36.0%
MSM/IDU	80.6%	57.1%	36.7%	36.0%
IDU	76.1%	60.2%	53.7%	46.5%
Hetero	71.5%	58.4%	51.8%	43.8%
Total	75.4%	54.3%	44.5%	39.0%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	70.2%	54.8%	44.7%	54.3%
HIV symp	75.0%	67.5%	57.1%	43.7%
AIDS asymp	81.5%	52.3%	46.2%	51.9%
AIDS symp	74.8%	57.3%	46.6%	43.1%
Homeless	72.6%	68.7%	56.2%	22.2%
Rec Inc	79.6%	67.7%	57.6%	30.4%
Total	75.4%	54.3%	44.5%	39.0%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.8%	5.5%
Male	10.4%	5.2%
Female	7.0%	7.0%
MSM	9.6%	5.2%
MSMIDU	20.4%	0.8%
IDU	6.5%	7.2%
Hetero	6.5%	8.0%
Anglo	11.4%	4.4%
African Am	7.3%	9.4%
Latino	6.1%	5.4%
HIV asymp	10.1%	-9.7%
HIV symp	10.4%	13.5%
AIDS asymp	6.2%	-5.8%
AIDS symp	10.7%	3.5%
Homeless	12.5%	33.9%
Recently Incarcerated	10.1%	27.2%

Consumer Rank 12 out of 42

Barriers

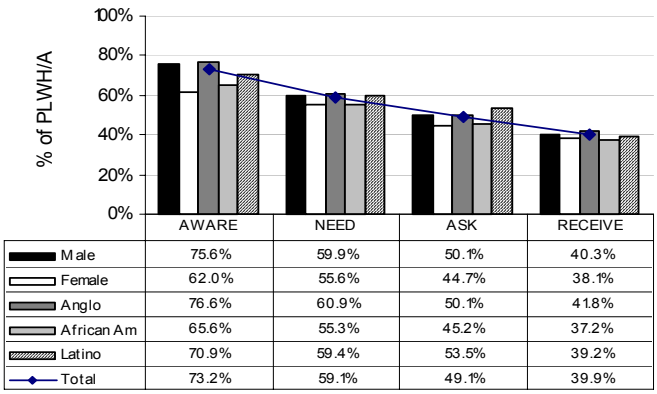
- Not knowing about service
- Not enough funding for vouchers
- Limit supply available for consumers
- Not eligible

Notes

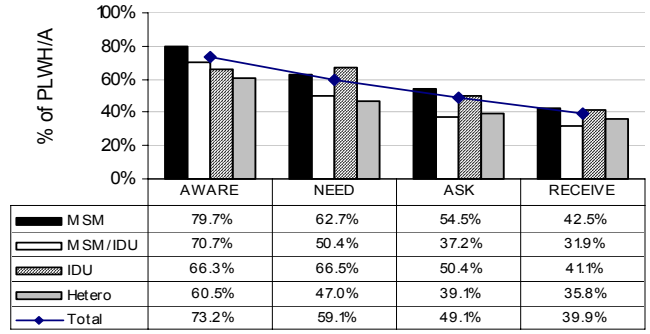
Financial Assistance

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 vendor dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific, only in avoiding homelessness or unhealthy living conditions; have taken conservation education program, does not include cellular phone or pager bills..

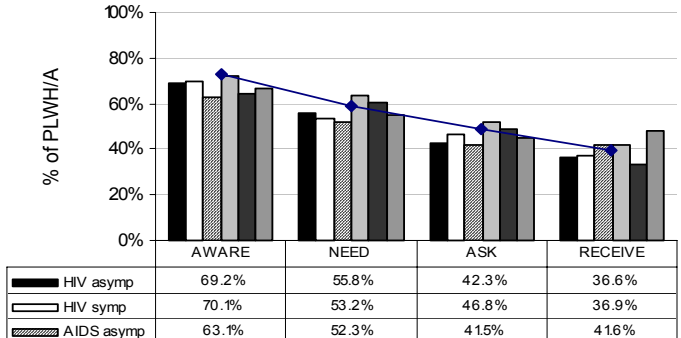
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$91,940	Number duplicated	83,638	98,338
RW Care Title II		Number unduplicated	719	723
Other		Average Used	116	136
Total Allocated		Expenditure	$92,001	$108,172



	AWARE	NEED	ASK	RECEIVE
Male	75.6%	59.9%	50.1%	40.3%
Female	62.0%	55.6%	44.7%	38.1%
Anglo	76.6%	60.9%	50.1%	41.8%
African Am	65.6%	55.3%	45.2%	37.2%
Latino	70.9%	59.4%	53.5%	39.2%
Total	73.2%	59.1%	49.1%	39.9%



	AWARE	NEED	ASK	RECEIVE
MSM	79.7%	62.7%	54.5%	42.5%
MSM/IDU	70.7%	50.4%	37.2%	31.9%
IDU	66.3%	66.5%	50.4%	41.1%
Hetero	60.5%	47.0%	39.1%	35.8%
Total	73.2%	59.1%	49.1%	39.9%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	69.2%	55.8%	42.3%	36.6%
HIV symp	70.1%	53.2%	46.8%	36.9%
AIDS asymp	63.1%	52.3%	41.5%	41.6%
AIDS symp	71.8%	63.8%	52.3%	41.5%
Homeless	64.6%	60.5%	49.0%	33.3%
Rec Inc	66.7%	54.8%	45.2%	47.8%
Total	73.2%	59.1%	49.1%	39.9%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	10.0%	9.3%
Male	9.8%	9.8%
Female	10.9%	6.6%
MSM	8.3%	12.0%
MSMIDU	13.2%	5.3%
IDU	16.1%	9.3%
Hetero	7.8%	3.3%
Anglo	10.8%	8.3%
African Am	10.1%	8.0%
Latino	5.9%	14.3%
HIV asymp	13.5%	5.7%
HIV symp	6.5%	9.9%
AIDS asymp	10.8%	0.0%
AIDS symp	11.5%	10.8%
Homeless	11.6%	15.6%
Recently Incarcerated	9.7%	-2.7%

Consumer Rank 9 out of 42

Barriers

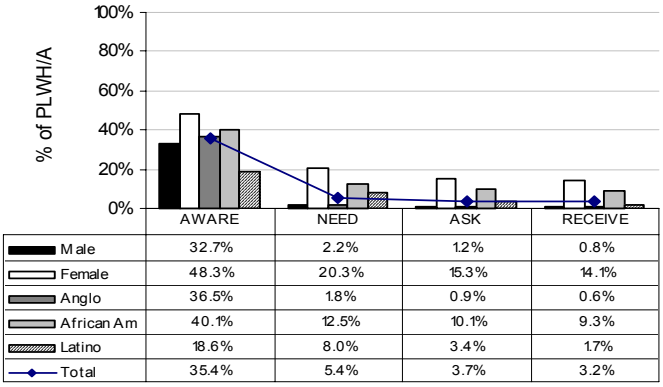
- Not knowing about service
- Eligibility criteria
- Lack of funding for service
- Limited financial assistance provided – not enough

Notes

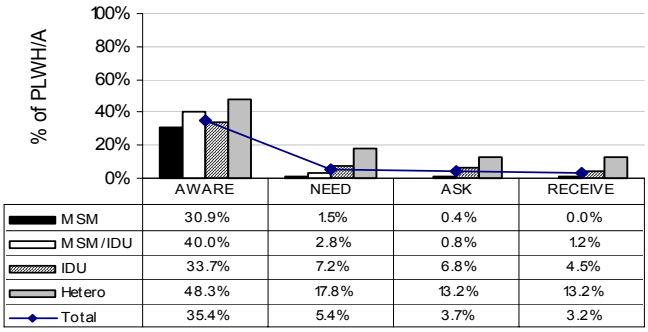
Child care services

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Vendor dollar
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific; shall be used only for medical, social, or support service with documentation, in event of a hospital stay, time will not exceed 7 days and only if there are no other arrangements.

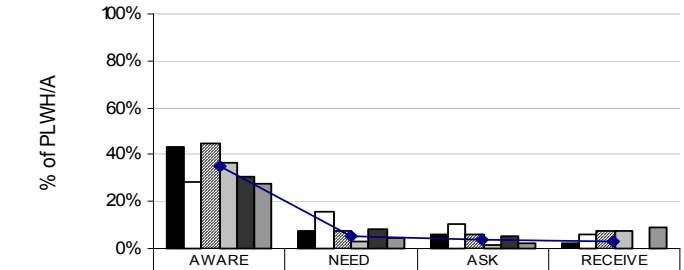
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$19,740	Number duplicated	15,394	19,031.8
RW Care Title II		Number unduplicated	23	31
Other		Average Used	669	614
Total Allocated		Expenditure	$15,394	$20,935



	AWARE	NEED	ASK	RECEIVE
Male	32.7%	2.2%	1.2%	0.8%
Female	48.3%	20.3%	15.3%	14.1%
Anglo	36.5%	1.8%	0.9%	0.6%
African Am	40.1%	12.5%	10.1%	9.3%
Latino	18.6%	8.0%	3.4%	1.7%
Total	35.4%	5.4%	3.7%	3.2%



	AWARE	NEED	ASK	RECEIVE
MSM	30.9%	1.5%	0.4%	0.0%
MSM/IDU	40.0%	2.8%	0.8%	1.2%
IDU	33.7%	7.2%	6.8%	4.5%
Hetero	48.3%	17.8%	13.2%	13.2%
Total	35.4%	5.4%	3.7%	3.2%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	43.3%	7.7%	5.8%	2.2%
HIV symp	28.6%	15.6%	10.5%	5.8%
AIDS asymp	44.6%	7.7%	6.2%	7.8%
AIDS symp	36.6%	3.1%	1.5%	7.7%
Homeless	30.6%	8.2%	5.4%	0.0%
Rec Inc	28.0%	4.3%	2.2%	8.7%
Total	35.4%	5.4%	3.7%	3.2%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	1.7%	0.5%
Male	1.0%	0.4%
Female	5.0%	1.2%
MSM	1.0%	0.4%
MSMIDU	2.1%	-0.4%
IDU	0.4%	2.3%
Hetero	4.6%	0.0%
Anglo	0.9%	0.3%
African Am	2.4%	0.8%
Latino	4.7%	1.6%
HIV asymp	1.9%	3.6%
HIV symp	5.1%	4.8%
AIDS asymp	1.5%	-1.6%
AIDS symp	1.5%	-6.2%
Homeless	2.7%	5.4%
Recently Incarcerated	2.2%	-6.5%

Consumer Rank	42 out of 42

Barriers

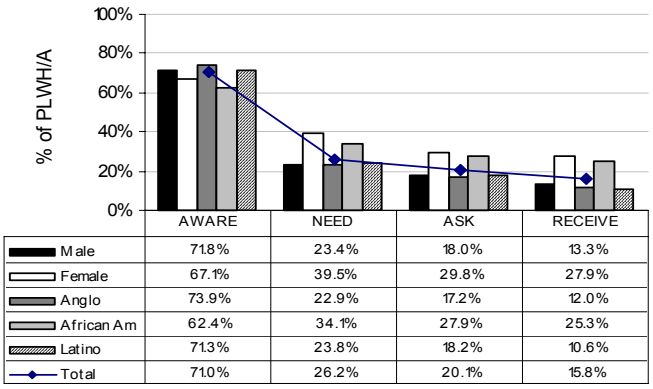
- Not knowing about service

Notes

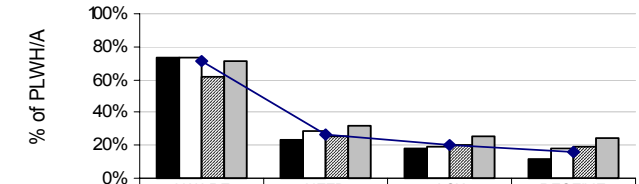
Mental Health Group

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Each adult
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

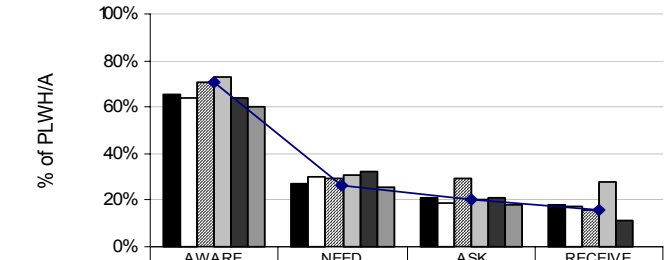
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	56	
RW Care Title II		Number unduplicated	11	
Other		Average Used	5	
Total Allocated		Expenditure	$1,680	



	AWARE	NEED	ASK	RECEIVE
Male	71.8%	23.4%	18.0%	13.3%
Female	67.1%	39.5%	29.8%	27.9%
Anglo	73.9%	22.9%	17.2%	12.0%
African Am	62.4%	34.1%	27.9%	25.3%
Latino	71.3%	23.8%	18.2%	10.6%
Total	71.0%	26.2%	20.1%	15.8%



	AWARE	NEED	ASK	RECEIVE
MSM	73.0%	23.9%	18.5%	12.0%
MSM/IDU	73.1%	29.2%	18.8%	18.0%
IDU	61.9%	25.5%	20.2%	18.8%
Hetero	71.6%	32.2%	25.9%	24.0%
Total	71.0%	26.2%	20.1%	15.8%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	65.4%	26.9%	21.2%	18.3%
HIV symp	63.6%	30.3%	18.4%	17.3%
AIDS asymp	70.8%	29.2%	29.2%	15.8%
AIDS symp	73.3%	30.5%	20.6%	27.7%
Homeless	63.9%	32.0%	21.1%	11.1%
Rec Inc	60.2%	25.8%	18.3%	0.0%
Total	71.0%	26.2%	20.1%	15.8%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	6.1%	4.3%
Male	5.3%	4.8%
Female	9.7%	1.9%
MSM	5.4%	6.5%
MSMIDU	10.4%	0.8%
IDU	5.3%	1.4%
Hetero	6.3%	1.9%
Anglo	5.8%	5.2%
African Am	6.2%	2.6%
Latino	5.6%	7.6%
HIV asymp	5.8%	2.9%
HIV symp	11.8%	1.1%
AIDS asymp	0.0%	13.4%
AIDS symp	9.9%	-7.1%
Homeless	10.9%	10.0%
Recently Incarcerated	7.5%	18.3%

Consumer Rank 22 out of 42

Barriers

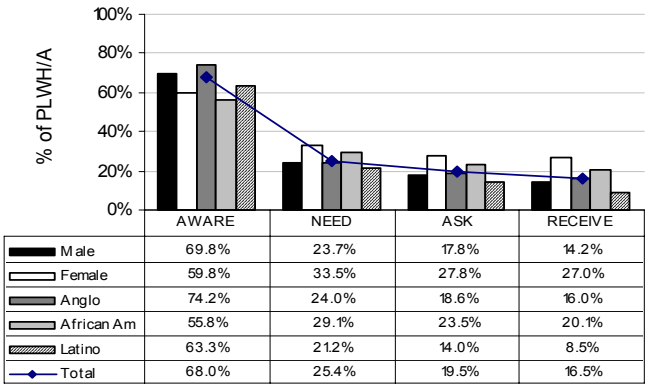
- Not knowing about service
- Hours of operation

Notes

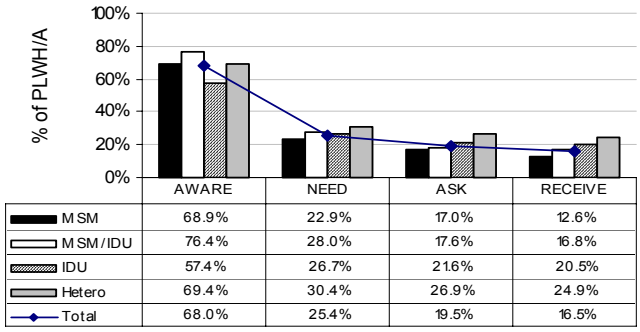
Peer Counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

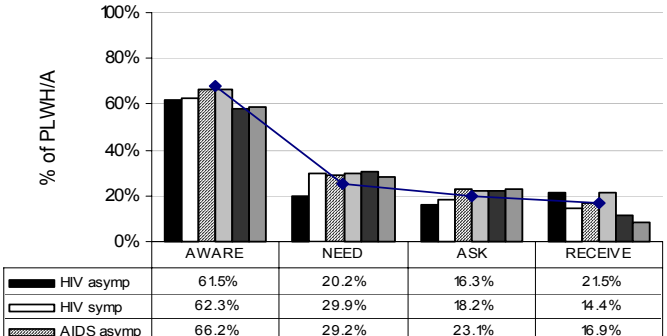
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	69.8%	23.7%	17.8%	14.2%
Female	59.8%	33.5%	27.8%	27.0%
Anglo	74.2%	24.0%	18.6%	16.0%
African Am	55.8%	29.1%	23.5%	20.1%
Latino	63.3%	21.2%	14.0%	8.5%
Total	68.0%	25.4%	19.5%	16.5%



	AWARE	NEED	ASK	RECEIVE
MSM	68.9%	22.9%	17.0%	12.6%
MSM/IDU	76.4%	28.0%	17.6%	16.8%
IDU	57.4%	26.7%	21.6%	20.5%
Hetero	69.4%	30.4%	26.9%	24.9%
Total	68.0%	25.4%	19.5%	16.5%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	61.5%	20.2%	16.3%	21.5%
HIV symp	62.3%	29.9%	18.2%	14.4%
AIDS asymp	66.2%	29.2%	23.1%	16.9%
AIDS symp	66.4%	29.8%	22.1%	21.5%
Homeless	57.8%	30.6%	21.8%	11.1%
Rec Inc	59.1%	28.0%	22.6%	8.7%
Total	68.0%	25.4%	19.5%	16.5%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	5.9%	3.0%
Male	5.9%	3.5%
Female	5.7%	0.8%
MSM	5.9%	4.4%
MSMIDU	10.4%	0.8%
IDU	5.2%	1.1%
Hetero	3.5%	2.0%
Anglo	5.4%	2.6%
African Am	5.6%	3.4%
Latino	7.3%	5.5%
HIV asymp	3.8%	-5.2%
HIV symp	11.7%	3.8%
AIDS asymp	6.2%	6.2%
AIDS symp	7.6%	0.6%
Homeless	8.8%	10.7%
Recently Incarcerated	5.4%	13.9%

Consumer Rank 24 out of 42

Barriers

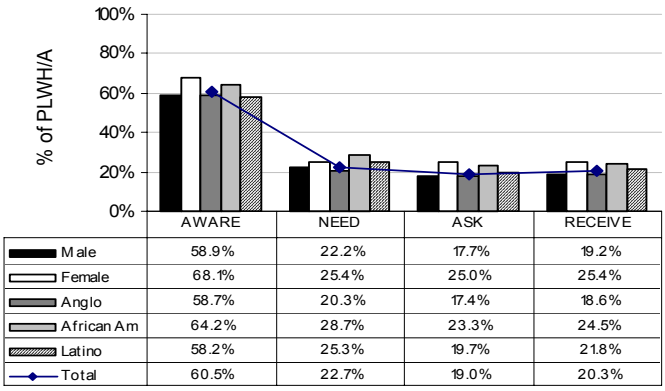
- Not knowing about service
- Not enough groups for heterosexuals

Notes

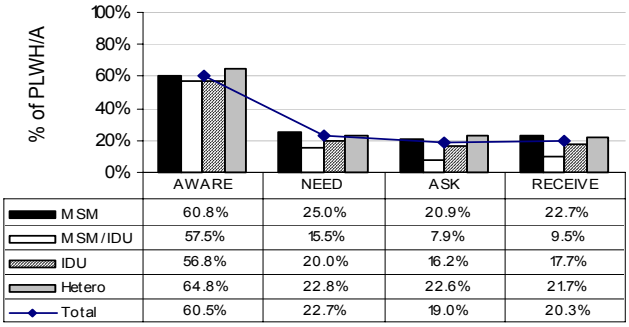
Adherence Support

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Encounter
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

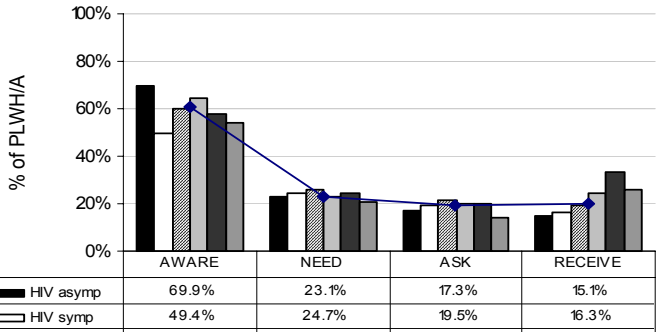
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$6,079	Number duplicated	44	126.9
RW Care Title II		Number unduplicated	18	18
Other		Average Used	2	7
Total Allocated		Expenditure	$8,030	$23,854



	AWARE	NEED	ASK	RECEIVE
Male	58.9%	22.2%	17.7%	19.2%
Female	68.1%	25.4%	25.0%	25.4%
Anglo	58.7%	20.3%	17.4%	18.6%
African Am	64.2%	28.7%	23.3%	24.5%
Latino	58.2%	25.3%	19.7%	21.8%
Total	60.5%	22.7%	19.0%	20.3%



	AWARE	NEED	ASK	RECEIVE
MSM	60.8%	25.0%	20.9%	22.7%
MSM/IDU	57.5%	15.5%	7.9%	9.5%
IDU	56.8%	20.0%	16.2%	17.7%
Hetero	64.8%	22.8%	22.6%	21.7%
Total	60.5%	22.7%	19.0%	20.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	69.9%	23.1%	17.3%	15.1%
HIV symp	49.4%	24.7%	19.5%	16.3%
AIDS asymp	60.0%	26.2%	21.5%	19.5%
AIDS symp	64.1%	22.9%	19.8%	24.6%
Homeless	57.5%	24.5%	19.7%	33.3%
Rec Inc	54.3%	20.4%	14.0%	26.1%
Total	60.5%	22.7%	19.0%	20.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	3.8%	-1.3%
Male	4.5%	-1.4%
Female	0.4%	-0.4%
MSM	4.1%	-1.8%
MSMIDU	7.6%	-1.6%
IDU	3.8%	-1.6%
Hetero	0.1%	1.0%
Anglo	2.9%	-1.2%
African Am	5.4%	-1.2%
Latino	5.6%	-2.1%
HIV asymp	5.8%	2.3%
HIV symp	5.2%	3.1%
AIDS asymp	4.6%	2.1%
AIDS symp	3.1%	-4.8%
Homeless	4.8%	-13.6%
Recently Incarcerated	6.5%	-12.1%

Consumer Rank	29 out of 42

Barriers

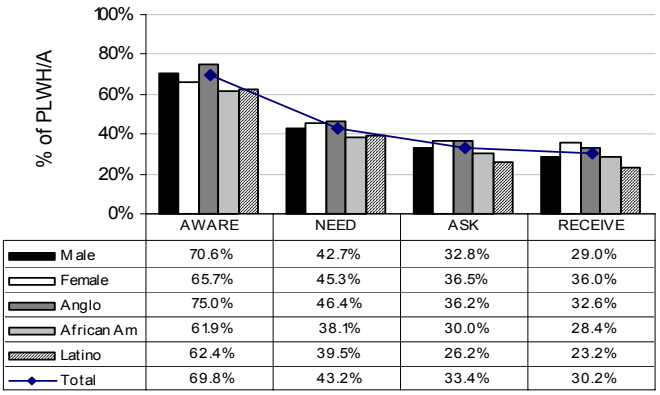
- Not knowing about service

Notes

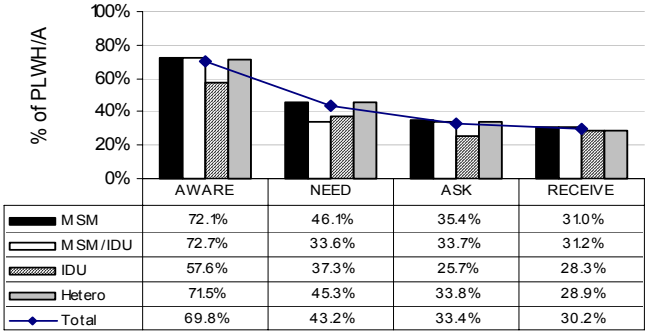
Nutrition Counseling

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	visit
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific, to be administered by registered dietician or other qualified person.

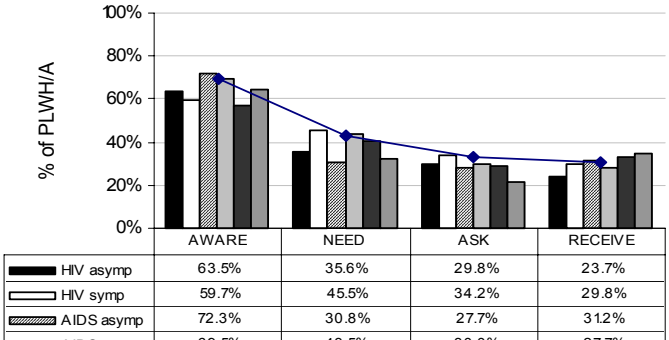
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	5.652	
RW Care Title II		Number unduplicated	117	
Other		Average Used	48	
Total Allocated		Expenditure	$10,250	



	AWARE	NEED	ASK	RECEIVE
Male	70.6%	42.7%	32.8%	29.0%
Female	65.7%	45.3%	36.5%	36.0%
Anglo	75.0%	46.4%	36.2%	32.6%
African Am	61.9%	38.1%	30.0%	28.4%
Latino	62.4%	39.5%	26.2%	23.2%
Total	69.8%	43.2%	33.4%	30.2%



	AWARE	NEED	ASK	RECEIVE
MSM	72.1%	46.1%	35.4%	31.0%
MSM/IDU	72.7%	33.6%	33.7%	31.2%
IDU	57.6%	37.3%	25.7%	28.3%
Hetero	71.5%	45.3%	33.8%	28.9%
Total	69.8%	43.2%	33.4%	30.2%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	63.5%	35.6%	29.8%	23.7%
HIV symp	59.7%	45.5%	34.2%	29.8%
AIDS asymp	72.3%	30.8%	27.7%	31.2%
AIDS symp	69.5%	43.5%	30.0%	27.7%
Homeless	57.1%	40.1%	28.8%	33.3%
Rec Inc	64.5%	32.3%	21.7%	34.8%
Total	69.8%	43.2%	33.4%	30.2%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.7%	3.2%
Male	9.9%	3.8%
Female	8.8%	0.5%
MSM	10.7%	4.4%
MSMIDU	-0.2%	2.5%
IDU	11.6%	-2.6%
Hetero	11.5%	4.9%
Anglo	10.1%	3.6%
African Am	8.1%	1.6%
Latino	13.3%	3.1%
HIV asymp	5.8%	6.2%
HIV symp	11.2%	4.4%
AIDS asymp	3.1%	-3.5%
AIDS symp	13.5%	2.3%
Homeless	11.4%	-4.6%
Recently Incarcerated	10.5%	-13.0%

Consumer Rank	17 out of 42

Barriers

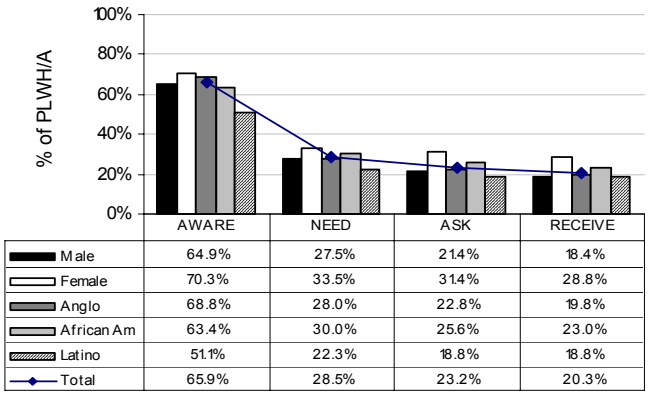
- Not knowing about service

Notes

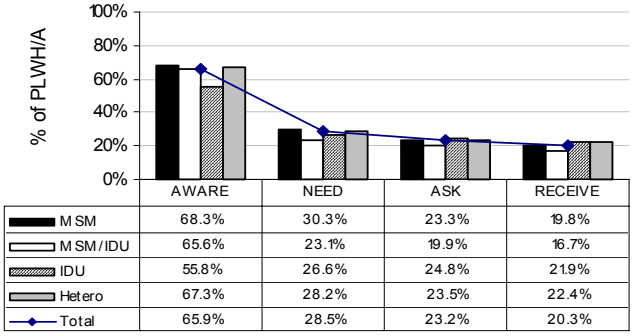
Home Health Care

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	Encounter
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

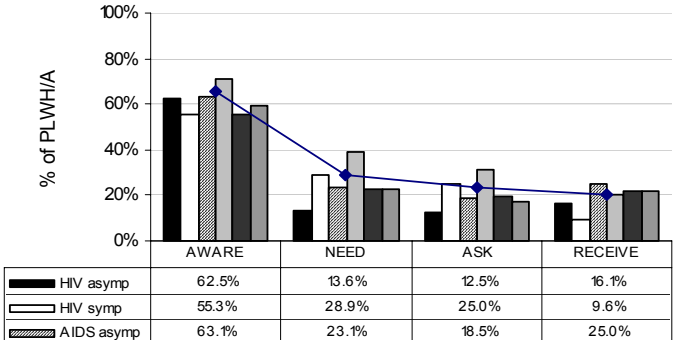
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI	$142,222	Number duplicated	1747	1861
RW Care Title II		Number unduplicated	18	18
Other		Average Used	97	103
Total Allocated		Expenditure	$141,837	$155,669



	AWARE	NEED	ASK	RECEIVE
Male	64.9%	27.5%	21.4%	18.4%
Female	70.3%	33.5%	31.4%	28.8%
Anglo	68.8%	28.0%	22.8%	19.8%
African Am	63.4%	30.0%	25.6%	23.0%
Latino	51.1%	22.3%	18.8%	18.8%
Total	65.9%	28.5%	23.2%	20.3%



	AWARE	NEED	ASK	RECEIVE
MSM	68.3%	30.3%	23.3%	19.8%
MSM/IDU	65.6%	23.1%	19.9%	16.7%
IDU	55.8%	26.6%	24.8%	21.9%
Hetero	67.3%	28.2%	23.5%	22.4%
Total	65.9%	28.5%	23.2%	20.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	62.5%	13.6%	12.5%	16.1%
HIV symp	55.3%	28.9%	25.0%	9.6%
AIDS asymp	63.1%	23.1%	18.5%	25.0%
AIDS symp	71.0%	38.9%	31.3%	20.0%
Homeless	55.5%	22.6%	19.2%	22.2%
Rec Inc	59.1%	22.6%	17.2%	21.7%
Total	65.9%	28.5%	23.2%	20.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	5.4%	2.9%
Male	6.1%	2.9%
Female	2.0%	2.6%
MSM	7.0%	3.4%
MSMIDU	3.2%	3.2%
IDU	1.8%	2.9%
Hetero	4.7%	1.1%
Anglo	5.3%	2.9%
African Am	4.4%	2.6%
Latino	3.5%	0.0%
HIV asymp	1.1%	-3.6%
HIV symp	3.9%	15.4%
AIDS asymp	4.6%	-6.5%
AIDS symp	7.6%	11.3%
Homeless	3.4%	-3.0%
Recently Incarcerated	5.4%	-4.5%

Consumer Rank	20 out of 42

Barriers

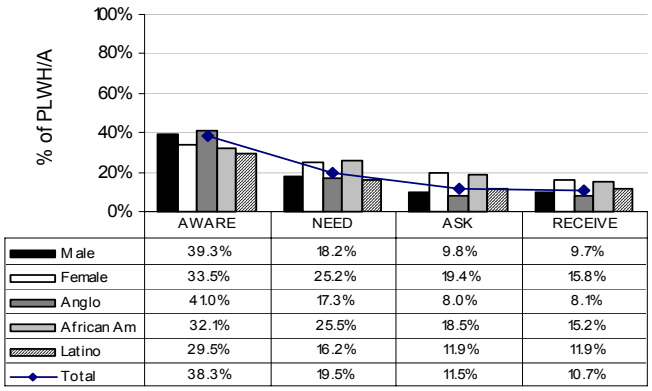
- Not knowing about service

Notes

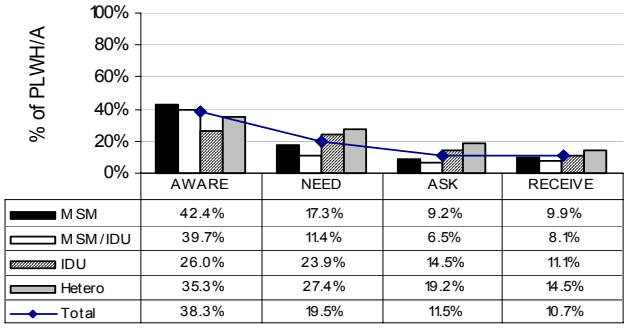
Insurance Assistance

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

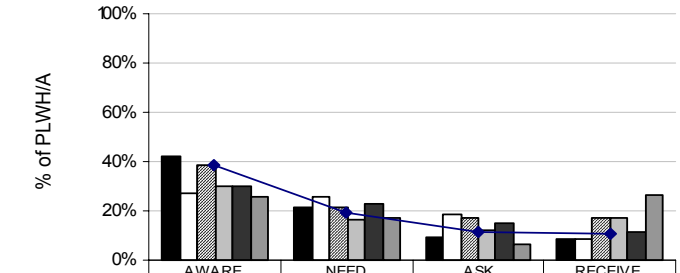
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	39.3%	18.2%	9.8%	9.7%
Female	33.5%	25.2%	19.4%	15.8%
Anglo	41.0%	17.3%	8.0%	8.1%
African Am	32.1%	25.5%	18.5%	15.2%
Latino	29.5%	16.2%	11.9%	11.9%
Total	38.3%	19.5%	11.5%	10.7%



	AWARE	NEED	ASK	RECEIVE
MSM	42.4%	17.3%	9.2%	9.9%
MSM/IDU	39.7%	11.4%	6.5%	8.1%
IDU	26.0%	23.9%	14.5%	11.1%
Hetero	35.3%	27.4%	19.2%	14.5%
Total	38.3%	19.5%	11.5%	10.7%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	42.3%	21.2%	9.6%	8.7%
HIV symp	27.3%	26.0%	18.4%	8.7%
AIDS asymp	38.5%	21.5%	16.9%	17.1%
AIDS symp	30.2%	16.4%	12.5%	16.9%
Homeless	30.1%	22.8%	15.2%	11.1%
Rec Inc	25.8%	17.4%	6.5%	26.1%
Total	38.3%	19.5%	11.5%	10.7%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need -Ask	Ask - Received
Total	7.9%	0.8%
Male	8.4%	0.2%
Female	5.8%	3.6%
MSM	8.1%	-0.7%
MSMIDU	4.9%	-1.7%
IDU	9.4%	3.3%
Hetero	8.2%	4.7%
Anglo	9.3%	-0.1%
African Am	7.0%	3.3%
Latino	4.3%	0.0%
HIV asymp	11.5%	0.9%
HIV symp	7.6%	9.7%
AIDS asymp	4.6%	-0.2%
AIDS symp	3.9%	-4.4%
Homeless	7.6%	4.1%
Recently Incarcerated	10.9%	-19.6%

Consumer Rank	32 out of 42

Barriers

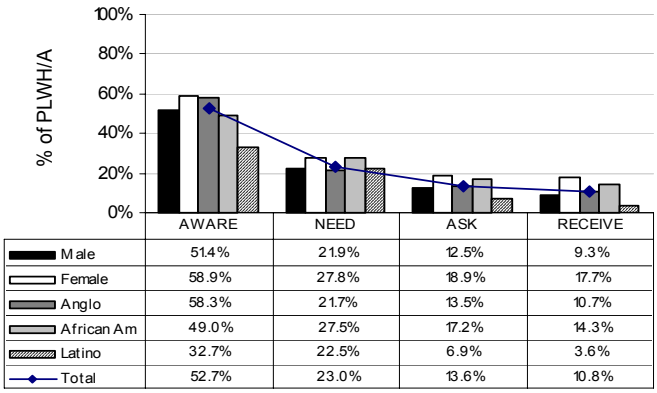
- Not knowing about service
- Service has been denied

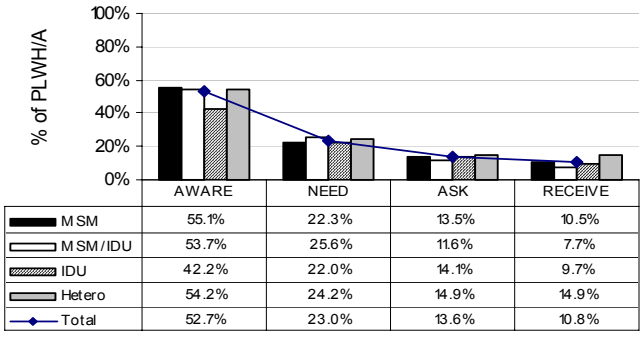
Notes

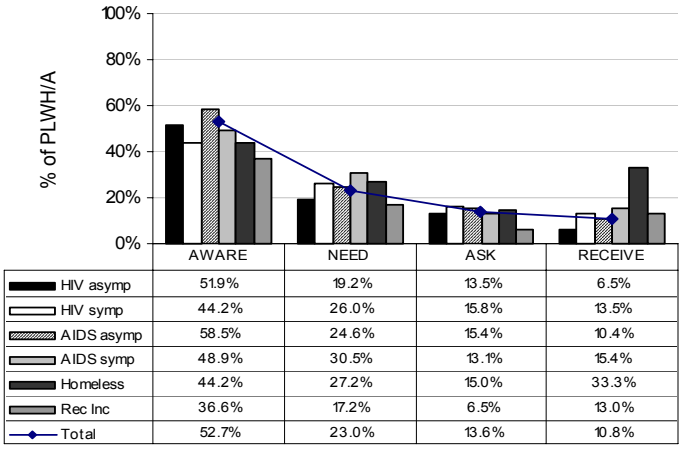
Buddy emotional support

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	637	
RW Care Title II		Number unduplicated	49	
Other		Average Used	13	
Total Allocated		Expenditure	$13,377	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.4%	2.8%
Male	9.5%	3.1%
Female	8.9%	1.2%
MSM	8.9%	3.0%
MSMIDU	14.0%	3.9%
IDU	7.9%	4.4%
Hetero	9.3%	0.0%
Anglo	8.3%	2.7%
African Am	10.2%	3.0%
Latino	15.5%	3.3%
HIV asymp	5.8%	7.0%
HIV symp	10.2%	2.3%
AIDS asymp	9.2%	5.0%
AIDS symp	17.5%	-2.3%
Homeless	12.2%	-18.4%
Recently Incarcerated	10.8%	-6.6%

Consumer Rank 27 out of 42

Barriers

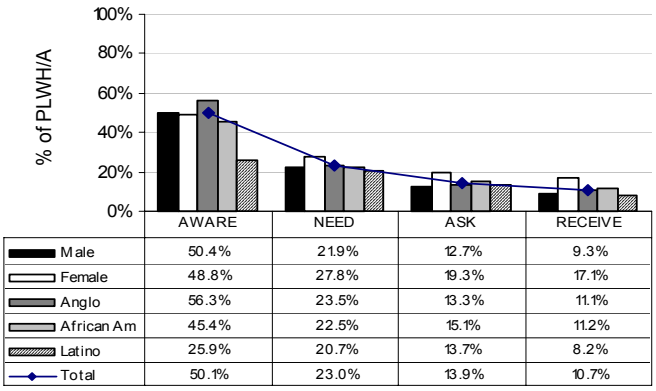
- Not knowing about service
- Waiting for service

Notes

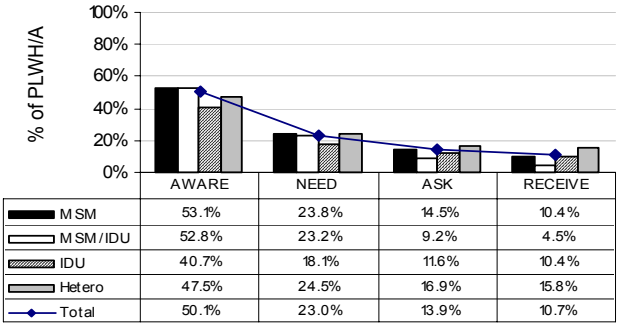
Buddy household tasks

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	1 hour
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

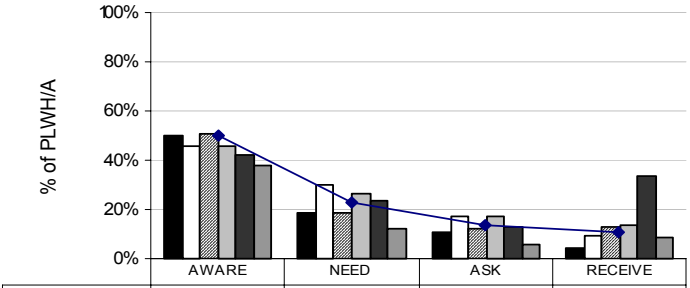
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	1,029	
RW Care Title II		Number unduplicated	91	
Other		Average Used	11	
Total Allocated		Expenditure	$20,408	



	AWARE	NEED	ASK	RECEIVE
Male	50.4%	21.9%	12.7%	9.3%
Female	48.8%	27.8%	19.3%	17.1%
Anglo	56.3%	23.5%	13.3%	11.1%
African Am	45.4%	22.5%	15.1%	11.2%
Latino	25.9%	20.7%	13.7%	8.2%
Total	50.1%	23.0%	13.9%	10.7%



	AWARE	NEED	ASK	RECEIVE
MSM	53.1%	23.8%	14.5%	10.4%
MSM/IDU	52.8%	23.2%	9.2%	4.5%
IDU	40.7%	18.1%	11.6%	10.4%
Hetero	47.5%	24.5%	16.9%	15.8%
Total	50.1%	23.0%	13.9%	10.7%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	50.0%	18.3%	10.6%	4.3%
HIV symp	45.5%	29.9%	16.9%	9.6%
AIDS asymp	50.8%	18.5%	12.3%	13.0%
AIDS symp	45.8%	26.7%	17.1%	13.8%
Homeless	42.2%	23.8%	12.9%	33.3%
Rec Inc	37.6%	11.8%	5.4%	8.7%
Total	50.1%	23.0%	13.9%	10.7%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	9.1%	3.2%
Male	9.2%	3.4%
Female	8.5%	2.2%
MSM	9.3%	4.1%
MSMIDU	14.0%	4.7%
IDU	6.5%	1.3%
Hetero	7.6%	1.1%
Anglo	10.2%	2.2%
African Am	7.4%	3.9%
Latino	7.0%	5.5%
HIV asymp	7.7%	6.3%
HIV symp	13.0%	7.3%
AIDS asymp	6.2%	-0.7%
AIDS symp	9.7%	3.2%
Homeless	10.9%	-20.4%
Recently Incarcerated	6.5%	-3.3%

Consumer Rank	28 out of 42

Barriers

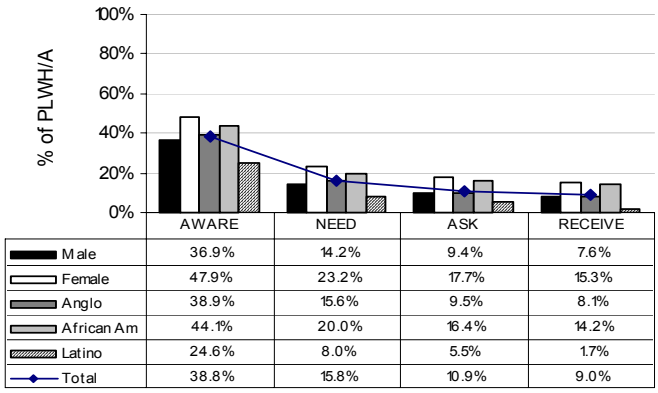
- Not knowing about service
- Not enough volunteers available

Notes

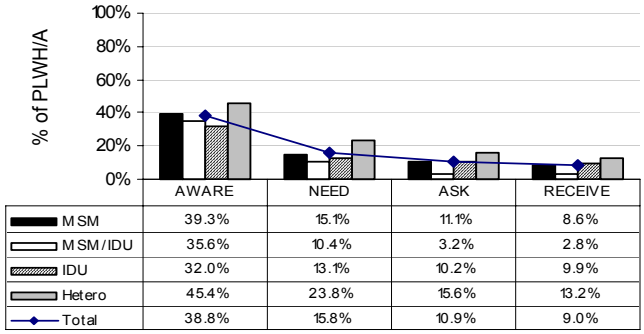
Buddy advocate

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific.

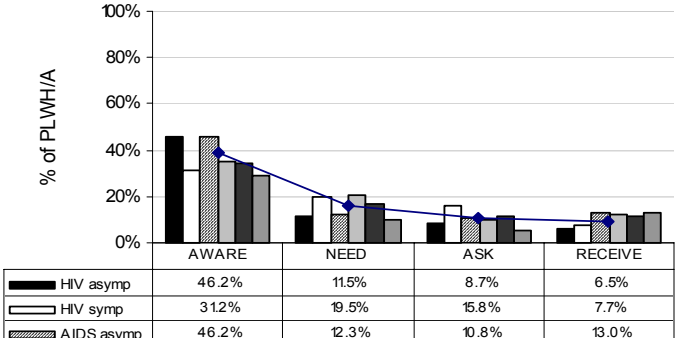
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	36.9%	14.2%	9.4%	7.6%
Female	47.9%	23.2%	17.7%	15.3%
Anglo	38.9%	15.6%	9.5%	8.1%
African Am	44.1%	20.0%	16.4%	14.2%
Latino	24.6%	8.0%	5.5%	1.7%
Total	38.8%	15.8%	10.9%	9.0%



	AWARE	NEED	ASK	RECEIVE
MSM	39.3%	15.1%	11.1%	8.6%
MSM/IDU	35.6%	10.4%	3.2%	2.8%
IDU	32.0%	13.1%	10.2%	9.9%
Hetero	45.4%	23.8%	15.6%	13.2%
Total	38.8%	15.8%	10.9%	9.0%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	46.2%	11.5%	8.7%	6.5%
HIV symp	31.2%	19.5%	15.8%	7.7%
AIDS asymp	46.2%	12.3%	10.8%	13.0%
AIDS symp	35.1%	20.8%	10.0%	12.3%
Homeless	34.0%	16.4%	11.6%	11.1%
Rec Inc	29.0%	9.8%	5.4%	13.0%
Total	38.8%	15.8%	10.9%	9.0%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask – Received
Total	4.9%	1.9%
Male	4.8%	1.7%
Female	5.5%	2.5%
MSM	4.0%	2.5%
MSMIDU	7.2%	0.3%
IDU	3.0%	0.2%
Hetero	8.2%	2.4%
Anglo	6.1%	1.4%
African Am	3.6%	2.3%
Latino	2.6%	3.7%
HIV asymp	2.9%	2.2%
HIV symp	3.7%	8.1%
AIDS asymp	1.5%	-2.2%
AIDS symp	10.8%	-2.3%
Homeless	4.8%	0.5%
Recently Incarcerated	4.3%	-7.6%

Consumer Rank 36 out of 42

Barriers

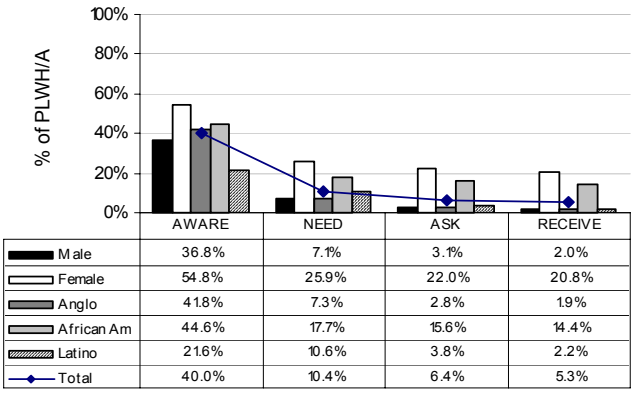
- Not knowing about service
- Not provided proper referrals
- Length of time for an appointment
- Individual physical or mental health
- Cost of service/ inadequate insurance

Notes

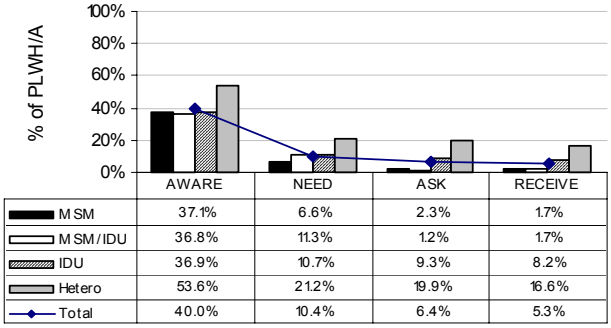
Respite Services

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

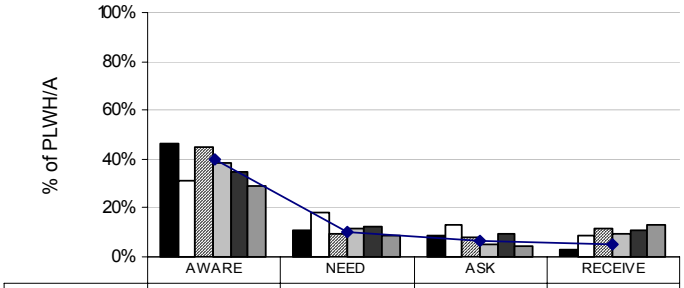
FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated		
RW Care Title II		Number unduplicated		
Other		Average Used		
Total Allocated		Expenditure		



	AWARE	NEED	ASK	RECEIVE
Male	36.8%	7.1%	3.1%	2.0%
Female	54.8%	25.9%	22.0%	20.8%
Anglo	41.8%	7.3%	2.8%	1.9%
African Am	44.6%	17.7%	15.6%	14.4%
Latino	21.6%	10.6%	3.8%	2.2%
Total	40.0%	10.4%	6.4%	5.3%



	AWARE	NEED	ASK	RECEIVE
MSM	37.1%	6.6%	2.3%	1.7%
MSM/IDU	36.8%	11.3%	1.2%	1.7%
IDU	36.9%	10.7%	9.3%	8.2%
Hetero	53.6%	21.2%	19.9%	16.6%
Total	40.0%	10.4%	6.4%	5.3%



	AWARE	NEED	ASK	RECEIVE
HIV asymp	46.2%	10.6%	8.7%	3.2%
HIV symp	31.2%	18.2%	13.2%	8.7%
AIDS asymp	44.6%	9.2%	7.7%	11.7%
AIDS symp	38.2%	11.5%	5.3%	9.2%
Homeless	34.7%	12.2%	9.5%	11.1%
Rec Inc	29.0%	8.6%	4.3%	13.0%
Total	40.0%	10.4%	6.4%	5.3%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	4.0%	1.1%
Male	4.0%	1.0%
Female	3.8%	1.2%
MSM	4.3%	0.6%
MSMIDU	10.0%	-0.4%
IDU	1.4%	1.1%
Hetero	1.3%	3.3%
Anglo	4.5%	0.9%
African Am	2.0%	1.3%
Latino	6.8%	1.6%
HIV asymp	1.9%	5.4%
HIV symp	5.0%	4.5%
AIDS asymp	1.5%	-4.0%
AIDS symp	6.1%	-3.9%
Homeless	2.7%	-1.6%
Recently Incarcerated	4.3%	-8.7%

Consumer Rank	39 out of 42

Barriers

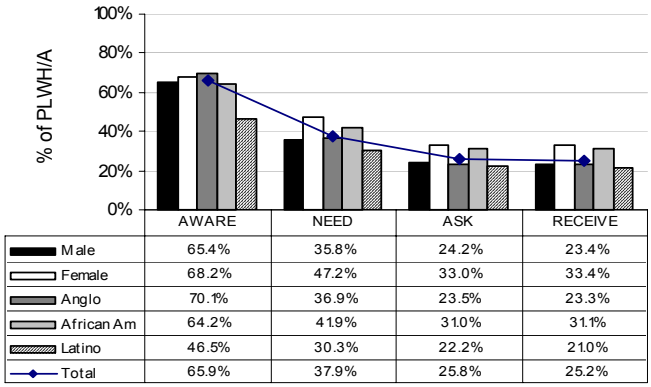
- Not knowing about service

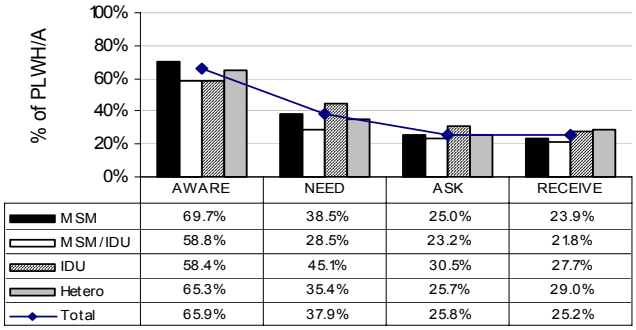
Notes

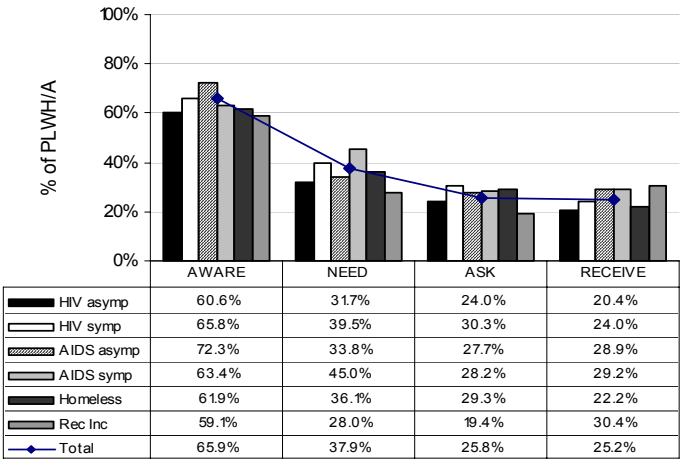
Client Advocacy

Service Unit, Eligibility, and Funding	
Total PLWH/A:	3,360
Unit:	15 minute face-to-face
Eligibility:	Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level, Agency specific

FUNDING 2002-2003		EXPENDED AND PROJECTED		
SOURCES	AMOUNT FUNDED	UNITS	EXPENDED 2002-2003	PROJECTED 2004-2005
RW Care Title I & MAI		Number duplicated	389	
RW Care Title II		Number unduplicated	23	
Other		Average Used	17	
Total Allocated		Expenditure	$16,660	







GAPS (a "-" indicates that more service was provided than was asked for or needed.)

Population	Need – Ask	Ask - Received
Total	12.0%	0.6%
Male	11.6%	0.9%
Female	14.2%	-0.4%
MSM	13.5%	1.1%
MSMIDU	5.3%	1.4%
IDU	14.5%	2.9%
Hetero	9.7%	-3.3%
Anglo	13.4%	0.2%
African Am	10.9%	-0.1%
Latino	8.1%	1.2%
HIV asymp	7.7%	3.6%
HIV symp	9.2%	6.2%
AIDS asymp	6.2%	-1.3%
AIDS symp	16.8%	-1.0%
Homeless	6.8%	7.0%
Recently Incarcerated	8.6%	-11.1%

Consumer Rank 19 out of 42

Barriers

- Not knowing about service
- Service not available
- Not enough funding for service

Notes

2. WHERE ARE WE GOING?

SHARED VISION, AND VALUES FOR A CONTINUUM OF CARE FOR PLWH/A

Vision

The shared vision of the Council is an HIV/AIDS Continuum of Care that will assure 100% access to HIV related health care and prevention-for-positives, with 0% disparities among the populations infected and affected by HIV and AIDS. For persons infected with HIV and AIDS, treatment for their infection will be available, accessible, affordable, and culturally appropriate.

Values

- Availability of services to all PLWH/A and assurances that those eligible receive Ryan White funded care. No person will be denied services because of inability to pay.
- Accessibility of services through reducing the individual, organizational and structural barriers to care including:
  - Increasing knowledge about the continuum of care, treatment, and eligibility.
  - Addressing issues of denial.
  - Providing culturally and linguistically appropriate services.
  - Assuring nondiscriminatory and high quality services to all PLWH/A.
  - Providing client-centered services including convenient and timely appointments.
  - Minimizing red tape and facilitating navigation of the continuum of care.
  - Increasing cooperation, coordination, and integration of service providers.
- Affordability of services through assuring all PLWH/A are aware of, and apply for all benefits they need and are eligible to receive.
- Empowerment through community planning where those infected and affected collaborate with the Council and providers in establishing policies, allocating resources, designing and delivering services.
  - Aligning the expectation of services to match the eligibility and capacity of the continuum of care.
- Encouragement of self-sufficiency of clients.
- Acceptance of responsibility of those infected to use safer practices with partners.
- Effective and efficient use of resources through ongoing monitoring of the quality and cost of services and outcomes of the care model.
- Leveraging funds and resources to better use non-Ryan White funding to access housing, drug treatment, transportation, and other services and resources.
- Making decisions based on the most current data and scientific research regarding the needs of those affected by HIV/AIDS and the methods of providing care that produce the most positive outcomes for infected people.

CORE STRENGTHS AND WEAKNESSES

Strengths

1. The Council committees encourage community-based participation.
2. Scope of the continuum of services.
3. The high quality of medical care.
4. Regionally AIDS Education Training Center (AETC) center is accessible.
5. Outreach and testing are done well – culturally appropriate.
6. Insurance continuation is done well in the metropolitan area.
7. Well-developed standards of care for core services.
8. Documented outcomes for significant number of core services.
9. Increased services that are culturally and linguistically appropriate.
10. Improved collaboration with DHHS.
11. Better understanding of the HRSA requirements.
12. Structure in place for initiating action on a range of issues.
13. System of reporting monitoring services that is used by most providers and permits unit costing and monitoring services.
14. The EMA has a group of experienced individuals who offer expertise.
15. Have system-wide standardized forms- referral, intake, and release of information.

Weaknesses

1. Council and delivery system could improve ability to maintain clients in care.
2. Council does not sufficiently communicate the common vision and values to providers
3. Many of the services are enabling rather than empowering. Self-sufficiency has to be a goal.
4. HIV/AIDS care services are not well linked to the care system outside of HIV/AIDS services.
5. Inadequate collaboration between HIV/AIDS service providers.
6. Committee process and procedures are not adequately explained to new members or those unfamiliar with committee process.
7. Council lacks a system of periodic review of existing planning and policy documents to ensure ongoing accuracy and consistency.
8. Access to Ryan White services is not consistent across the system.
9. Points of access could be improved.
10. Benefits counseling could be improved.
11. Client advocacy model has not met the needs of all clients, and is being redeveloped.
12. The case management model needs to be reevaluated to improve efficiency of use by all clients.
13. There is a poor public transportation system and the supplementary system of transportation for PLWH/A does not meet the needs of all clients.
14. The EMA lacks peer-counseling services.
15. Council activities and goals are not well-publicized, known or understood outside of Planning Council and providers.

GOALS AND OBJECTIVES

This section details the EMA's primary objectives for the next three years. They are based on workshops conducted with a project advisory group on February 7, 2003[6], the implementation plan drafted for the FY 2004 Ryan White CARE Act Title I application, the Sacramento Ryan White Title I and II directives and standards of care, and input from the Committee and Council members. Relevant Directives and Standards are shown in Attachment 2.

Shown below are goals and specific objectives to meet the goals. It is organized by the recommended continuum of HIV services. The objectives are designed to meet the needs of eligible PLWH/A throughout the EMA, resolve unmet needs and service gaps, and overcome barriers and disparities noted earlier in the plan.

The goals and objectives are based on a case management-centered system where the main access to Ryan White-funded services is through a case manager. It is further based on the universal adoption of the client tracking system being introduced into Sacramento EMA. Last, as indicated in the next section, it is outcome-based, and there is a presumption that baseline and continuing data will be collected on outcomes.

Table 2-1 Goals and Objectives- Who & When

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
System-Wide		
1. Adopt an HIV/AIDS Continuum of Services with emphasis on recent HRSA directives to bring those with unmet need into care and to coordinate prevention-for-positives with ongoing care.		
1.1. Adopt recommended Continuum of HIV Services in 2003 Comprehensive Plan.	Council	Dec 2003
1.2. Adapt HRSA tools to measure unmet need to Sacramento EMA.	Council, NAC Support Staff Grantee Consultant	Jan 2004 – Jul 2004
1.3. Develop and adopt plan for outreach to those out-of-care or with delayed care.	Council, Support Staff Grantee Consultant Providers HIV Testing	Jan 2004 – Aug 2004
2. Adopt service standards for all services and enforce standards through outcome-based reporting and monitoring.		

[6] See Minutes from the Planning Workshop February 17, 2003. Members of the ad hoc committee included: Kane Ortega, Katana Barnes, Ola Adams-Best, Alan Lange, Lisa DaValle, Julie Gallelo, Marty Keale, Adrienne Rogers, Bill Puryear, Kay Merrill, Peter Feeley, Craig Spatola*

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
2.1. Continue to develop and revise standards for all services to comply with HRSA directives and needs of PLWH/A. Must meet Public Health Service (PHS) guidelines.	Council (SSC)	Ongoing
2.2. Assure precise service definitions, units of service, outcome measures, and indicators of care.	Grantee Council (SSC) Support Staff	Ongoing
2.3. Specify outcomes and quality control indicators in standards.	Grantee Council (SSC)	Yearly, March-April
3. Advocate for increased access to the community-wide resource guide by making it more widely available and accessible in paper and on-line formats in English and Spanish.		
3.1. Contract to have the guide converted to a database web-accessible guide.	DHHS HIV Education and Prevention Program Sacramento Alliance to Prevent AIDS (SAPA) Consultant	Jan 2004 – Jan 2005
3.2. Update through provider information form on a semi-annual basis.	Sacramento Alliance to Prevent AIDS Grantee	June 2005 - Ongoing
3.3. Have the guide conform to the adopted continuum of HIV services.	Grantee Sacramento Alliance to Prevent AIDS Consultant	Sept 2004 – Jan 2005
3.4. Develop bilingual version(s) of the resource guide, as determined necessary by needs assessment.	DHHS HIV Education and Prevention Program Sacramento Alliance to Prevent AIDS Consultant	Feb 2006
4. Coordinate care across providers for PLWH/A.		
4.1. Reduce the proportion of Sacramento residents who test HIV positive but do not return for their results or delay care.	Council SAPA Providers	Ongoing
4.2. Improve local ability to appropriately screen clients for service eligibility.	Grantee Providers Consultant(s)	Jan 2004 – Ongoing
4.3. Share client data across providers, with assurances that client information is adequately protected in accordance with confidentiality laws.	Grantee Providers Consultant(s)	March 2004 – Ongoing
5. Integrate STD testing and medication into outpatient standards of care and directives in accordance with PHS guidelines.		
5.1. Revise outpatient standards to include standard STD testing, counseling, and medication.	Grantee Council (SSC)	March 2004 – June 2004

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
5.2. Assure logistics in place to do STD tests.	Grantee Support Staff Clinics	July 2004 – Oct 2004
5.3. Monitor to assure compliance with protocol for STD testing, counseling, and medication.	Grantee	Oct 2004 - ongoing
6. Integrate protocols for treatment adherence into outpatient care standards and directives.		
6.1. Revise outpatient and case management standards to include adherence counseling and follow-up.	Council (SSC) Grantee	Mar 2004 - June 2004
6.2. Assure clinics and providers have expertise to follow-up on adherence issues.	Grantee Support Staff Providers	May 2005
6.3. Monitor to assure compliance with treatment adherence and follow-up.	Grantee	July 2005
7. Plan for increased caseloads as a result of intensified case-finding and procedures bringing those out-of-care into care.		
7.1. Monitor clinic caseloads and adjust allocations where client loads are increasing for new clients.	Council (PAC) Grantee	Yearly, July-Nov
7.2. Adjust protocols to track and assist those who have been out-of-care to outpatient services.	Grantee (QM) Council (SSC) Providers	Nov 2004 - Mar 2005 – Ongoing
8. Improved ability to track clients, services, and costs system-wide.		
8.1. Universal adoption and use of web-based client tracking tool developed by grantee (after appropriate beta testing – see Objective 9).	Grantee Providers.	Mar 2004
9. Understanding of unit cost and cost reimbursement programs used.		
9.1. Workshops on cost reimbursement, unit costs, and financial control should be offered by the grantee.	Grantee	Apr 2004, and yearly
Core Services		
Primary Care *Early intervention*		
10. Bring those out-of-care into care.		
10.1. Create links to HIV/AIDS counseling and testing to track HIV positives who delay care.	Grantee County HIV Education and Prevention Program SAPA	April 2004 – Ongoing

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
10.2. Track those brought into care for first time and track contact with clients using web-based client tracking system.	Grantee Providers	April 2004 - ongoing
10.3. Outreach to populations known to be more likely to be out-of-care.	Council (ACC) Grantee Providers	Ongoing
10.4. Provide culturally appropriate case management to those out-of-care.	Providers	Dec 2004-Ongoing
10.5. Provide appropriate follow-up case management visit if positive person does not seek care after 6 months.	Grantee County HIV Education and Prevention Program Providers	Dec 2004
11. Improve the entry and maintenance to care to those testing positive.		
11.1. Use system-wide case tracking system to monitor individual patterns of care.	Grantee	January 2006
11.2. Assure that there is a minimum of 2 primary care visits a year per HIV positive client.	Council (SSC) Grantee Providers`	January 2005 - Ongoing
Outpatient Care		
12. Coordinate primary HIV/AIDS outpatient care with substance abuse services.		
12.1. Identify substance users who seek / need substance abuse treatment through intake or care.	Grantee Providers (caregivers and CM)	Ongoing
12.2. Refer person to residential or outpatient substance abuse treatment.	Providers	Ongoing
12.3. Use CAADS client-tracking system to chart progress of individual.	Grantee Providers	January 2006 - Ongoing
12.4. Use intensive case management to help persons obtain substance abuse treatment.	Council (SSC) Providers	Mar 2005 – Ongoing
13. Target those with difficulty adhering to regimens for adherence counseling and support.		
13.1. Adhere to standards of care and directives for adherence (see Goal 2).	Council (SSC) Grantee Providers	May 2004 – Ongoing
13.2. Create individualized treatment adherence plans.	Grantee. Providers	May 2004 – Ongoing
13.3. Increase client knowledge about the positive outcome of adhering to medication and possible negative outcomes of developing resistant strains by stopping regimens.	Grantee Providers Consumers. Consultant	July 2004 – Ongoing

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
13.4. Make information about medication and adherence available in newsletters and on website.	Council (ACC) Grantee	Sept 2004-Ongoing
14. Integrate health education/risk reduction counseling into medical visits.		
14.1. Adhere to standards of care and directives (see Goal 2).	Council (SSC) Grantee Providers	June 2004 – Ongoing
15. Improve services to special populations to improve their access to and maintaining care.		
15.1. Expanding clinical hours and providing childcare.	Council (PAC) Grantee Providers	Mar 2006 – Ongoing
15.2. Use case conferencing to discuss family need among providers seeing family members.	Grantee Providers	Sept 2004- May 2005
15.3. Adhere to standards of care.	Council (SSC) Grantee Providers	April 2005 – Ongoing
15.4. Work with primary care giver and case manager to update individual service plan.	Providers	Ongoing
Oral Health		
16. Offer access to emergency dental care. (See Title I - Ryan White HIV Dental Program Operations Manual, 1999).		
16.1. Offer all clients emergency dental visits.	Council (PAC, SSC) Grantee Providers	Ongoing
17. Develop system of dental referrals with area dentists.		
17.1. For more intensive / specialty dental treatments beyond limit in standard of care, create referrals with area dentists.	Grantee Providers	April 2004 - Ongoing
18. Reduce waiting time for clients to make dental appointments and receive care.		
18.1. Monitor and establish protocols for appointments and waiting time.	Council (SSC) Grantee	Mar 2005
Substance Abuse Services – Residential		
19. To provide residential drug and alcohol treatment for PLWH/A ready to begin treatment in order to increase their opportunities for appropriately accessing HIV primary care and medication therapies and improving health outcomes. (See Substance Abuse Treatment Services. July 1999.)		
19.1. Identify individual from intake or care assessment.	Providers	Ongoing

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
19.2. Provide residential treatment programs for clients who require intensive alcohol/drug treatment.	Council (PAC) Grantee Providers	Ongoing
19.3. Monitor and evaluate residential treatment program completion compared to community standard.	Providers	Mar 2006
Substance Abuse Services – Outpatient		
20. Provide outpatient treatment designed to reduce or eliminate alcohol and drug use/abuse by PLWH/A in order to allow initiation of or improve adherence to HIV medication regimes. (See Substance Abuse Treatment Services. July 1999.)		
20.1. Identify individual from intake or care assessment.	Providers	Ongoing
20.2. Provide outpatient treatment programs for clients who require alcohol/drug treatment.	Council (SSC) Grantee Providers	Sept 2004 – Ongoing
20.3. Monitor and evaluate outpatient treatment program completion compared to community standard.	Providers	Mar 2005
Mental Heath		
21. Individual or group mental health services to address clinically diagnosed mental illnesses and overcome issues of denial. (see Mental Health Standards. July, 1999.)		
21.1. Increase services to chronically and severely mentally ill by a licensed psychiatrist or social worker.	Council (PAC) Grantee Providers	Mar 2006
21.2. Provide access to specialized mental health services for those with special needs.	Council (PAC) Grantee Providers	Mar 2006
21.3. Provide and monitor psychotropic medications for treatable mental illnesses as dictated in standards of service, directives, and PHS guidelines.	Council (SSC) Grantee Providers	Ongoing
Hospice Services		
22. To provide hospice service to all PLWH/A who need intensive residential care.		
22.1. Maintain hospice program's residential, full-care facility.	Council (PAC) Grantee Providers	Mar 2007
22.2. Based on acuity and/or demonstrated need, provide residential hospice or full-service residential housing to those needing medical care for OIs. (March 2007)	Council (PAC, SSC) Grantee Providers	Mar 2007

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Primary Linking and Access Services		
Case Management		
23. Outreach to clients in need of case management. (See Case Management Service Standards for Persons Living with HIV/AIDS. July, 2001)		
23.1. Provide uniform intake with eligibility check for Ryan White and non-Ryan White services. Update every 6 months to maximize all Ryan White and non-Ryan White benefits.	Grantee Consultants Providers	Sept 2004
23.2. Provide accessibility to case management services (e.g. field/home based).	Council (PAC) Grantee Providers	Ongoing
23.3. Determine eligibility for insurance continuation or applying for insurance.	Providers	Ongoing
24. Provide culturally and linguistically appropriate case management.		
24.1. Provide culturally appropriate individualized treatment plan that coordinates multiple needs assessed at intake.	Providers	Ongoing
25. Uniform acuity assessment.		
25.1. All case managers to use uniform intake and check for eligibility for Ryan White Funded and other care services.	Grantee Provider	Sept 2004
25.2. Utilize acuity scale to develop service plan and make referrals.	Provider	Mar 2005
Transportation		
26. Assess transportation needs of clients and develop long-term transportation plan for services. (See Transportation Services. January, 2003.)		
26.1. Provide transportation based on need.	Council (PAC, SSC) Grantee Providers	Ongoing
26.2. Monitor quality of transportation provided.	Grantee	Jan 2005
Insurance Continuation		
27. If client is eligible, pay insurance premiums to continue insurance coverage.		
27.1. Pay co-payment on existing insurance if PLWH/A unable to pay.	Council (PAC) Grantee Providers	Ongoing
27.2. Effort to keep all PLWH/A on existing insurance, COBRA, or other insurance and pay premium if necessary.	Grantee Provider	Ongoing

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Support Services		
Emergency Financial Assistance		
28. Provide emergency financial assistance to clients with pressing emergency needs.		
28.1. Standardize process of distributing emergency funds in accordance with service standards.	Council (SSC) Grantee Providers.	Jan 2005
28.2. Provide assessment of need in acuity rating; update every 6 months.	Provider	Oct 2005 – ongoing
28.3. Distribute funds based on directives for emergency care.	Provider	Jan 2005
28.4. Clients accessing Emergency Financial Assistance continue to access routine medical care (minimum 2 primary care visits per year).	Council (SSC) Grantee Providers	Feb 2005; annual analysis.
Housing		
29. Stabilize living situation to ensure maintenance of medical care and treatment adherence through the provision of short-term housing assistance or rental assistance subsidy.		
29.1. Coordinate housing referrals with HOPWA, Section 8 housing, and Shelter Plus Care.	Providers	Jan 2005 – July 2005
29.2. Develop linkages with landlords and other providers of housing to develop capacity to meet demand for housing.	Providers	Ongoing
29.3. Monitor the number of clients receiving housing assistance who maintain routine medical care (minimum 2 primary care visits per year).	Grantee Providers	Feb 2005 – Ongoing; annual analysis
Food		
30. To ensure that that persons with HIV/AIDS who are having difficulty getting nutritious foods have access to proper nutrition to improve health outcomes. (See Objective 34)		
30.1. Provide home-delivered meals or food bags to PLWH/A who would otherwise be unable to provide for their own nutritional needs.	Providers	Ongoing
30.2. Provide nutritional supplements to clients receiving nutritional counseling.	Providers	Ongoing
30.3. Monitor quality and clients satisfaction of home-delivered meals.	Grantee	Mar 2005, Yearly survey

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Child Care		
31. Provide childcare for PLWH/A in order to improve clients' ability to access and maintain primary and supportive service care. (See Standard on Child Care Services).		
31.1. Develop a pool of reliable day-care providers for PLWH/A to access while attending appointments.	Providers Grantee	Mar 2005- Feb 2006
Psychosocial Support Services		
32. Provide psychosocial support services as identified by need.		
32.1. Assure that clients understand and have access to psychosocial support services.	Providers	Ongoing
Complementary Care		
33. Provide massage, acupuncture, and chiropractic services to those eligible. (See Complementary/Alternative Therapies. January 2003.)		
33.1. Based on standards and directives, direct all persons requesting and eligible to complementary care.	Providers	Ongoing
33.2. Develop outcomes of complementary care (functionality and side effects).	Grantee Providers	Mar 2005
Services to Providers		
34. Provide trainings to providers on non-HIV sources for services and funding.	Council Grantee	Mar 2004- ongoing
35. Use of the most effective and efficient service delivery practices based on research findings.		
35.1. Distribution of and training on best practices for prevention to positives, core, linking, and support services to line and management staff of providers with semi-annual updates.	Council Grantee Consultant	Oct 2004; semi –annual updates
36. Improve client ability to navigate the continuum of HIV services.		
36.1. Extensive provider education offered to help them be fully familiar with continuum of HIV services and options for clients.	Council Grantee Consultant	January 2005, once every quarter
36.2. Provide updated resource guide that is accessible to clients and case managers.	DHHS HIV Education and Prevention Program Sacramento Alliance to Prevent AIDS	July 2005
37. Monitor and evaluate new models of outreach and maintaining services for special populations.		

	Who	When
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Program Administration Assessment and Evaluation		
38. Distribute and train providers on client-tracking system.		
38.1. Full beta testing of system.	Grantee Consultants	Mar 2004
38.2. Provider training and protocols.	Grantee	Jul 2003 – ongoing
38.3. Rollout with scheduled benchmarks.	Grantee	Mar 2004
39. Continuous data collection among PLWH/A.		
39.1. Develop plan for continuous data collection among clients of HIV/AIDS care and those out of care.	Council Grantee Consultant	Jan 2004 - Aug 2004
39.2. Annual special studies among a specific target population with special needs.	Council (NAC) Consultant	Mar 2004 – Ongoing
39.3. Inclusion of client satisfaction surveys at providers.	Grantee Consultant Providers	Ongoing
39.4. Increase return rate of client satisfaction surveys.	Grantee Providers Council	Nov 2004 – ongoing
40. Transparency in costing and reimbursement.		
40.1. Conduct a full audit of the financial reimbursement system to provide a clean bill of health to the cost-reimbursement system and make suggestions where it may be improved.	Council Grantee Consultant	June 2006

Timeline

The timeline below displays the beginning and ending time for each objective.

Table 2-2 Timeline

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)													
System-Wide													
1. Adopt an HIV/AIDS Continuum of Services with emphasis on recent HRSA directives to bring those with unmet need into care and to coordinate prevention-for-positives with ongoing care.													
1.1. Adopt recommended Continuum of HIV Services in 2003 Comprehensive Plan.	XXXX												
1.2. Adapt HRSA tools to measure unmet need to Sacramento EMA.		XXXX	XXXX	XXXX									
1.3. Develop and adopt plan for outreach to those out-of-care or with delayed care.		XXXX	XXXX	XXXX									
2. Adopt service standards for all services and enforce standards through outcome-based reporting and monitoring.													
2.1. Continue to develop and revise standards for all services to comply with HRSA directives and needs of PLWH/A. Must meet Public Health Service (PHS) guidelines.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
2.2. Assure precise service definitions, units of service, outcome measures, and indicators of care.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
2.3. Specify outcomes and quality control indicators in standards.		XXXX				XXXX				XXXX			
3. Advocate for increased access to the community-wide resource guide by making it more widely available and accessible in paper and on-line formats.													
3.1. Contract to have the guide converted to a database web-accessible guide.		XXXX	XXXX	XXXX	XXXX								
3.2. Update through provider information form on a semi-annual basis.				XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
3.3. Have the guide conform to the adopted continuum of HIV services.					XXXX								
3.4. Develop bilingual version(s) of the resource guide, as determined necessary by needs assessment.										XXXX			
4. Coordinate care across providers for PLWH/A.													

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
4.1. Reduce the proportion of Sacramento residents who test HIV positive but do not return for their results or delay care.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
4.2. Improve local ability to appropriately screen clients for service eligibility.		XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
4.3. Share client data across providers, with assurances that client information is adequately protected in accordance with confidentiality laws.			XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
5. Integrate STD testing and medication into outpatient standards of care and directives in accordance with PHS guidelines.													
5.1. Revise outpatient standards to include standard STD testing, counseling, and medication.		XXXX	XXXX	XXXX									
5.2. Assure logistics in place to do STD tests.				XXXX	XXXX								
5.3. Monitor to assure compliance with protocol for STD testing, counseling, and medication.						XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
6. Integrate protocols for treatment adherence into outpatient care standards and directives.													
6.1. Revise outpatient and case management standards to include adherence counseling and follow-up.		XXXX	XXXX	XXXX									
6.2. Assure clinics and providers have expertise to follow-up on adherence issues.							XXXX						
6.3. Monitor to assure compliance with treatment adherence and follow-up.								XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
7. Plan for increased caseloads as a result of intensified case-finding and procedures bringing those out-of-care into care.													
7.1. Monitor clinic caseloads and adjust allocations where client loads are increasing for new clients.	XXXX			XXXX	XXXX			XXXX	XXXX			XXXX	XXXX
7.2. Adjust protocols to track and assist those who have been out-of-care to outpatient services.						XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
8. Improved ability to track clients, services, and costs system-wide.													
8.1. Universal adoption and use of web-based client tracking tool developed by grantee (after appropriate beta testing – see Objective 9)			XXXX										
9. Understanding of unit cost and cost reimbursement programs used.													
9.1. Workshops on cost reimbursement, unit costs, and financial control should be offered by the grantee.			XXXX				XXXX				XXXX		
Core Services													

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
Primary Care													
Early intervention													
10. Bring those out-of-care into care.													
10.1. Create links to HIV/AIDS counseling and testing to track HIV positives who delay care.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
10.2. Track those brought into care for first time and maintain contact with clients using web-based client tracking system.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
10.3. Outreach to populations known to be more likely to be out-of-care.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
10.4. Provide culturally appropriate case management to those out-of-care.						xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
10.5. Provide appropriate follow-up case management visit if positive person does not seek care after 6 months.						xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
11. Improve the entry and maintenance to care to those testing positive.													
11.1.Use system-wide case tracking system to monitor individual patterns of care.										xxxx	xxxx	xxxx	xxxx
11.2.Assure that there is a minimum of 2 primary care visits a year per HIV positive client.						xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Outpatient Care													
12. Coordinate primary HIV/AIDS outpatient care with substance abuse services.													
12.1. Identify substance users who seek / need substance abuse treatment through intake or care.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
12.2. Refer person to residential or outpatient substance abuse treatment.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
12.3. Use CAADS client-tracking system to chart progress of individual.										xxxx	xxxx	xxxx	xxxx
12.4. Use intensive case management to help persons obtain substance abuse treatment.							xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
13. Target those with difficulty adhering to regimens for adherence counseling and support.													
13.1. Adhere to standards of care and directives for adherence (see Goal 2).			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
13.2. Create individualized treatment adherence plans.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
13.3. Increase client knowledge about the positive outcome of adhering to medication and possible negative outcomes of developing resistant strains by stopping regimens.				xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
13.4. Make information about medication and adherence available in newsletters and on website.					xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
14. Integrate health education/risk reduction counseling into medical visits.													
14.1. Adhere to standards of care and directives (see Goal 2).													
15. Improve services to special populations to improve their access to and maintaining care.													
15.1. Expanding clinical hours and providing childcare.										xxxx	xxxx	xxxx	xxxx
15.2. Use case conferencing to discuss family need among providers seeing family members.							xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
15.3. Adhere to standards of care.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
15.4. Work with primary care giver and case manager to update individual service plan.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Oral Health													
16. Offer access to emergency dental care. (See Title I - Ryan White HIV Dental Program Operations Manual, 1999).													
16.1. Offer all clients emergency dental visits.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
17. Develop system of dental referrals with area dentists.													
17.1. For more intensive / specialty dental treatments beyond limit in standard of care, create referrals with area dentists.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
18. Reduce waiting time for clients to make dental appointments and receive care.													
18.1. Monitor and establish protocols for appointments and waiting time.						xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Substance Abuse Services – Residential													
19. To provide residential drug and alcohol treatment for PLWH/A ready to begin treatment in order to increase their opportunities for appropriately accessing HIV primary care and medication therapies and improving health outcomes. (See Substance Abuse Treatment Services. July 1999.)													
19.1. Identify individual from intake or care assessment.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
19.2. Provide residential treatment programs for clients who require intensive alcohol/drug treatment.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
19.3. Monitor and evaluate residential treatment program completion compared to community standard										XXXX	XXXX	XXXX	XXXX
Substance Abuse Services – Outpatient													
20. Provide outpatient treatment designed to reduce or eliminate alcohol and drug use/abuse by PLWH/A in order to allow initiation of or improve adherence to HIV medication regimes. (See Substance Abuse Treatment Services. July 1999.)													
20.1 Identify individual from intake or care assessment.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
20.2. Provide outpatient treatment programs for clients who require alcohol/drug treatment.					XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
20.3 Monitor and evaluate outpatient treatment program completion compared to community standard.						XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Mental Heath													
21. Individual or group mental health services to address clinically diagnosed mental illnesses and overcome issues of denial. (See Mental Health Standards. July, 1999.)													
21.1. Increase services to chronically and severely mentally ill by a licensed psychiatrist or social worker.											XXXX	XXXX	XXXX
21.2. Provide access to specialized mental health services for those with special needs.											XXXX	XXXX	XXXX
21.3. Provide and monitor psychotropic medications for treatable mental illnesses as dictated in standards of service, directives, and PHS standards.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Hospice Services													
22. To provide hospice service to all PLWH/A who need intensive residential care.													
22.1. Maintain hospice program's residential, full-care facility (March 2007).													
22.2. Based on acuity and/or demonstrated need, provide residential hospice or full-service residential housing to those needing medical care for OIs (March 2007).													
Primary Linking and Access Services													
Case Management													

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
23. Outreach to clients in need of case management. (See Case Management Service Standards for Persons Living with HIV/AIDS. July, 2001)													
23.1. Provide uniform intake with eligibility check for Ryan White and non-Ryan White services. Update every 6 months to maximize all Ryan White and non-Ryan White benefits.					xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
23.2. Provide accessibility to case management services (e.g. field/ home based).	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
23.3. Determine eligibility for insurance continuation or applying for insurance.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
24. Provide culturally and linguistically appropriate case management.													
24.1. Provide culturally appropriate individualized treatment plan that coordinates multiple needs assessed in intake.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
25. Uniform acuity assessment.													
25.1. All case managers to use uniform intake and check for eligibility for Ryan White Funded and other care services.					xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
25.2. Utilize acuity scale to develop service plan and make referrals.							xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Transportation													
26. Assess transportation needs of clients and develop long-term transportation plan for services. (See Transportation Services. January, 2003.)													
26.1. Provide transportation based on need.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
26.2. Monitor quality of transportation provided.						xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Insurance Continuation													
27. If client is eligible, pay insurance premiums to continue insurance coverage.													
27.1. Pay co-payment on existing insurance if PLWH/A unable to pay.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
27.2. Effort to keep all PLWH/A on existing insurance, COBRA, or other insurance and pay premium if necessary.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Support Services													
Emergency Financial Assistance													
28. Provide emergency financial assistance to clients with pressing emergency needs.													

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
28.1. Standardize process of distributing emergency funds in accordance with service standards.						XXXX							
28.2. Provide assessment of need in acuity rating; update every 6 months.									XXXX	XXXX	XXXX	XXXX	XXXX
28.3. Distribute funds based on directive for emergency care.						XXXX							
28.4. Clients accessing Emergency Financial Assistance to continue to access routine medical care (minimum 2 primary care visits per year).					XXXX				XXXX				XXXX
Housing													
29. Stabilize living situation to ensure maintenance of medical care and treatment adherence through the provision of short-term housing assistance or rental assistance subsidy.													
29.1. Coordinate housing referrals with HOPWA, Section 8 housing, and Shelter Plus Care.						XXXX	XXXX						
29.2. Develop linkages with landlords and other providers of housing to develop capacity to meet demand for housing.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
29.3 Monitor the number of clients receiving housing assistance who maintain routine medical care (minimum 2 primary care visits per year).						XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Food													
30. To ensure that that persons with HIV/AIDS who are having difficulty getting nutritious foods have access to proper nutrition to improve health outcomes. (See Objective 34)													
30.1. Provide home-delivered meals or food bags to PLWH/A who would otherwise be unable to provide for their own nutritional needs.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
30.2. Provide nutritional supplements to clients receiving nutritional counseling.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
30.3. Monitor quality and clients satisfaction of home-delivered meals.							XXXX				XXXX		
Child Care													
31. Provide childcare for PLWH/A in order to improve clients' ability to access and maintain primary and supportive service care. (See Standard on Child Care Services).													
31.1. Develop a pool of reliable day-care providers for PLWH/A to access while attending appointments.							XXXX	XXXX	XXXX	XXXX			
Psychosocial Support Services													

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
32 Provide psychosocial support services as identified by need.													
32.1. Assure that clients understand and have access to psychosocial support services.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Complementary Care													
33. Provide massage, acupuncture, and chiropractic services to those eligible. (See Complementary/Alternative Therapies. January 2003.)													
33.1. Based on standards and directives, direct all persons requesting and eligible to complementary care.	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
33.2. Measure outcomes of complementary care (functionality and side effects).						XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Services to Providers													
34. Provide trainings to providers on non-HIV sources for services and funding.			XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
35. Use of the most effective and efficient service delivery practices based on research findings.													
35.1. Distribution of and training on best practices for prevention to positives, core, linking, and support services to line and management staff of providers with semi-annual updates.					XXXX		XXXX		XXXX		XXXX		XXXX
36. Improve client ability to navigate the continuum of HIV services.													
36.1. Extensive provider education offered to help them be fully familiar with continuum of HIV services and options for clients.		XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
36.2. Provide updated resource guide that is accessible to clients and case managers.								XXXX		XXXX		XXXX	
37. Monitor and evaluate new models of outreach and maintaining services for special populations			XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
Program Administration Assessment and Evaluation													
38. Distribute and train providers on client-tracking system.													
38.1. Full beta testing of system.			XXXX										
38.2. Provider training and protocols.			XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
38.3. Rollout with scheduled benchmarks.					XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX
39. Continuous data collection among PLWH/A.													
39.1. Develop plan for continuous data collection among clients of HIV/AIDS care and those out of care.		XXXX	XXXX	XXXX									

Goals and Objectives	Fall 2003	Winter 2004	Spring 2004	Sum 2004	Fall 2004	Winter 2005	Spring 2005	Sum 2005	Fall 2005	Winter 2006	Spring 2006	Sum 2006	Fall 2006
39.2. Annual special studies among a specific target population with special needs.			xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
39.3. Inclusion of client satisfaction surveys at providers.	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
39.4. Increase return rate of client satisfaction surveys.					xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
40. Transparency in costing and reimbursement.													
40.1. Conduct a full audit of the financial reimbursement system to provide a clean bill of health to the cost-reimbursement system and make suggestions where it maybe improved.								xxxx					

3. HOW WILL WE MONITOR OUR PROGRESS AND RESULTS

The various objectives noted in the previous section can be monitored using a number of different methods. For contract work, existence of RFPs, disbursement of funds in a timely manner, and products (reports, systems, guides, etc.) and events (trainings, meetings, seminars, etc.) can be tracked. For services, number of clients can be tracked as well as outcomes, satisfaction, need and gaps. Below, there is a recommended method for monitoring and an indicator for each objective noted in the previous section.

In Table 3-1, the "how" reflects actions that must be taken for the objective to be implemented. It involves Council actions, provider implementation, and consumer participation. It assumes the successful implementation of a client database with shared data, the adoption and funding of continuous data collection and ongoing data analysis. The Council must pay particular attention to detailed standards and directives. The recommendations increase the monitoring of standards and directives, and measure their impact.

The successful implementation of the objectives require the active participation of Council subcommittees, not only in planning but in reviewing data and making corrections in the system where indicated.

The final objectives are made to increase the transparency of funding among providers and consumers and lift a veil of misunderstanding about the procedures and methods of the grantee in allocating funds.

Table 3-1 Goal and Objectives - How & Indicators

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
System-Wide		
1. Adopt an HIV/AIDS Continuum of Services with emphasis on recent HRSA directives to bring those with unmet need into care and to coordinate prevention-for-positives with ongoing care.		
1.1. Adopt recommended Continuum of HIV Services in 2003 Comprehensive Plan.	Council vote.	Minutes.
1.2. Adapt HRSA tools to measure unmet need to Sacramento EMA.	Hire consultant.	Report. Estimate of unmet need.
1.3. Develop and adopt plan for outreach to those out-of-care or with delayed care.	Committee discussion. Hire consultant.	Plan (document).
2. Adopt service standards for all services and enforce standards through outcome-based reporting and monitoring.		

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
2.1. Continue to develop and revise standards for all services to comply with HRSA directives and needs of PLWH/A. Must meet Public Health Service (PHS) guidelines.	Committee discussion and vote.	Minutes. Standards document.
2.2. Assure precise service definitions, units of service, outcome measures, and indicators of care.	Committee discussion with Grantee input.	Service definition updates (document). Unit costs.
2.3. Specify outcomes and quality control indicators in standards.	Committee discussion. Research into other EMA quality controls tools.	Outcomes for each service (document).
3. Advocate for increased access to the community-wide resource guide by making it more widely available and accessible in paper and on-line formats in English and Spanish.		
3.1. Contract to have the guide converted to a database web-accessible guide.	Hire consultant.	Executed contract. Paper and on-line resource guide.
3.2. Update through provider information form on a semi-annual basis.	Mail and on-line provider information form updates.	Biannual updates in guide.
3.3. Have the guide conform to the adopted continuum of HIV services.	Consultant to design / program guide to match continuum of services.	Match between continuum of HIV services and guide.
3.4. Develop bilingual version(s) of the resource guide, as determined necessary by needs assessment.	Hire translators	Existence of bilingual guide.
4. Coordinate care across providers for PLWH/A.		
4.1. Reduce the proportion of Sacramento residents who test HIV positive but do not return for their results or delay care.	Coordinate with HIV counseling and testing to follow-up on positives.	HARS database tracking.
4.2. Improve local ability to appropriately screen clients for service eligibility.	Develop and distribute eligibility module for client database.	Track time it takes to determine eligibility and number referred to non-Ryan White funded services.
4.3. Share client data across providers, with assurances that client information is adequately protected in accordance with confidentiality laws.	Implement client database.	Report use of client data by more than one provider.
5. Integrate STD testing and medication into outpatient standards of care and directives in accordance with PHS guidelines.		
5.1. Revise outpatient standards to include standard STD testing, counseling, and medication.	Council committee discussion and vote.	Updated standard / protocol includes STD testing, counseling, and medication (document).

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
5.2. Assure logistics in place to do STD tests.	Assure funding, tests and counselors are available at providers.	# STD tests and counseling sessions.
5.3. Monitor to assure compliance with protocol for STD testing, counseling, and medication.	Adopt client tracking with reported STD testing, counseling and medication.	Report of STD testing, counseling, and medication.
6. Integrate protocols for treatment adherence into outpatient care standards and directives.		
6.1. Revise outpatient and case management standards to include adherence counseling and follow-up.	Standards committee discussion and recommendation. Council vote.	Revised outpatient standards that include adherence protocols (document).
6.2. Assure clinics and providers have expertise to follow-up on adherence issues.	Develop and provide training manual on adherence. Collect information on provider information form.	Report from provider information form.
6.3. Monitor to assure compliance with treatment adherence and follow-up.	Client database and provider info form to collect adherence information.	Monitoring report from client database and provider information form.
7. Plan for increased caseloads as a result of intensified case finding and procedures bringing those out-of-care into care.		
7.1. Monitor clinic caseloads and adjust allocations where client loads are increasing for new clients.	Provider use of client database. Run monitoring reports on new clients. Check with HARS.	Trend reports of new clients in the system.
7.2. Adjust protocols to track and assist those who have been out-of-care to outpatient services.	Council discussion and vote.	Revised protocols on measuring and contacting out-of-care.
8. Improved ability to track clients, services, and costs system-wide.		
8.1. Universal adoption and use of web-based client tracking tool developed by grantee (after appropriate beta testing – see Objective 9).	Finish beta testing. Train providers. Distribute.	Use of client-tracking system.
9. Understanding of unit cost and cost reimbursement programs used.		
9.1. Workshops on cost reimbursement, unit costs, and financial control should be offered by the grantee.	Develop workbook, schedule, and give two workshops on cost reimbursements.	Workshops held and report.
Core Services		
Primary Care *Early intervention*		
10. Bring those out-of-care into care.		

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
10.1. Create links to HIV/AIDS counseling and testing to track HIV positives who delay care		
10.2. Track those brought into care for first time and track contact with clients using web-based client tracking system.	HARS and client tracking.	Reports from HARS and client tracking on new clients.
10.3. Outreach to populations known to be more likely to be out-of-care.	Outreach to high-risk communities.	Number of outreach sessions. New clients in system.
10.4. Provide culturally appropriate case management to those out-of-care.	Assign CM for intensive follow-up for new clients who have delayed care or miss first appointment.	CM reports.
10.5. Provide appropriate follow-up case management visit if positive person does not seek care after 6 months.	CM to do home visit to those delaying care or not.	CM reports.
11. Improve the entry and maintenance to care to those testing positive.		
11.1. Use system-wide case tracking system to monitor individual patterns of care.	Develop a report on care patterns.	Report.
11.2. Assure that there is a minimum of 2 primary care visits a year per HIV positive client.	Develop report on primary care visits.	Report.
Outpatient Care		
12. Coordinate primary HIV/AIDS outpatient care with substance abuse services.		
12.1. Identify substance users who seek / need substance abuse treatment through intake or care.	Intake questions and referrals from caregivers based on clinical observations.	Report on number of referrals to substance abuse counseling.
12.2. Refer person to residential or outpatient substance abuse treatment.	Provider (CM or caregiver referral) and include code in client database.	Client database report.
12.3. Use CAADS client-tracking system to chart progress of individual.	Create module in client database that charts outcomes of clients (morbidity, QOL / functionality).	Client database report.
12.4. Use intensive case management to help persons obtain substance abuse treatment.	Modify standard to allow intensive CM to assist substance user to enroll in substance abuse program. Create code in database.	Client database report.
13. Target those with difficulty adhering to regimens for adherence counseling and support.		
13.1. Adhere to standards of care and directives for adherence (see Goal 2).	Contract monitoring. Include questions in provider information form.	Monitoring report. Analysis of provider information form.

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
13.2. Create individualized treatment adherence plans.	Provider follows protocol and enters into chart. Chart reviews.	Results of chart review.
13.3. Increase client knowledge about the positive outcomes of adhering to medication and possible negative outcomes of developing resistant strains by stopping regimens.	Adopt brochure to distribute at provider. Include in provider protocol during site visits. Measure by consumer survey (continuing data collection).	Consumer survey data report.
13.4. Make information about medication and adherence available in newsletters and on website.	Add info to county website. Develop Council website. Regular mailing of newsletters.	Newsletters and website.
14. Integrate health education/risk reduction counseling into medical visits.		
14.1. Adhere to standards of care and directives (see Goal 2).	Monitoring.	Monitoring reports.
15. Improve services to special populations to improve their access to and maintaining care.		
15.1. Expanding clinical hours and providing childcare.	Providers have appropriate clinic hours.	Monitoring report.
15.2. Use case conferencing to discuss family need among providers seeing family members.	Grantee identifies clients with multiple providers. Provider collaboration among providers for case conferencing consumer needs. Complete logs.	Client conference logs.
15.3. Adhere to standards of care.	Council to modify standards for special populations, as determined necessary. Providers adhere to standards. Capture adherence in charts and client survey.	Monitoring reports. Consumer survey analysis & report.
15.4. Work with primary care giver and case manager to update individual service plan.	Main provider updates plan based on case conference.	Chart review.
Oral Health		
16. Offer access to emergency dental care. (See Title I - Ryan White HIV Dental Program Operations Manual, 1999).		
16.1. Offer all clients emergency dental visits.	Provider (CM, caregiver to offer referral to dental care).	Chart review analysis. Consumer survey analysis.
17. Develop system of dental referrals with area dentists.		
17.1. For more intensive / specialty dental treatments beyond limit in standard of care, create referrals with dental schools and area dentists.	Create LOAs with area dentists.	LOAs. Monitoring reports.

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
18. Reduce waiting time for clients to make dental appointments and receive care.		
18.1. Monitor and establish protocols for appointments and waiting time.	SSC committee discussion and recommendation. Council vote.	Monitoring report. Consumer survey.
Substance Abuse Services – Residential		
19. To provide residential drug and alcohol treatment for PLWH/A ready to begin treatment in order to increase their opportunities for appropriately accessing HIV primary care and medication therapies and improving health outcomes. (See Substance Abuse Treatment Services. July 1999.)		
19.1. Identify individual from intake or care assessment.	If intake or clinical assessment includes substance abuse further assess for treatment program.	Chart reviews. Referral logs.
19.2. Provide residential treatment programs for clients who require intensive alcohol/drug treatment.	CM assures residential substance abuse referrals or court ordered substance treatment participation.	Consumer survey (special pop). Client database.
19.3. Monitor and evaluate residential treatment program completion compared to community standard.	Audit programs for quality and follow-up with participant to determine barriers.	CAADS Client database.
Substance Abuse Services – Outpatient		
20. Provide outpatient treatment designed to reduce or eliminate alcohol and drug use/abuse by PLWH/A in order to allow initiation of or improve adherence to HIV medication regimes. (See Substance Abuse Treatment Services. July 1999.)		
20.1. Identify individual from intake or care assessment.	If intake or clinical assessment includes substance abuse further assess for treatment program.	Chart reviews. Referral logs.
20.2. Provide outpatient treatment programs for clients who require alcohol/drug treatment.	CM assures outpatient substance abuse referrals or court ordered substance treatment participation.	Consumer survey (special pop). Client database.
20.3. Monitor and evaluate outpatient treatment program completion compared to community standard	Audit programs for quality and follow-up with participant to determine barriers.	CAADS Client database.
Mental Heath		
21. Individual or group mental health services to address clinically diagnosed mental illnesses and overcome issues of denial. (See Mental Health Standards. July, 1999.)		
21.1. Increase services to chronically and severely mentally ill by a licensed psychiatrist or social worker.	Improve definition and directive for psychological treatment. Direct providers to conduct assessments. Refer where appropriate.	Client tracking system report.

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
21.2. Provide access to specialized mental health services for those with special needs.	Develop directive and standard. Council discussion & vote. Implement and track programs.	Revised standards and directives. Client tracking system report.
21.3. Provide and monitor psychotropic medications for treatable mental illnesses as dictated in standards of service, directives, and PHS standards.	Chart review.	Chart review report.
Hospice Services		
22. To provide hospice service to all PLWH/A who need intensive residential care.		
22.1. Maintain hospice program 's residential, full-care facility.	Revise standards and directives. Council and Priorities and Allocations Committee discussion and vote.	Revised standard and directives. Minutes indicating vote.
22.2. Based on acuity and/or demonstrated need, provide residential hospice or full-service residential housing to those needing medical care for OIs.	Include threshold of residential full service in acuity scale. Refer where indicated by scale and clinician.	Client database report.
Primary Linking and Access Services		
Case Management		
23. Outreach to clients in need of case management. (See Case Management Service Standards for Persons Living with HIV/AIDS. July, 2001)		
23.1. Provide uniform intake with eligibility check for Ryan White and non-Ryan White services. Update every 6 months to maximize all Ryan White and non-Ryan White benefits.	Mandate uniform intake for RW providers, provide to non-RW providers. Update eligibility every 6 months.	Intake analysis report. Eligibility updates every 6 months.
23.2. Provide accessibility to case management services (e.g. field/home based).	Provider assessment of field visits for clients who miss or delay appointments. Offer home and field-based case management.	Client database report.
23.3. Determine eligibility for insurance continuation or applying for insurance.	Assure intake has screening questions for insurance status. Determine eligibility for insurance continuation. Provide general information to consumers about eligibility.	Client database report. Consumer survey analysis.
24. Provide culturally and linguistically appropriate case management.		
24.1. Provide culturally appropriate individualized treatment plan that coordinates multiple needs assessed at intake.	Assure intake includes assessment of cultural appropriateness. Audit individual assessment plans.	Reports.
25. Uniform acuity assessment.		

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
25.1. All case managers to use uniform intake and check for eligibility for Ryan White Funded and other care services.	Monitor CM use of intake and eligibility check.	On-site visit report.
25.2. Utilize acuity scale to develop service plan and make referrals.	Training for CM. Monitor CM use of acuity scale. Chart review.	Chart review report.
Transportation		
26. Assess transportation needs of clients and develop long-term transportation plan for services. (See Transportation Services. January, 2003.)		
26.1. Provide transportation based on need.	Enforce standards and directive for transportation. Monitor transportation vouchers. Consumer survey (continuous data collection).	Monitoring reports. Consumer survey analysis.
26.2. Monitor quality of transportation provided.	Contract monitoring. Consumer survey (continuous data collection).	Monitoring report. Consumer survey analysis.
Insurance Continuation		
27. If client is eligible, pay insurance premiums to continue insurance coverage.		
27.1. Pay co-payment on existing insurance if PLWH/A unable to pay.	Create insurance payment group at Grantee. Grantee to pay insurers (vendor dollars).	Client database report.
27.2. Effort to keep all PLWH/A on existing insurance, COBRA, or other insurance and pay premium if necessary.	At intake assess insurance status. Refer to Grantee insurance department. Consumer survey (special pop).	Client database report.
Support Services		
Emergency Financial Assistance		
28. Provide emergency financial assistance to clients with pressing emergency needs.		
28.1. Standardize process of distributing emergency funds in accordance with service standards	Revise standards / directive. Council vote. Providers implement.	Revised standards or directive. Consumer survey analysis.
28.2. Provide assessment of need in acuity rating; update every 6 months.	Assess consumer need for emergency financial assistance every 6 months.	Client database report.
28.3. Distribute funds based on directive for emergency care.	Among eligible for DEFA, follow distribution rules.	Client database report. Monitoring report.
28.4. Clients accessing Emergency Financial Assistance to continue to access routine medical care (minimum 2 primary care visits per year).	Consumer survey analysis of DEFA and medical care.	Consumer survey report.

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Housing		
29. Stabilize living situation to ensure maintenance of medical care and treatment adherence through the provision of short-term housing assistance or rental assistance subsidy.		
29.1. Coordinate housing referrals with HOPWA, Section 8 housing, and Shelter Plus Care.	Joint meeting between HOPWA and Council Committee.	Minutes. Coordination plan.
29.2. Develop linkages with landlords and other providers of housing to develop capacity to meet demand for housing.	Case management and housing providers to create LOAs with landlords.	Executed LOAs. Monitor housing units available.
29.3. Monitor the number of clients receiving housing assistance who maintain routine medical care (minimum 2 primary care visits per year).	Consumer survey (continuing data collection).	Consumer survey analysis.
Food		
30. To ensure that that persons with HIV/AIDS who are having difficulty getting nutritious foods have access to proper nutrition to improve health outcomes. (See Objective 34).		
30.1. Provide home-delivered meals or food bags to PLWH/A who would otherwise be unable to provide for their own nutritional needs.	Based on intake assessment arrange for home-delivered meals.	Client database report.
30.2. Provide nutritional supplements to clients receiving nutritional counseling.	Providers	Client's report increased use of supplements.
30.3. Monitor quality and clients satisfaction of home-delivered meals.	Client survey (special pop).	Survey analysis report.
Child Care		
31. Provide childcare for PLWH/A in order to improve clients' ability to access and maintain primary and supportive service care. (See Standard on Child Care Services).		
31.1. Develop a pool of reliable day-care providers for PLWH/A to access while attending appointments.	Register and audit day care and individuals qualifying for reimbursement for childcare. Monitor demand and use.	Updates list of eligible providers for day care.
Psychosocial Support Services		
32. Provide psychosocial support services as identified by need.		
32.1. Assure that clients understand and have access to psychosocial support services.	Provide nutritional info as part of care.	Client database report. Consumer survey analysis.

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
Complementary Care		
33. Provide massage, acupuncture, and chiropractic services to those eligible. (See Complementary/Alternative Therapies. January 2003.)		
33.1. Based on standards and directives, direct all persons requesting and eligible to complementary care.	Based on standards and directives, fulfill client request for complementary care.	Client database report. Consumer survey analysis.
33.2. Measure outcomes of complementary care (functionality and side effects).	Chart review.	Chart review analysis.
Services to Providers		
34. Provide trainings to providers on non-HIV sources for services and funding.	Council	Trainings scheduled and provider feedback.
35. Use of the most effective and efficient service delivery practices based on research findings.		
35.1. Distribution of and training on best practices for prevention to positives, core, linking, and support services to line and management staff of providers with semi-annual updates.	Hire consultant to write and distribute and train on prevention-for-positive programs.	Report. Scheduled trainings. Trainings. Provider feedback forms.
36. Improve client ability to navigate the continuum of HIV services.		
36.1. Extensive provider education offered to help them be fully familiar with continuum of HIV services and options for clients.	Hire consultant to create training on continuum of HIV services.	Report. Scheduled trainings. Trainings. Provider feedback forms.
36.2. Provide updated resource guide that is accessible to clients and case managers.	Provider information form updates sent (online or by paper)	Updated guide every 6 months.
37. Monitor and evaluate new models of outreach and maintaining services for special populations.		
Program Administration Assessment and Evaluation		
38. Distribute and train providers on client-tracking system.		
38.1. Full beta testing of system.	Complete beta testing.	Operational web-based database.
38.2. Provider training and protocols.	Create training manuals and protocols for entry. Tie use to funding.	Adoption of client database.
38.3. Rollout with scheduled benchmarks.	Schedule client database for release. Monitor adoption.	Use of database.
39. Continuous data collection among PLWH/A.		

Goals and Objectives	How	Indicators
Note: Goals are numbered items (e.g. 1,2,3 etc.) and objectives are sub-items (e.g. 1.1, 1.2, etc.)		
39.1. Develop plan for continuous data collection among clients of HIV/AIDS care and those out of care.	Council contracts consultant to develop continuous data plan and protocols, including IRB. Council to allocate funds and contract continuous data collection.	Implement consumer data collection and analysis. Database that links consumer database and client tracking database.
39.2. Annual special studies among a specific target population with special needs.	Identify and schedule special studies. Develop protocols to supplement core questions.	Schedule special studies. Data from special studies.
39.3. Inclusion of client satisfaction at providers.	Develop standard satisfaction questions and analysis. Monitor implementation at provider level.	Standard client satisfaction data.
39.4. Increase return rate of client satisfaction surveys.	Council to establish uniform satisfaction protocol. Providers to sample yearly for client satisfaction.	Monitoring of client satisfaction returns as part of contract monitoring.
40. Transparency in costing and reimbursement.		
40.1. Conduct a full audit of the financial reimbursement system to provide a clean bill of health to the cost-reimbursement system and make suggestions where it maybe improved.	Council to authorize funds for audit. Hire consultant. Grantee to participate in audit.	Audit report. Distribution of findings to community.

4. ATTACHMENTS

Attachment 1 Project Advisory Group

Sacramento EMA Needs Assessment / Comprehensive Plan
PROJECT ADVISORY GROUP

NAME	EMAIL	AFFILIATION
Adrienne Rogers	rogersad@saccounty.net	Ryan White Fiscal Administrative Agent
Alix Gillam	gillama@saccounty.net	Epidemiologist
Bill Puryear		Planning Council Alternate Member: Affected Community
Craig Spatola	cspatola@yahoo.com	Planning Council Chair
David Pilcher	pilched@sutterhealth.org	Physician
Jeff Cowen	sfafjeff@jps.net	Planning Council Member: Non-elected Community Leader; Provider
Julie Gallelo	galleloj@saccounty.net	HIV/AIDS Education and Prevention Program Coordinator
Kane Ortega		Planning Council Member: Affected Community
Katana Barnes	katanabarnes@aol.com	Planning Council Vice-Chair
Lisa Boch	cdcw@cwo.com	Planning Council Member: Substance Abuse Provider; Needs Assessment Committee Chair
Lisa DaValle	lisa.davalle@ucdmc.ucdavis.edu	AIDS Education and Training Center
Marty Keale	mkeale@caresclinic.org	Planning Council Member: Title III; Provider
Michael Ungeheuer	munger@co.el-dorado.ca.us	Planning Council Member: El Dorado County Dept. of Public Health
Ola Adams Best	oadams@dhs.ca.gov	HIV/AIDS Service Provider
Otashe Golden	ogolden47@aol.com	Planning Council Member: Physician
Peter Feeley	pfeeley856@aol.com	Planning Council Member: AIDS Service Organization; Priorities and Allocations Committee Chair

Attachment 2 Directives and Standards of Care

HIV Health Services Planning Council DIRECTIVES

Sacramento EMA

General – All direct Services Funded by the Ryan White CARE Act

Directive 1

In order to receive services funded by the Ryan White CARE Act, the person seeking said services must:

a) Have a confirmed diagnosis of HIV or AIDS.
b) Be in medical care for his or her HIV/AIDS condition, or at minimum, actively seeking medical care for HIV/AIDS.
c) Meet all financial guidelines as established by the HIV Health Services Planning council (when implemented later this fiscal year).
d) Clearly establish that any service requested (excepting primary medical care) is necessary to access or remain in medical care or maintain the health of the client.

In addition:

a) *Providers will assist clients, as needed, in obtaining proof that requested services are necessary to access or remain in medical care, or to maintain health, via collateral contact (or other communication) with the client's primary care physician, other care provider, or case manager.*

b) Ryan White contract service providers must document proof that these conditions have been met before any services can be rendered.

Directive 2

Direct services must be delivered in a culturally appropriate manner, sensitive to the special needs of under represented populations served. HIV service providers funded by the Ryan White CARE Act must make a good faith effort to employ direct services staff reflective of the culture and ethnicity of the populations they serve or intend to serve.

Directive 3

The service system must include access to services for all targeted populations: gay and bisexual men; African-American and Hispanic men and women; IDUs; infants and children; and other high-risk women.

Directive 4

Contractors must identify which targeted populations they are serving and to what degree and any specific methods they use to address both physical and psychological barriers to treatment and services.

Directive 5

The service system must show culturally appropriate methods of outreach, intake and service delivery which are responsive to applicable differences in geography, language, income, education, gender, age, sexual orientation, drug abuse, personal denial, responsibility for dependent children, and other variables.

Directive 6

Contractors must identify the methods by which they can provide accessibility for treatment and service to any person with a physical or mental disability including people with impaired speech, hearing or sight when needed.

Directive 7

The service standards approved by the HIV Health Services Planning Council will be followed by the contract agency and will supersede any agency policy.

Directive 8

Eligibility for services will be based on need as outlined in the service Plan of Care. Services may not be based upon the amount, or cost, of services being received currently, or in the past by the consumer.

Directive 9

Lack of money will not be considered a denial of service. If all agency money has been expended for a specific category, the consumer needing the service will be notified in writing and placed on a "waiting list". The Fiscal Agent and the Planning Council must be advised of "waiting lists" immediately and updated monthly.

Directive 10

The service provider must have a process in place that documents that Ryan White is the payer of last resort, that no other resources are available, and that all appropriate referrals were made.

Directive 11

Vendor dollars issued will only be reimbursed on a dollar basis, with no contractor markup allowed (i.e. Vendor paid dollar = $1.00 reimbursed dollar)

(Note: All items in Bold are new directives for FY 2003-2004)

General – All direct Services Funded by the Ryan White CARE Act

Directive 1

The service provider must have a process in place that documents that Ryan White is the payer of last resort, that no other resources are available, and that all appropriate referrals were made.

Directive 2

All Ryan White care service categories will be provided in a manner that provides for 100% access and 0% disparity to all populations.

FY 2003 –2004 Priorities

Ambulatory Care

Directive 1: Alternative Therapies

Regardless of the type of service (i.e. acupuncture, chiropractic, massage) a maximum of two (2) visits/sessions/treatments may be paid for, per calendar month, per client by Ryan White CARE Act funds. Any additional visits/sessions/treatments accessed during any calendar month will be the sole financial responsibility of the individual client. This does not apply to the Acupuncture Services (Substance Abuse) sub-category.

Case Management

Directive 1

Case management is a fundamental approach to efficient and effective intervention whether provided as an office based or as a home or field deployed strategy. To ensure and facilitate continued home or field case management services, a minimum of 35% of Sacramento-based case management services must be provided through the home or field orientation. Placer and El Dorado Counties are to determine case management ratios based on individual community need consistent with the local services allocation process for each jurisdiction.

Service Directives
Policy Number: SSC 07
Date Approved: 9/27/00
Date Revised:

Subject: General Policy Directives for Ryan White Title I/II-Funded Services
Reference: Ryan White CARE Act (Amended 1996) SEC. IV-62
Action Taken by the Affected Communities Committee (8/28/00), as amended by the Executive Committee (9/13/00)

Policy: Over the past few years, the HIV Health Services Planning Council has taken great care to develop a coordinated system of care accessible to all PLWH within the Sacramento EMA. In order to continue this tradition, the Affected Communities Committee (ACC) has developed the following general policy directives for Ryan White-funded services:

Determination of Eligibility
Effective March 1, 2001, a determination of whether or not a client is eligible to Ryan White Title I/II-funded services will be made by no later than the end of the next business day.

2. Timely Provision of Services
Effective March 1, 2001, Ryan White Title I/II-funded services will be provided in a timely manner to all eligible clients when services are requested by the client or prescribed by the client's care provider, in accordance with the client's plan of care.

3. Share of Cost
Effective March 1, 2001, all providers contracted by the Ryan White CARE Act will implement the attached Financial Eligibility/Share of Cost for Ryan White Services Guidelines (SSC-05), as adopted by the HIV Health Services Planning Council.

4. Removal of Cap on Services
Effective March 1, 2001, the Planning Council will amend current and future Service Standard guidelines to remove maximum entitlements (or caps) for all Ryan White Title I/II-funded services for which there is no existing HRSA guideline, in accordance with the client's plan of care. In so doing, the Grantee will commit to periodic and sustained monitoring of provider agencies to ensure against provider and/or client abuse. Reports of said monitoring activities will be provided to the Council on a quarterly basis.

SERVICE STANDARDS: Eligibility and Fees Service Standard

Policy No. SSC 05
Date Approved: 9/27/00
Dates Revised: 1/22/03

Subject: **Eligibility and Fees for Ryan White Title I/II Services**

1. Ryan White Title I & II funding ("RW Funding") is to be used for HIV/AIDS medical services and for psychosocial and support services which significantly improve access and adherence to such medical services. As such, client access to RW Funding support shall be determined in the context of each client's need for HIV/AIDS related healthcare services or other critical needs.

2. RW Funding is to be expended in accordance with the Ryan White CARE Act, and in a cost effective, equitable manner which is based upon verified client need and encourages self-empowerment of clients. RW Funding is to be the payer of last resort. Client eligibility for services which are paid for with RW Funding shall be evaluated through Case Management services provided in accordance with the allocation priorities and directives which are adopted by the Sacramento EMA HIV Health Services Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by an agency receiving Ryan White Title I & II funding ("RW Agency").

3. In accordance with the above:

A. All persons who test positive for HIV, and who reside in any of the counties which make up the Sacramento Eligible Metropolitan Area ("Sacramento EMA"), or are homeless and claiming residency within the Sacramento EMA, shall be eligible for RW Funded services ("Eligible Persons"). Family members or caretakers who can document their relationship to persons living with HIV/AIDS MAY be defined as Eligible Persons for limited RW Funded services. The financial eligibility criteria defined within this Standard apply equally to all Eligible Persons.

- The counties which make up the Sacramento EMA include El Dorado, Placer and Sacramento. (Alpine County, Title II only.)
- Proof of residence or of homelessness shall be based on any combination of documentation and/or personal statements which are considered reasonable by each RW Agency.

B. In accordance with the Ryan White CARE Act and the limitations set out below, all Eligible Persons shall be subject to Service Fees which shall be assessed by each RW Agency at the time of service.

C. The level of fees charged to each Eligible Person shall be based on the relationship of that person's household gross annual income to the Federal Poverty Guidelines published by the US Department of Health & Human Services ("Poverty Guidelines"). Client statements on household gross annual income should be verified with IRS data, if available.

1. Persons earning an amount equal to or less than 200% of the Poverty Guidelines shall not be charged any Service Fees for RW Funded services.

2. Persons earning an amount greater than 200% but no more than 300% of the Poverty Guidelines shall be charged a share of the full Service Fees charged by each Agency, which share shall be proportionate to the client's earnings as a percentage of the Poverty Guidelines less 200%. For example, a person earning 210% of the Poverty Guidelines will be charged 10% of the full Service Fees, while a person earning 290% of the Poverty Guidelines will be charged 90% of the full Service Fees. Service Fees shall be no more than the charges paid for each such service by to RW Agency by the Ryan White Title I & II Fiscal Agent ("RW Fiscal Agent").

3. Persons earning an amount greater than 300% of the Poverty Guidelines shall be charged 100% of the Service Fees charged by each RW Agency.

4. In the event that any person provides documentary proof that their total out-of-pocket expenditures for health services in the current calendar year (1 January through 31 December) have exceeded 10% of their anticipated gross income for the year, such person shall not be charged any fees by any RW Agency from that date forward to the end of such year.

D. Each RW Agency is responsible for defining and implementing such fee collection procedures as it may deem reasonable and necessary. Such Service Fees as are actually collected by each RW Agency may be retained by that agency, but must be deducted from amounts normally billable to the RW Fiscal Agent. RW Fiscal Agent will pay each RW Agency 100% of amounts normally due to such agency, less only a deduction for fees actually collected.

E. RW services which are primarily designed to enhance access by Eligible Persons to RW Services or to grievance procedures established by the various service Agencies or the RW Fiscal Agent shall not be subject to any of the fee requirements of this Services Standard. This exclusion specifically applies to Case Management, Outreach, Client Advocate or Ombudsman, and Peer Support Group services.

5. Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

6. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing any available advocacy or ombudsman services.

Reference Other Service Standards and Directives

HIV Dental Program, Operations Manual. February, 1999.
Case Management Service Standards for Persons Living with HIV/AIDS. July, 2001.
Complementary/Alternative Therapies. January 2003
Child Care Services. July 2000.
Mental Health Standards. July, 1999.
Substance Abuse Treatment Services. July 1999.
Food & Nutritional Services. January, 2003
Transportation Services. January, 2003.