LAFRANCE ASSOCIATES

San Francisco
2002 HIV/AIDS NEEDS ASSESSMENT REPORT

Prepared for
the San Francisco HIV Health Services Planning Council

May 2002

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ACKNOWLEDGMENTS

The 2002 San Francisco Eligible Metropolitan Area (EMA) Title I Needs Assessment was a collaborative effort among researchers, service providers, government officials, public health departments, consumers of services, and community members. This broad partnership has created a needs assessment with the input of many key players in providing and receiving HIV/AIDS Care, and the Partnership for Community Health (PCH) in New York City and LaFrance Associates (LFA) in San Francisco wish to acknowledge the many individuals, organizations, and institutions who assisted in the design, recruitment, execution, coordination, data analysis and writing of this needs assessment report.

Foremost, PCH and LFA would like to thank Laura Thomas of the San Francisco Department of Public Health (SFDPH) AIDS Office. Laura was responsive to our many requests and needs, provided critical insight, guidance, and information in the design and execution of the research, and generously shared her considerable knowledge and experience throughout the project. Many other AIDS Office staff gave of their time and experience during the project and we would like to pay special thanks to them. First, thank you to Joseph Cecere for his assistance in executing the consultant contract and facilitating the activities needed to start the project. Thanks to Rani Marx and Steve Solnit for their assistance in working with the Reggie data system, and to Sandy Schwartz for her guidance on surveillance and epidemiology issues. Ling Hsu provided special runs of epidemiological information on very short notice, and we are extremely grateful for her assistance. Thanks to Maree Kay Parisi for providing surveillance information that was helpful in estimating system capacity. Thanks also to Dean Goodwin for his assistance and access to contract and provider information.

Thanks also to the Positive Resource Center for their participation in the research: Eric Whitney and Robert Owens assisted us by making it possible to conduct interviewer training sessions and focus groups at their agency site. They also provided assistance in recruiting PLWH/A to participate in the project, and were our liaison to the Planning Council. Mary Vollinger and Dennis Reilly, also of Positive Resource Center, helped us identify PLWH/A interested in administering the survey throughout the EMA. Those they identified represented a wide diversity of populations and communities to better reflect the diverse community of PLWH/A who were the focus of this research.

Special thanks to the members of the Needs Assessment Task Force (NATF), convened especially for this project, for providing guidance and feedback on each phase of the project. A listing of the NATF members is shown in Attachment 1. We also gratefully acknowledge the assistance and insight of the three San Francisco HIV Health Services Planning Council co-chairs, Catherine Geanuracos, Jim Mitulski, and Donald Frazier.

A special thanks to the individuals trained to conduct the survey in the field. Their enthusiastic participation and commitment to the many communities they represented made it possible to implement a complex survey instrument to a large number of people in a short time period. We would also like to acknowledge their professionalism in working with clients to collect the data, and adjusting their schedules to accommodate clients who required special assistance.

The needs assessment project would not have been possible without the cooperation of the many providers throughout San Francisco and San Mateo who provide services to persons living with HIV/AIDS (PLWH/A). A full list of all participating agencies is provided in Attachment 2, and we wish to extend our extreme gratitude for their patience, assistance, and cooperation during the data collection phase of the project. Over 40 agencies in San Francisco and San Mateo assisted in the recruitment of participants and were particularly helpful in recruiting hard to reach populations. We would like to acknowledge several service providers here who generously allowed us to use their facilities for trainings and to conduct consumer focus groups. They include Andrew Alvarez and the San Francisco AIDS Foundation, Sylvia Moreno and the Mission Neighborhood Health Center, Gustavo Cravioto and Vlademere Oliveros and Instituto Familiar de la Raza, Andrea Goetz and Glide Foundation / Glide Memorial United Methodist Church, Duane Poe and the Black Coalition on AIDS, and William Blum and the San Mateo County Health Services AIDS Program. Special thanks to Jim Illig of Project Open Hand for providing access to the HIV/AIDS Provider Network.

We would also like to acknowledge the efforts made by Kate Monico Klein of the Forensic AIDS Project and Guy Vandenberg at Continuum who attempted to facilitate our entry into the criminal justice system to interview incarcerated persons. Although, in the end, we were unable to gain access in the limited time that we were in the field, they made every effort possible to help.

We also want to acknowledge the time and effort that providers spent completing the provider information form. We realize considerable effort required to compile the information asked for in the forms. While the effort was not as successful as we hoped for, it highlighted the need for more uniform and accessible data. We are extremely grateful to providers who took time to fill out the forms.

In the final analysis, however, what made the needs assessment possible was the time and effort of the nearly 600 PLWH/A who participated in the survey and focus groups and over 40 service providers and key informants who participated in the recruitment efforts. They were generous in their time and candid in their responses. The results presented in this report are their collective voice about their service needs and barriers.

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Abbreviations

ADAP	AIDS Drug Assistance Program
API	Asian / Pacific Islander
ASO	AIDS Service Organization
Council	Ryan White Title I Planning Council
EMA	Eligible Metropolitan Area
HARS	HIV/AIDS Reporting System
HET	Heterosexual
IDU	Injecting drug user
IRB	Internal Review Board
LFA	LaFrance Associates
MOU	Memorandum of Understanding
MSM	Men-who-have-sex-with-men
NATF	Needs Assessment Task Force
OI	Opportunistic infection
PCH	Partnership for Community Health
PLWH/A	Person living w/ HIV/AIDS
SFDPHAO	San Francisco Department of Public Health AIDS Office
STD	Sexually transmitted diseases
TB	Tuberculosis
TG	Transgender
VA	Veteran's Assistance
Youth	PLWH/A 24 years of age or younger

1. INTRODUCTION

In the beginning of 2002 Ryan White Title I Planning Council (Council) through its administrative agent the Positive Resource Center, awarded LaFrance Associates (LFA) and the Partnership for Community Health (PCH) a contract to conduct an HIV/AIDS Needs Assessment within San Francisco and San Mateo counties.[1] The goal of the needs assessment is to provide the San Francisco Department of Public Health AIDS Office (SFDPHAO) and the Council with data on HIV/AIDS that is necessary for effective services planning.

This report presents the needs, unmet needs (or gaps), and barriers to HIV/AIDS care of PLWH/A in San Francisco and San Mateo counties. Primary information was obtained through a survey of 572 PLWH/A, 8 focus groups with key populations and the data collected through a provider information form.

The conceptual framework for the needs assessment is shown in Figure 1-1. Needs, unmet needs, and barriers were determined for nine different service categories and 35 sub-services.

Figure 1-1 Definition of Needs and Gaps

Service need or absolute need	Theoretical estimate based on a policy protocol and standards / model of care. It is an estimate of the number of people who would benefit from a service, regardless of whether they are actually receiving it.
Perceived need and demand	Perceived need and demand of PLWH/A for services based on qualitative and quantitative data is highly correlated.
Fulfilled need	Actual utilization of services measured by surveys or other non-direct counts by source of funding. It is expressed by the fact that an HIV-infected individual has actually received a service that is paid for by a multitude of sources.
Service capacity	Number of clients who can be served and the number of slots available for a particular service, by funding source (RW, insurance, public assistance, grant-funded, compassionate drug programs, etc.)

From these four "raw" calculations, four gap measures are calculated.

Unmet absolute need	This refers to a need-capacity gap and is the difference between the number needing a service and the capacity of the system.
Unmet perceived need	This refers to the difference between the perceived need/demand and utilization. It is the services that PLWH/A say they need and what services they actually sought.
Unmet demand or perceived excess capacity	This refers to a demand-capacity gap and is the difference between the number seeking service and the capacity of the system. It is the difference between the units of service utilized and the number of units of service that are available.
Need-demand gap	This refers to individuals needing, but not perceiving they need, services and is the difference between the number who in theory should receive services and the number perceiving they need services.

This Needs Assessment Report specifically addresses the absolute service needs, the perceived needs or demand, fulfilled need, unmet absolute need, unmet perceived need, and barriers to care reported by PLWH/A.

[1] Marin County, which is the third county comprising the San Francisco EMA had recently completed a needs assessment and opted not to participate in this study.

2. METHODS

Four data collection methods were used by LFA and PCH for the San Francisco EMA HIV/AIDS Care Needs Assessment. First the team reviewed secondary information, including past needs assessments, epidemiological data available from the SFDPH AIDS Surveillance Unit and aggregate client data from the REGGIE system. The AIDS Quarterly Report (December 2001) and the data obtained from the Surveillance Unit was used to estimate the incidence and prevalence of HIV and AIDS and the sampling frame. The REGGIE system was used to estimate the number of units of service provided by the care system, and the general health status of PLWH/A. Mortality data was collected as one outcome measure for the continuum of HIV/AIDS care.

Second, a survey was conducted among a sample of PLWH/A recruited by providers based on their client profiles and from outreach to those out-of-care and other difficult to reach populations. Surveys were conducted over seven weeks from mid-February to early April 2002.

While the sample was not randomly drawn, a stratified sampling plan was followed and every effort was made to select participants randomly from a wide variety of venues. Providers and recruiters were given detailed instructions on selecting participants randomly. The stratified quota of PLWH/A was used to over-sample populations such as women, IDUs, APIs, and transgendered persons in order to have a sufficient sample size for subpopulation analysis.

The overall size of the sample and diversity of clients obtained through quota sampling, and the weighting back of the oversampled populations to their appropriate proportion in the population (based on PLWA), 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.

Third, 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 within key populations such as APIs, Native Americans, and youth not captured in the focus groups

Fourth, a provider information form was completed by recipients of Ryan White Care funds and other providers of care services to PLWH/A. It collected information on the services provided, all funding for services, number of clients serviced, and unduplicated client counts, and estimates of care system capacity was made using the information.

A Needs Assessment Task Force (NATF) was formed to provide oversight to the needs assessment process and feedback on survey and focus group tools and draft reports. The consumer survey, focus group outline, and provider form were part of a highly participatory process involving members of the NATF. All decisions regarding content and length were approved by the NATF and they continued to be consulted throughout the project. The names of those on the task force are shown in Attachment 1.

Consumer Survey

The survey instrument was designed and approved by February 18, 2002. The process included a draft submitted by PCH/LFA and several rounds of revisions based on comments and specification of the NATF, Council, and Health Department. The final consumer survey is shown in Attachment 3 The initial part of the questionnaire captured key demographics, insurance and benefits, level of care, stage of infection, medication and adherence, and quality of life. Question 43 measures awareness, current need, demand, and utilization of services. The list of services developed by the research team was derived from the continuum of care and includes the nine categories of services funded by Ryan White, and 35 sub-services that were reviewed by SFDPH as representing services that were funded, or of interest to, the Council. At the end of each major service category, PLWH/A had an opportunity to say what problems they had in obtaining the services.

Following the measurement of service need, PLWH/A ranked the 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 later in the report. The final questions in the survey measured drug use and residency status.

The survey instrument was designed and approved by February 18, 2002. It was pre-tested with the interviewers during the instrument training session. The consumer survey was translated into Spanish by Ms. Lucia Orellana of PCH, and checked by a second Spanish translator.

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. A majority of the interviewers were living with HIV/AIDS and also consumers of services provided in the EMA.

Interviewer Training

Twenty-nine interviewers were trained to administer the consumer survey. The majority of recruits which were identified by the Positive Resource Center and were PLWH/A. Interviewers were introduced to needs assessment and the survey was reviewed. Services categories were reviewed, and the difference between knowledge (awareness), current need, demand, and utilization were reviewed. Basic procedures such as circling responses and answering all applicable questions were emphasized. In those questions with a “yes”, “no” option, interviewers were asked to check each questionnaire to assure that each item was complete.

As part of the training, potential interviewers were asked to complete the survey so they would experience the survey first hand through their participation. They were asked to note any questions that confusing or not clear to them. After everyone in the session was finished completing the survey, Basil Reyes, Field Supervisor, went over the survey question by question and answered questions and clarified any areas for the candidates.

After the training a few interviewers proved unable to administer the survey and were not given assignments. Interviewers that were given assignments were accompanied by Mr. Reyes or Mr.

DeMayo to their first session to insure that they were able to administer the survey and perform quality checks. With the review of the interviewer's work, the initial twenty-nine interviewers were subsequently reduced to eighteen based on their performance in administering the surveys including accurate data collection and ability to work independently in the field. Those who did not continue were compensated for their attendance of the training session.

The active field staff of eighteen interviewers was asked to reconvene for another training session to review the instrument and to reiterate the importance of obtaining accurate and complete data with each survey administered. Specific are as included:

- Being sure the participant fills out the unique identifier and asking them if they have completed the survey before (to avoid duplicates);
- Assuring that participants filled in correct dates;
- Confirming the out-of-care series of questions about if and when the participant visited a doctor; and
- Probing for barriers at the end of each service area in question 43.

Interviewers were instructed to check each questionnaire for completeness before providing the incentive, and they were checked again by field supervisors prior to sending them to data entry.

Incentives

Participants of the consumer survey received a $20 grocery food certificate. Anyone unable to complete the entire consumer survey for reasons such as illness or fatigue still received the incentive. Another incentive for participants to complete the survey was their inclusion in a raffle with two grand prizes of a computer.

Sample Design

The survey recruitment strategies were based on a stratified quota sample based on race and risk group. The stratified sample obtained is shown in Table 2-1. For the purpose of this needs assessment and to assure that there were sufficient numbers of respondents to analyze, special effort was made to include populations that are disproportionately affected by the epidemic including females, transgender persons, and communities of color. The interviewing process was designed to draw a representative sample of clients from AIDS service organizations (ASO), clinics, and other sites where PLWH/A were known to gather.

Table 2-1 Stratified Sample

		MSM	MSM/ IDU	IDU	Het	Total
Af Am	**Male**	50	33	24	11	**118**
	Female	0	0	25	17	**42**
	Transgender	10	9	2	2	**23**
Anglo	**Male**	50	51	20	1	**122**
	Female	0	0	17	10	**27**
	Transgender	1	6	2	1	**10**
API	**Male**	27	5	2	3	**37**
	Female	0	0	2	4	**6**
	Transgender	4	2	1	0	**7**
Latino	**Male**	59	23	7	5	**94**
	Female	0	0	5	14	**19**
	Transgender	10	6	1	2	**19**
Native Am	**Male**	8	9	9	1	**27**
	Female	0	0	8	1	**9**
	Transgender	0	2	1	0	**3**
Other	**Male**	1	3	1	0	**5**
	Female	0	0	2	1	**3**
	Transgender	1	0	0	0	**1**
TOTAL		**221**	**149**	**129**	**73**	**572**

Recruitment

In order to recruit a representative sample while maintaining confidentiality, participants were recruited by personal invitation, through the collaboration of case managers, receptionists, and other staff of these agencies and through outreach. Flyers were also distributed and posted at various agencies around the EMA. Those participants called the project team directly to schedule their participation.

The study team produced a list of client demographics by agency through the REGGIE database in order to determine where clients that met the quota sampling were receiving care. This list was particularly helpful to identify the agencies frequented by the hard to reach populations including youth, females, and heterosexual non-IDU males. Agencies were requested to call clients to ask them to participate in the project. In addition, with the permission of the providers, individuals were recruited when they sought service.

No contact with clients was initiated by the project team without the explicit permission of the PLWH/A in order to protect their confidentiality.

Most respondents were recruited from providers where clients went for care or services. Some interviews were scheduled in advance through providers while other participated were "intercepted" at providers and recruited for interviews. Notably, those clients who were home-bound or were seriously disabled with dementia are underrepresented in the sample.

Interviewing

There was no centralized location for interviewing. Instead, an agency typically was able to provide a space in their agency in which to conduct the interviews. In several instances where participants could not travel or were concerned about their confidentiality, interviews were conducted by telephone. Agencies were required to provide private space for the interviewing.

Considerable efforts were made to reach eligible individuals among those hardest to reach including Native Americans, APIs, recently incarcerated, and the homeless through outreach and working with provider staff. In addition to appointments made by providers, "intercept" interviews were conducted at over 30 different agencies in the EMA.[2] Agencies were asked to post and distribute a flyer which noted the details of the project including the two incentives being offered. The Ryan White funded agencies were directly contacted through personal visits and various memoranda from the SFDPH and the research team describing the Needs Assessment project and underscoring the need for assistance locating particularly hard to reach populations.

Bilingual interviewers administered Spanish questionnaires. Out of the 132 surveys conducted with Latinos, 86 were conducted with the Spanish language instrument. There was criticism by the Asian/Pacific Islander Wellness Center that the instrument was not available in Cantonese, Mandarin, or Tagalog. Although 50 APIs were interviewed with the English language instrument, it was suggested that a higher number of APIs, particularly those who rarely participate in these projects, could have been interviewed if the instrument was available in their language. The large number of languages spoken by APIs made it difficult to translate the questionnaire into different Chinese dialects, Japanese, and other languages spoken by APIs. One interviewer that spoke Cantonese interviewed a few participants but was limited in the hours he worked by health problems.[3]

Unfortunately currently incarcerated PLWH/A were not interviewed as part of this needs assessment because of the time necessary to obtain clearances and organize interviewing in the corrective jail systems. While efforts were made to "piggy-back" this needs assessment onto other studies currently being conducted in the jail system in the hopes that this would minimize the time needed to facilitate background checks on interviewers, it did not leave time to obtain the necessary Internal Review Board (IRB) approval. Yet, there were 111 PLWH/A interviewed who had been released within the last two years. This population (labeled "Rec Inc") can be examined in the data attachments.

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[2] "Intercept interviews" are when the respondent is recruited based on the stratification criteria at the time he or she sought service, and is interviewed immediately after recruitment.

[3] Representatives of the API Wellness Center were asked for their suggestions for how we could successfully interview monolingual APIs. Efforts were made to recruit other interviewers who spoke Cantonese, Mandarin, or Tagalog to administer the survey to their clients. Participants were promised that no care provider would be able to link their responses to names, so the API Wellness Center's prevention service providers that spoke those languages were asked to administer surveys to PLWH/A in hopes of reaching out to at least 5 monolingual APIs. Despite extension of the interviewing dates, this provided unsuccessful. In the future recruiting for monolingual API participants should begin earlier.

Interviewer assisted needs assessment surveys with incentives are vulnerable to duplicate respondents who would like additional incentives. To a large degree, by maintaining a list of unique confidential identifiers using a fixed algorithm created at the time of survey administration, it allowed the early identification of duplicate surveys unless the respondent cleverly lied on the survey to create two separate confidential ID's. About 20 duplicate surveys were removed prior to analysis. A few interviews were not entered that were found to be largely incomplete by the interviewer and the participants were unwilling to complete the survey.

Focus Groups and Key Informant Interviews

Focus Groups

The focus group outline was developed and approved in March 2002 and is shown in Attachment 4. The purpose of the focus groups was to supplement the quantitative findings of the consumer survey and to gain greater insight into the perception of needs, gaps, and barriers. Eight focus groups were held with consumers at different locations as shown in Table 2-2. The research team attempts to have between eight and ten individuals in a group, however sizes vary depending on recruiting efforts and high rates of no-shows. More than 10 participants in a group make it difficult for every one in the group to have an opportunity to share their viewpoints and opinions. As shown in Table 2-2, five of the eight groups had eight or more participants. Focus group participants received a $30 grocery food certificate as their incentive.

Table 2-2 Focus Group

Population	Location	Date	Attendance
1. Latino MSM	Instituto Familiar de la Raza	6/14/02	11 males, 1 transgender
2. African American non-MSM	SF AIDS Foundation	6/14/01	2 males, 8 females
3. Latino non-MSM	Mission Neighborhood Hlt Center	6/14/01	5 females
4. Transgender	SF AIDS Foundation	6/14/01	7 MtF
5. Homeless	Glide Health Services	6/14/01	9 Males: 1 Lat, 1 NA, 2 Af Am, 5 Anglos
6. African American MSM	Black Coalition on AIDS	6/15/01	10 males
7. Out of Care	Positive Resource Center	6/15/01	5 males, 1 female
8. San Mateo County residents	ACRC (Redwood City)	6/15/01	8 males, 4 females

Several methods were used to select and recruit participants for focus groups, while maintaining their confidentiality:

1. The primary source for recruiting participants in the focus groups was based on a survey participant's response to a question on the consent form asking if they would like to join a focus group. This was particularly helpful in recruiting for the hard to reach populations (including those with a history of being homeless or out-of-care). Once it was apparent which clients were in which populations, the research team contacted up to twenty individuals for each group to ask them to participate in a focus group.
2. When there were not enough PLWH/A to contact through the above method, whether because of a PLWH/A not having a phone line or their inability or disinterest to participate in the focus group, some providers assisted by calling their clients directly to ask them to participate or by contacting them through other means when a telephone call was not an option. Ark of Refuge and Transgender Resource and Neighborhood Space (TRANS) were helpful with the transgender focus group. Instituto Familiar de la Raza and the Mission Neighborhood Health Center were helpful with the Latino focus groups.

3. Participants were also recruited through flyers distributed at various agencies. Those participants called a member of the research team directly to schedule their participation. This method was of particular assistance for the San Mateo focus group.

Key Informant Interviews

Key informant, or one-on-one, interviews were conducted with 10 additional PLWH/A. The goal was to include the hard-to-reach populations to participate in the qualitative data collection process. Three were conducted with APIs, four with Native Americans, and three with PLWH/A 24 years or younger. The same method was used to recruit key informants as for recruiting focus group participants. Survey participants that noted an interest in participating in a focus group were called asking if they would like to participate in a 15-20 minute discussion over the telephone regarding services offered to PLWH/A in the San Francisco EMA. The focus group outline was used as a guide in conducting the key informant interviews.

Provider Information Form

As part of the HIV/AIDS Care needs assessment, provider information forms were developed to provide information for estimating capacity of the continuum of HIV/AIDS care to meet the demand for services and determining gaps in services where capacity was insufficient. Information forms were designed in early April 2002 for Title I funded service providers, non-CARE funded services providers, and physicians. Forms were customized for each provider and all forms were sent to providers in mid-April, 2002.

A variety of sources were used to identify providers receiving CARE funds, non-CARE providers, and physicians, as well as to determine the comprehensive list of services offered in the San Francisco EMA. The REGGIE database was used to identify the number of service categories in the continuum of care. The San Francisco HIV Health Services staff provided a list of 53 Title-I funded agencies, and also provided a complete list of all DPH contractors not specifically funded through the CARE Act. Through the non-CARE funded list, 10 providers were identified who provide various services used by PLWH/A and these ten providers were sent a shorter information form, bringing the total number of provider information forms distributed to 63. The Annual Administration Report (AAR), which is a mid-year progress report summarizing service utilization and funding information and completed by all CARE providers, was also used to identify additional funding sources for each agency.

Several agencies that receive Title I grants were not included in the survey since they do not directly provide services to PLWH/A. These agencies, such as CompassPoint, receive CARE Act dollars to provide various forms of technical assistance to the Council and to the DPH HIV Health Services Section.

Ryan White Title I Funded Agencies

The Provider Information Form for Title I funded agencies consisted of two separate sections. Section I, the Agency Information Form (Attachment 5), asked for information regarding the type of agency, contact information, and agency-wide funding sources and amounts for the FY

2001-2002. Each agency was asked to complete Section I only once for the agency regardless of the number of different services they provide.

Section II, the Services Information Form (Attachment 5), requested detailed information on specific services provided, including information regarding eligibility for services, units of services provided over the FY2001-2002, unduplicated client counts, and service specific funding. This section also asked providers to assess the barriers to each service faced by their clients. A separate Services Information Form was sent for each service being provided, and in some instances meant that an agency would receive three or four separate Service Information Forms to complete. The purpose of separating the information in this way is to determine capacity for each service in the continuum of care. As shown in Table 2-3, for the 53 Ryan White funded providers, 131 different services and sub-services were identified. The "Other" service noted in the table

Prior to distributing the forms to the providers secondary data sources were used to complete as much information on the forms as possible in order to minimize the burden on providers when completing the forms. Providers were asked to confirm this information. For Title I funded agencies, data was collected from the REGGIE database and other Department of Public Health (DPH) source materials, for the FY2001-2002. This information, which included both service utilization data and funding information, was entered into both sections of the form for each agency.

Non-Ryan White Funded Agencies

Ten surveys were distributed to agencies in San Francisco who provide critical services to PLWH/A, yet are not specifically funded through Title I of the CARE Act. As mentioned previously, these agencies were identified through a list of all DPH contractors provided by the DPH HIV Health Services staff. The survey for these providers was considerably less detailed, asking general agency information, funding information, and client caseload and service utilization information. By mid June, however, no non-CARE Act agency returned a survey and given the cost and time necessary for follow-up, obtaining information from non-Ryan White funded providers was not pursued for this needs assessment.

Distribution and Completion

The epidemiology and surveillance unit of the AIDS Office provided a list of 186 physicians who provide HIV/AIDS care of which contact information was correct for 144 physicians. Of the 144 physician information forms distributed, eight physicians completed and returned the form.

The provider surveys were mailed to each provider in mid April. A request was made to complete the surveys and return them via mail within two weeks. Approximately one-third of providers returned their completed surveys within the time frame requested. The remaining provider surveys required the project team to engage in several follow-up calls to encourage them to return the forms. By mid-June, 44 out of 53 surveys were returned, with two being submitted in the last week of June.

It should be noted that a variety of problems were encountered by providers that hindered their ability to respond to the survey in a timely manner. They included:

1. Not receiving their survey in the original mailing. The project team discovered that a significant number of addresses provided by the health department were either out-of-date or incorrect. We discovered during follow-up phone calls with providers that many had not received the forms.
2. Change of staff at agencies. Key staff contacts at some agencies had changed over the previous months, though had not yet been officially noted in the information provided by the health department. As a result, provider information forms were sent to staff no longer employed at agencies and their mail was either discarded or undelivered to replacement staff.
3. Many providers, over time, misplaced or discarded the provider information forms when they received it. During follow-up contacts with those providers who had not returned their surveys, we discovered that a sizeable number had been unable to locate the forms, though they did recall receiving it. New forms were sent to these agencies.
4. Responding to the information forms was a low priority for some providers. It should be noted that completing the provider forms was entirely voluntary, since participating in the needs assessment was not a condition of award for any Title I funded agency. Since many agencies often struggle with understaffing and immense workloads, it is not surprising that the provider information forms was a low priority.

Due to the time and cost of follow-up, there was no further attempt to collect completed forms from the physicians and the non-Ryan White funded providers

Table 2-3 Provider Information Form Distribution List

Agency	Case management	Client Advocacy	Complementary Care	Day Respite Care	DEFA	Dental Care	Food Services	Home Health Care	Housing Assistance	Mental Health	Nutritional Education	Outpatient Care	Substance Abuse	Transportation	Other*	TOTAL
TOTAL	**25**	**24**	**3**	**2**	**1**	**3**	**2**	**5**	**10**	**15**	**2**	**17**	**8**	**1**	**13**	**131**
AIDS EMERGENCY FUND					x											1
AIDS LEGAL REFERRAL PANEL		x														1
AMERICAN COLLEGE OF TRADITIONAL CHINESE MEDICINE			x													1
ARK OF REFUGE		x											x			2
ASIAN & PACIFIC ISLANDER WELLNESS CENTER	x	x								x						3
BAKER PLACES, INC.									x			x	x			3
CATHOLIC CHARITIES ARCHDIOCESE OF SF	x	x						x	x	x						5
Circle of Care	x	x														2
COMMUNITY AWARENESS AND TREATMENT SERVICES, INC.										x			x			2
CONTINUUM HIV DAY SERVICES	x	x					x			x		x	x			6
DEAF AIDS SUPPORT SERVICES/UCSF CENTER ON DEAFNESS		x								x					x	3
DOLORES STREET COMMUNITY SVCS./ RICHARD M. COHEN RESIDENT								x								1
DPH/CMHS AIDS MENTAL HEALTH/CENTER FOR SPECIAL PROBLEMS										x						1
EARLY ACCESS CLINIC- GENERAL MEDICINE CLINIC												x				1
FAMILY SERVICE AGENCY OF SF										x						1
FAMILY SUPPORT SERVICES OF THEY BAY AREA				x												1
FORENSICS AIDS PROJECT/JAIL HEALTH SERVICES	x	x										x			x	4
GLIDE FOUNDATION/GLIDE-GOODLET HIV/AIDS PROJECT	x	x														2
HAFCI (HAIGHT ASHBURY FC/W ADDN RECVRY HSE/SMITH RYAN DTX)	x									x		x	x		x	5
HEALTH AT HOME, COMM HEALTH NETWORK, SFDPH								x								1
HOUSING WAIT LIST									x						x	2
IMMIGRANT HIV ASSISTANCE PROJECT/VOL.LEGAL SVCS./BASF		x														1
IMMUNE ENHANCEMENT PROJECT			x													1
INSTITUTO FAMILIAR DE LA RAZA	x	x								x						3
IRIS CENTER:WOMEN'S COUNSELING AND RECOV. SVCS.										x						1
LARKIN STREET YOUTH CENTER	x	x		x					x	x						5

* Other represents a major service category in the REGGIE system. It can include MUNI tokens, Taxi Scripts, Clothing Services, Resource Guide, and Treat ment Support.

Table 2-3 continued…

Agency	Case management	Client Advocacy	Complementary Care	Day Respite Care	DEFA	Dental Care	Food Services	Home Health Care	Housing Assistance	Mental Health	Nutritional Education	Outpatient Care	Substance Abuse	Transportation	Other*	TOTAL
TOTAL	**25**	**24**	**3**	**2**	**1**	**3**	**2**	**5**	**10**	**15**	**2**	**17**	**8**	**1**	**13**	**131**
LEGAL SERVICES FOR CHILDREN	x															1
LUTHERAN SOCIAL SERVICES OF NO CALIFORNIA/ HAZEL BETSY		x							x							2
LYON MARTIN WOMEN'S HEALTH SERVICES/IS-WIDS	x	x										x			x	4
MAITRI COMPASSIONATE CARE								x								1
MISSION NEIGHBORHOOD HEALTH CENTER	x	x									x	x			x	5
NATIVE AMERICAN AIDS PROJECT	x	x								x						3
Native American Health Center	x	x										x			x	4
NEW LEAF FOR OUR COMMUNITY										x			x		x	3
POSITIVE RESOURCE CENTER		x														1
PROJECT OPEN HAND							x									1
QUAN YIN HEALING ARTS CENTER			x													1
SAINT MARY'S MEDICAL CENTER	x	x								x		x			x	5
SAN FRANCISCO AIDS FOUNDATION	x	x							x			x			x	5
SF BLACK COALITION ON AIDS	x								x							2
SF DPH-COMMUNITY HEALTH NETWORK/CITY CLINIC	x											x				2
SHANTI PROJECT/CIRCLE OF CARE COLLABORATION	x	x							x			x		x	x	6
SOUTH OF MARKET HEALTH CENTER	x					x						x			x	4
TENDERLOIN AIDS RESOURCE CENTER	x	x							x							3
UCSF POSITIVE HEALTH PROGRAM@SFGH WARD 86-MEDICAL CLINIC	x	x										x				3
UCSF SCHOOL OF DENTISTRY						x										1
UCSF WOMEN'S AND CHILDREN'S SPECIALTY PROGRAM	x										x	x				3
UCSF WOMEN'S SPECIALTY CLINIC	x	x										x			x	4
UCSF/AIDS HEALTH PROJECT	x									x						2
UCSF-DEPT OF PSYCHIATRY/DIV SUBST.ABUSE & ADDICT.MEDICINE												x	x			2
UOP SCHOOL OF DENTISTRY CARE PROGRAM						x										1
WALDEN HOUSE, INC.									x				x			2
WESTSIDE COMMUNITY MENTAL HEALTH CENTER, INC.								x								1

* Other represents a major service category in the REGGIE system. It can include MUNI tokens, Taxi Scripts, Clothing Services, Resource Guide, and Treatment Support.

Data Entry and Cleaning Data

Data from pre-coded questions was entered by Access to Software for All People (ASAP) located in Berkeley. Open ended questions were coded and entered by PCH staff in New York. Most interviews were double punched to check for data entry errors. In addition data was checked for consistency, skip patters, and out-or-range codes through printed output at PCH.

Analysis

Quantitative Analysis

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 shown in Table 2-4 below:

Table 2-4 Analysis Populations

1. Total	6. Geographic Location
2. Gender	6.1 San Francisco County
2.1 Male	6.2 San Mateo County
2.2 Female	6.3 Tenderloin Neighborhood District
2.3 Transgender (TG)	7. Special Populations
3. Mode of Transmission	7.1 Undocumented (Undoc)
3.1 MSM	7.2 Recently Incarcerated (Rec Inc)
3.2 MSM/IDU	7.3 Homeless in last two years
3.3 IDU	8. Location of AIDS Diagnosis
3.4 Heterosexual (HET)*	8.1 EMA
4. Race	8.2 Non-EMA
4.1 African American (AfAm)	9. Medical Visit
4.2 Anglo	9.1 Within last six months (< 6 mos.)
4.3 Asian / Pacific Islander (API)	9.2 Six months or longer (>= 6 mos.)
4.4 Latino	10, Stage of Infection
4.5 Native American (Ntv Am)	10.1 HIV, asymptomatic (H asymp)
5. Age Group	10.2 HIV, symptomatic (H symp)
5.1 24 years or younger (<=24)	10.3 AIDS, asymptomatic (A asymp)
5.2 55 years or older (>=55)	10.4 AIDS, symptomatic (A symp)
*Abbreviations shown in parenthesis are used in Graphics throughout the text	

For the geographic analysis, the needs assessment focused on two of the three counties that make up the San Francisco EMA: San Francisco and San Mateo Counties. Marin County was not included because the county recently completed a comprehensive needs assessment within the county. An additional review of the Tenderloin District in San Francisco was included because it was suspected that the population of PLWH/A residing in this area of San Francisco may have greater needs and barriers to services than other areas of the city.

As noted above, selected populations were over-sampled to assure adequate sample sizes for analysis. For the total sample analysis, subpopulations are weighed back to their proportion in the estimated HIV population. Also when subpopulations are compared, the weighted sample is used. When special populations are analyzed, unweighted data is presented because they are purposefully oversampled to obtain adequate sample sizes for analysis. The population estimates

are based on epidemiological information, and are shown in Table 2-5. The unweighted sample shows the over-sampled populations, while the weighted sample is very close to the projected population estimates of PLWH/A.

The following sections of this report analyze demographics, stage of infection, medication and adherence, outcomes, service needs and unmet needs, and barriers. Selected analysis is shown in graphic and table form in the text. The barrier analysis was based on a multidimensional framework created by PCH using several needs assessment surveys. This analysis is further discussed in the barrier chapter of this report.

For those interested in further analysis of the data, the basic demographic, services and barriers cross tabulations by each of the analysis populations are shown in Attachment 7 through Attachment 11, and they contain a wealth of data not reported in this needs assessment report.

Table 2-5 Sample Frame

		% Total Pop (2001)*	Weighted %	Unweighted	Unweighted N = 572
Gender	Male	92.5%	92.5%	70.5%	403
	Female	5.9%	5.7%	18.5%	106
	Transgender	1.6%	1.8%	11.0%	63
Race	African American	14.6%	14.5%	32.0%	183
	Anglo	68.4%	68.5%	27.8%	159
	Asian/Pacific Islander	3.7%	3.6%	8.7%	50
	Latino	12.8%	12.8%	23.1%	132
	Native American	0.6%	0.6%	6.8%	39
Risk Group**	MSM	74.7%	74.0%	38.6%	221
	MSM/IDU	12.7%	12.8%	26.0%	149
	IDU	10.1%	10.5%	22.6%	129
	HET	2.5%	2.7%	12.8%	73
County	San Francisco	92.0%	93.1%	93.7%	526
	San Mateo	8.0%	6.9%	6.3%	36

* Epidemiological data is based on Surveillance Quarterly Report (December 2001) data.
** The risk categories have been adjusted to exclude "other" modes of exposure.

Qualitative Analysis

Focus group were audio taped, transcribed professionally, and were coded by PCH staff for qualitative analysis. Focus groups were transcribed and coded using the coding scheme shown in Attachment 6. All focus group participants were informed about the purpose and use of the recordings and the confidentiality of all participants was assured. Each comment was coded by relevant demographic group, service, and barrier. Comments are used throughout the report to add depth, reinforce, or emphasize minority positions of PLWH/A.

Study team members sorted these comments based on services and barriers and they were selected for inclusion in the report based on the comments 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. In reading these comments, recall that they are not representative of all PLWH/A.

Provider Information Form Analysis

The intended use of the data in the provider forms was to document the capacity of the continuum of care and the distribution of funding among providers. Data from the provider information forms also provides basic contact for each provider, eligibility for each service, and provider perceptions of barriers to services. Combined with the eligibility and epidemiological information, the information is used in the service templates to derive gaps in services.

The data presented in the service templates provides an estimate of the units of service delivered, clients served, and gap measures. The exact number of clients served and units of services provided by the care system is difficult to calculate. First, not all Ryan White funded providers submitted a completed form. Secondly, data collected from the provider survey relies on self-reports from the agencies and in many instances the data is incomplete. Even when reported, it is clear from the data that the unit of service reported is not always defined in the same way, and data collection by providers is often not very precise. Notably the REGGIE database has 22 codes for unit of service and over 3,800 codes for classifying a "minor" service. Therefore, there is often no direct way to match and verify provider reported numbers with the information entered in the REGGIE database.

All completed provider information forms were entered into an Excel workbook, with multiple worksheets. The worksheets sheets were designed to capture agency-wide information, budget information, client profile by service, service funding, and provider identified barriers.[4] Using REGGIE data, the total number of unduplicated clients served in 2001 and service-specific client and unit counts were verified by PCH with the REGGIE data manager.

Notably, as not all providers returned the provider information forms, the data does not reflect the entire continuum of care, and should be viewed as rough estimates of the capacity of the system. Also, for this needs assessment, no physician nor non-Ryan White provider information is included and they account for substantial capacity in the continuum of care.

[4] The worksheets were designed in a way that they can be readily exported to Access tables and form part of an Access database. The Access database can be used to generate a resource directory with a methodology to update and electronically distribute the resource directory.

3. DEMOGRAPHIC PROFILE OF PLWH/A

Epidemiological Overview[5]

The San Francisco EMA is estimated to have nearly 21,000 people living with HIV infection (Department of Public Health, 2001). AIDS surveillance documents 10,036 people living with AIDS as of June 2000, a 50% increase since 1991. There were 1,483 new AIDS diagnoses in the last two years, or 15% of living AIDS cases. It is estimated that there will be 1,084 new HIV infections during 2001 in San Francisco County alone. Nearly 50% of PLWH are diagnosed with AIDS, a higher proportion than many other EMAs, reflecting a population that has been infected longer, is sicker, and in need of more services per capita than many other areas (DPH, 2001).

The EMA includes San Francisco, San Mateo, and Marin Counties. Eighty-six percent of living AIDS cases are in San Francisco, with seven percent each in San Mateo and Marin. In San Francisco alone 10,657 PLWH are enrolled in the Reggie database of CARE-funded services, indicating that they meet CARE eligibility criteria (Reggie, 2001). The HIV prevalence rate for the EMA is 1.2% and for San Francisco it is 2.3%, indicating that one out of 43 people is HIV positive.

Within its relatively small geographical area, the San Francisco EMA has an ethnically diverse population that is 51% white, 5% African American, 17% Latino, 24% Asian/Pacific Islander, less than 1% Native American and 3% multi-ethnic and other ethnicities (Census Bureau, 2001). People of color are the majority population in San Francisco and 50% of the population in San Mateo County. Asian/Pacific Islanders are the largest people of color group in San Francisco at 31%, and Latinos are the largest in both San Mateo and Marin, with 22% and 11% respectively. Over 10,000 immigrants a year are admitted to San Francisco and well over a third of San Franciscans were born in another country (Census, 1990).

The distribution of AIDS cases in the EMA as of June 2000 was 67% white, 16% African American, 13% Latino, 4% Asian and Pacific Islander, and 1% Native American. The estimated distribution of HIV infection (non-AIDS) is similar to the distribution of AIDS cases: 64% white, 18% African American, 13% Latino, 4% Asian/Pacific Islander, and 2% Native American. African Americans and Latinos are a larger proportion of new AIDS cases, with 23% and 15% of new cases respectively. Because of the large numbers of persons infected among communities of color, the African American Communities and Latino Communities are discussed in more detail below.

<u>African Americans</u>

African Americans and whites are both disproportionately infected with HIV when compared to their share of the total population, and Native Americans have a slightly higher proportion of

[5] This profile is largely taken from the Fiscal Year 2002 Application for Gant Funds Under Title I, Ryan White Comprehensive AID Resources Emergency Act.

HIV cases. People of color, especially African Americans, make up an increasing percentage of new AIDS cases and estimated HIV infections in San Francisco. One-third of all PLWH are people of color. The proportion of new people of color AIDS cases has increased over the years. In San Francisco, people of color were 18% of all AIDS cases prior to 1990, but 43% of new cases diagnosed in 2000 (DPH, 2001). People of color make up 38% of clients receiving Title I-funded services in San Francisco, as reported by the Reggie system. African Americans and Latinos together make up 88% of all people of color cases.

African American are the most vulnerable to HIV infection and AIDS. A disproportionate number of HIV/AIDS cases are among African Americans: African Americans comprise only 5% of the San Francisco EMA's population yet 16% of living AIDS cases, 18% of estimated HIV infections, and 23% of people newly diagnosed with AIDS.

Sub-populations within the African American community have been hit even harder. A recent study of transgender individuals in San Francisco found an unprecedented 62% seroprevalence rate among male-to-female transgender African Americans (Clements, 1999). Forty-seven percent of women living with AIDS in San Francisco are African American, compared to only 13% of men living with AIDS. African American women in particular are hard hit, accounting for 47% of all cases of AIDS among women in San Francisco. Seroprevalence rates in childbearing women were three times higher in African American women than whites (SCBW, 1995). In addition, African American women are 53% of the women infected through injection drug use.

Latino/Hispanic

Latinos are not disproportionately affected by HIV, but do comprise a significant number of people with HIV/AIDS. An estimated 2,723 Latinos are living with HIV/AIDS in the San Francisco EMA, making up 13% of the total. Latinos are 17% of the EMA population, 13% of those living with AIDS and 13% of estimated HIV infections. Latinos account for 15% of AIDS cases diagnosed in the last two years, slightly below their proportion in the general population. They are over-represented among transgender persons , women, and heterosexual men with AIDS. Latinos comprise 13% of CARE clients (Reggie, 2001). Latinas are 14% of cases among women but they are disproportionately represented among women who are **not** IDUs, with 21% of living cases.

There is great diversity within the Latino communities in San Francisco. Many Latinos in the Bay Area have immigrated from Central and South America, particularly from Mexico, Guatemala, El Salvador, and Nicaragua. Undocumented immigrants are undercounted in most surveys due to fear of being identified to immigration officials. Although efforts were made in the needs assessment to recruit undocumented, it is difficult to get accurate information on the numbers of immigrants and their seroprevalence rates.

Men Who Have Sex With Men (MSM)

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 do not. MSM are 86% of living AIDS cases in San Francisco, 72% in San Mateo, and 60% in Marin. The most recent HIV prevalence and incidence estimates produced by DPH project a significant increase in new HIV infections among MSM in San Francisco, especially MSM/IDU. Infection rates have doubled since 1997. Multiple studies have shown increasing risk behaviors, such as unprotected sex, increasing independent markers for risky sex such as sexually transmitted diseases, and increasing seroincidence and seroprevalence.

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 half of all injection-related HIV cases in the EMA, compared to only 6% of national cases. An estimated 40% of all MSM/IDU in San Francisco are already HIV positive, and they have the highest incidence at 4.6% of any risk group. That is twice as high as the incidence estimated for MSM/IDU in 1997, representing a significant increase in infections from 53 per year to 144 per year for 2001. MSM and MSM/IDU are both heavily disproportionately affected by HIV: gay and bisexual men are estimated to be four percent of the EMA population, yet 83% of all living HIV/AIDS cases and 73% of new AIDS cases.

Needs Assessment Sample Description

Table 3-1 shows the total weighted survey sample of the 572 PLWH/A who participated in the consumer survey, representing San Francisco and San Mateo County. In this demographic analysis, the weighted sample is used because it is representative of the proportion of the PLWH/A in each demographic category. It is important to note that the actual number of completed survey's in some instances is larger than the number represented in the weighted sample. For example, 39 Native Americans were interviewed, but by weighting Native Americans back to their proportion in the population, they are shown as having a weighted sample size (N) of 4. This means that the data from all 39 PLWH/A who are Native American are represented proportionally in the final report. [6] The same logic is applied to other population that were oversampled.

Below are some highlights of the demographic analysis:

- The total weighted sample consists of 92% males, 6% females, and 2% transgender, reflecting the latest epidemiological figures.
- The majority of the PLWH/A is non-Latino Anglo (69%), followed by African Americans (14%), Latinos (13%), Asian/Pacific Islanders (4%), and Native Americans (<1%).
- People of color as a group, including African Americans, Latinos, Native Americans, and Asian/Pacific Islanders, represent 32% of PLWH/A.
- MSM represent the largest proportion of PLWH/A at 74%, followed by MSM/IDU at 13%, (non-MSM) IDUs at 11%, and heterosexuals at 3%.

[6] Although the weighting process shows a Native American N of 4, the process of weighting does not ignore the remaining 35 Native Americans. Each of their responses are used in making an estimate, just at a fraction of their unweighted value – thus the answer is more accurate. When only Native Americans are described – not as part of the all PLWH/A, the unweighted N is used for analysis.

- PLWA represent 59% of the sample and PLWH account for 41% of the sample. There is no epidemiological information to verify this break, but it is logical given that San Francisco was an early epicenter of the epidemic and consequently has more PLWA than newer EMAs
- The majority of the sample live in San Francisco (92%), followed by 7% from San Mateo and approximately 1% from Alameda and Contra Costa counties. Although the latter two counties are not part of the San Francisco EMA, we included these few surveys to demonstrate that some PLWH/A outside the San Francisco EMA are traveling to San Francisco to receive services.

Table 3-1 Demographic Analysis (N=572)

	Total		AfAm		Anglo		API		Latino		Native Am	
	N*	Col %	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
TOTAL	**572**	**100.0****	**83**	**14.5**	**392**	**68.5**	**20**	**3.6**	**73**	**12.8**	**4**	**0.6**
Male	529	92.5	64	77.3	379	96.8	17	85.2	66	89.9	3	78.3
Female	32	5.7	14	16.8	10	2.7	2	11.0	5	7.2	0	12.4
Transgender	10	1.8	5	5.9	2	0.6	1	3.8	2	2.8	0	9.2
MSM	423	74.0	36	43.2	316	80.8	15	72.7	55	74.6	1	36.9
MSM/IDU	73	12.8	15	18.0	48	12.1	1	6.5	8	11.2	1	33.8
IDU	60	10.5	28	33.6	24	6.0	1	5.2	7	9.1	1	26.6
Heterosexual	16	2.7	4	5.2	4	1.1	3	15.7	4	5.1	0	2.8
San Francisco	525	91.8	58	70.6	384	97.9	17	84.4	62	84.7	4	98.6
San Mateo	41	7.2	23	27.7	7	1.9	3	12.5	9	11.7	0	0.0
HIV asymp	144	25.2	25	29.9	93	23.7	4	19.9	22	29.9	0	13.1
HIV symp	89	15.6	19	23.2	57	14.5	4	19.4	8	11.0	1	27.3
AIDS asymp	82	14.3	10	11.9	46	11.7	4	18.6	22	30.1	0	6.1
AIDS symp	257	44.9	29	35.0	196	50.1	9	42.2	21	29.0	2	53.5

*Weighted N (see Table 2-5 for actual number of persons interviewed)
** May not always add to 100% due to rounding error.

Women

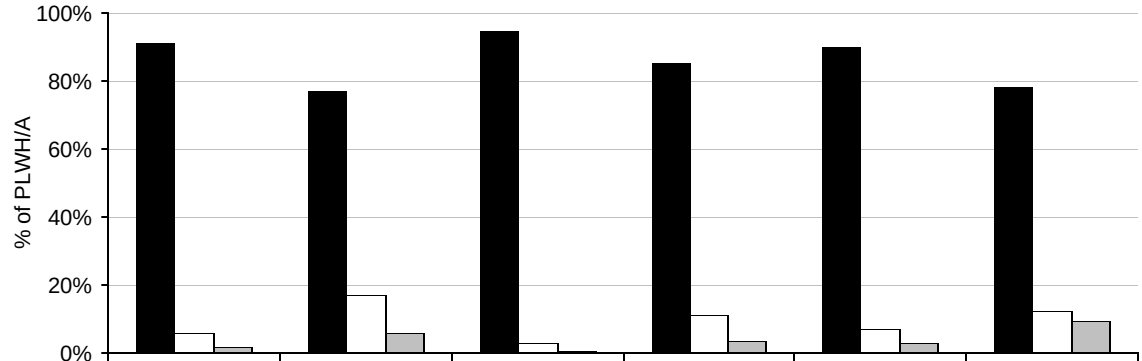
Figure 3-1 shows that women represent 6% of the PLWH/A sample, yet, among ethnic groups, women make up the largest percentage of the African American population at 17% and the smallest percent of the Anglo population at 3%. Women also represent a much larger proportion of the San Mateo sample (40%) than the San Francisco sample (3%). This analysis will reflect this over-representation of women from San Mateo.

Figure 3-2 further shows that women represent 72% of the heterosexuals, and 35% of the IDUs. It also shows that among the various stages of disease women account for about 6% of cases, with a greater representation of women among the symptomatic PLWA. However, not shown in the graph but shown in Attachment 7 is that women living with HIV are about evenly split between asymptomatic (22%) and symptomatic (16%), but women living with AIDS are much more likely to be symptomatic (45%) than asymptomatic (16%).

Attachment 7 also shows that women are much less likely to live alone than either males or transgender persons. Women are more likely than males to have lived with HIV from six to

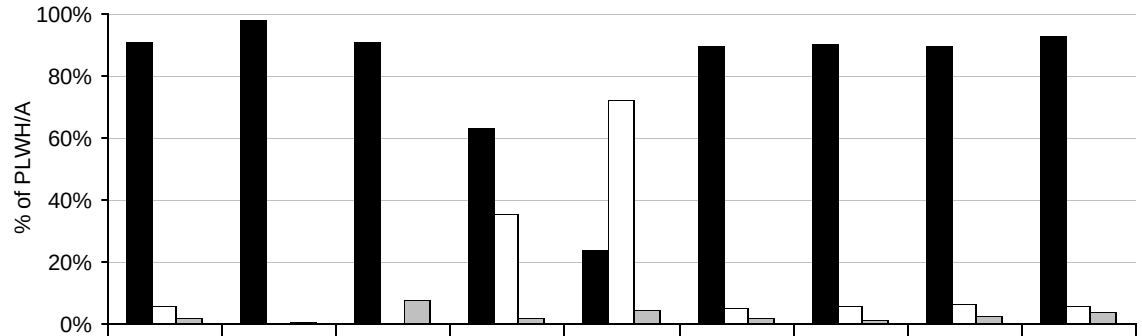
twelve years, and males and transgender persons are more likely to have lived with HIV for over 12 years. Female PLWH/A are more likely to have been diagnosed with depression and anxiety than either males or transgender persons. Women are disproportionately infected with Hepatitis C; nearly 61% of women living with HIV are infected with Hepatitis C, in contrast to 20% of the men. This is not surprising as women are much more likely than men to have contracted HIV through IDU or sex with an IDU partner, and over three quarters of those infected through IDU report Hepatitis C. About 25% of women living with HIV and AIDS report Hepatitis A or B. These rates are much higher than those for either males or transgender persons. Of particular note, more women indicate living in a homeless shelter in the previous month than did both males and transgender persons.

Figure 3-1 Gender by Mode and Ethnicity



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
Male	91.3%	77.3%	94.9%	85.2%	89.9%	78.3%
Female	5.7%	16.8%	2.7%	11.0%	7.2%	12.4%
TG	1.8%	5.9%	0.6%	3.8%	2.8%	9.2%

Figure 3-2 Gender by Mode and Stage of Infection



	TOTAL	MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
Male	91.3%	97.8%	90.9%	63.0%	23.7%	89.5%	90.6%	89.8%	92.9%
Female	5.7%	0.0%	0.0%	35.4%	72.1%	5.0%	6.0%	6.5%	5.7%
TG	1.8%	0.6%	7.8%	1.6%	4.2%	1.8%	1.0%	2.5%	3.7%

Transgender persons

Transgender persons, both male-to-female and female-to-male, make up under 2% of the overall sample, as shown in Figure 3-1. In order to conduct an analysis of transgender persons, they were oversampled. Eleven percent of the sample in San Francisco and six percent of the sample in San Mateo are transgender. The transgender group was not recruited randomly and may not be representative of all transgender persons in the San Francisco EMA. In the sample transgender persons are disproportionately Native American, African American, and MSM/IDU. They are more likely to be living with AIDS, either asymptomatic or symptomatic, than HIV.

Based on data from Attachment 7, transgender persons appear to be among the most vulnerable to infection and have a high level of need for treatment.

- Over three-quarters of transgender persons are people of color. In the sample, 47%, of Transgender persons are African American/Black, 22% Anglo, 20% Latino, and 7% are API, and 3% are Native American.
- Nearly 80% of transgender persons indicated that they became infected through sexual contact with a man, and 14% report their mode of transmission as injecting drugs.
- Transgender persons are much more likely to be currently homeless (that is, living on the street or in a car) than either males or females, and they are more likely to have a history of homeless in the last two years.
- Transgender persons reported a much higher rate of contact with the criminal justice system than did males or females.
- After first finding out they were HIV infected, transgender persons were more likely to wait over one year to see a medical care provider compared to males or females.
- Nearly 50% of transgender persons have gone for a period of six months or longer without seeing a medical provider compared to 19% of males and 17% of females.
- Compared to males and females, transgender persons are more likely to have stopped taking their HIV medications.

Ethnicity/Race and Mode of Transmission

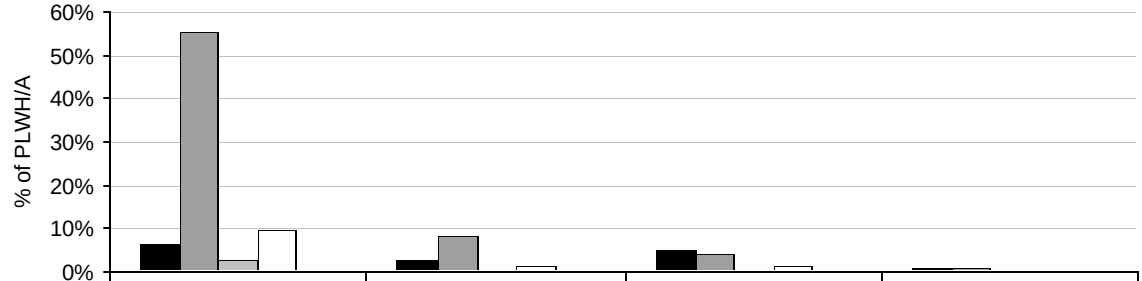
Figure 3-3 shows the overall proportion of each of the ethnic groups within each risk group. The total of all the bars for each group will equal its proportion in the population, for example, the MSM bars will show that 74% of all PLWH/A are MSM. Figure 3-3 indicates that:

- Among the total weighted sample, the largest numbers of PLWH/A are Anglo MSM (55%), followed by Latino MSM (10%), and Anglo MSM/IDU (8%).
- IDUs represent 11% of all PLWH/A and are concentrated among African Americans (5%) and Anglos (4%), while the majority of MSM/IDU are Anglo.
- Heterosexuals represent 3% of all PLWH/A. They are fairly equally divided among African Americans, Anglos, Asian/Pacific Islanders, and Latinos.

Based on data in Attachment 7:

- MSM represent the largest proportion of PLWH/A in all ethnic groups. MSM represent 81% of Anglos and 73% of APIs living with HIV/AIDS. Native Americans report the lowest number of MSM, 37%.
- Transgender persons are more likely to be IDUs in every ethnic group. Among Native Americans, 100% of transgender persons are IDUs.
- In nearly every ethnic group, the largest proportion of women are injection drug users. Within the Native American population, 89% of women are IDUs, the highest of all ethnic groups. Only among Asian/Pacific Islander do the majority of women (85%) report heterosexual contact as their mode of transmission.
- African Americans make up the largest percent of homeless PLWH/A population (55%) and those recently incarcerated (44%). Half of all people who are currently out-of-care are African Americans.
- More than 10% of the Native American and Anglo populations are currently homeless.

Figure 3-3 Ethnicity by Mode of Transmission



	MSM	MSM/IDU	IDU	Het
Af Am	6.2%	2.6%	4.9%	0.7%
Anglo	55.3%	8.3%	4.1%	0.7%
API	2.6%	0.2%	0.2%	0.6%
Latino	9.6%	1.4%	1.2%	0.6%
Ntv Am	0.2%	0.2%	0.2%	0.0%

Education

Sixty-two percent (62%) of the PLWH/A have some college, completed a four year college degree, or have graduate school experience. Twenty-six percent (26%) of PLWH/A have gone no further than high school.

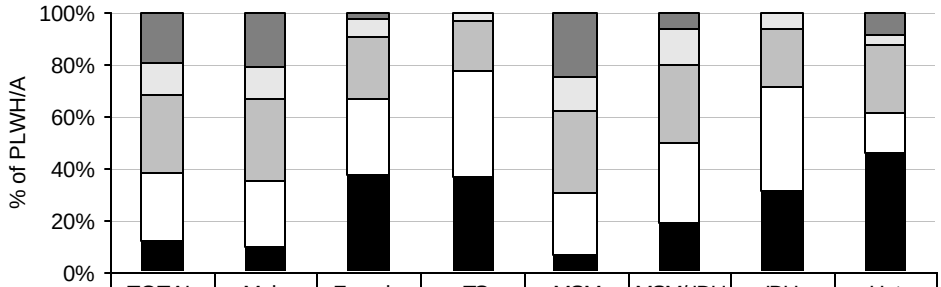
Figure 3-4 shows the different levels of education for gender and ethnic groups. It indicates that:

- Among gender groups, males have the highest education levels with 21% having graduate school experience compared to 2% of females and 0% of transgender persons. Transgender persons are more likely to have received a high school diploma (40%) compared to both males (26%) and females (29%).
- Among risk groups, heterosexuals and IDUs have the lowest level of education. MSM and MSM/IDU have the highest level of education, with 13% of MSM and 14% of MSM/IDU reporting that they have a four year college degree, compared to 7% for IDUs and 4% for heterosexuals.

Figure 3-5 shows educational levels across the ethnic/racial categories. The data indicate that:

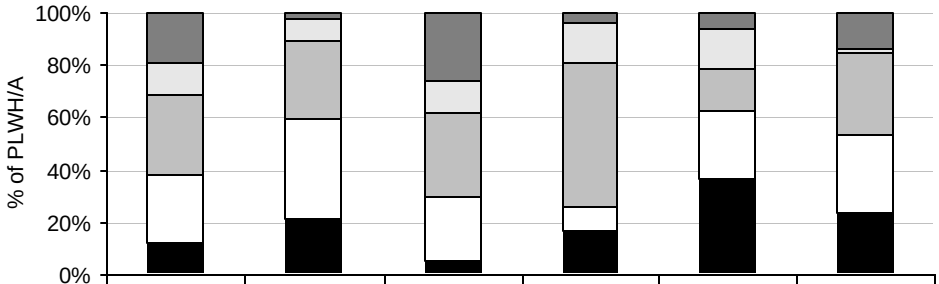
- Anglos have the highest rate of education with over 38% reporting a college education. Native Americans also have a relatively large percentage in graduate school (14%).
- Latinos are least educated with 30% reporting a high school education or less.
- APIs tend to report some college, but are less likely than Anglos to have graduate school.
- African Americans represent the largest group having completed high school and not gone to college.

Figure 3-4 Level of Education by Gender and Mode



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het
Graduate School	19.1%	20.5%	2.3%	0.0%	24.4%	6.2%	0.0%	8.2%
Completed College	12.3%	12.8%	6.6%	3.2%	13.1%	13.8%	6.5%	3.9%
Some College / Tech school	30.5%	31.0%	24.4%	19.3%	31.9%	29.8%	21.9%	26.4%
Graduated High School/GED	26.2%	25.7%	28.8%	40.3%	23.7%	31.0%	40.3%	15.6%
Some High School or Less	12.0%	9.9%	37.9%	37.1%	6.8%	19.2%	31.3%	46.0%

Figure 3-5 Level of Education by Race



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
Graduate School	19.1%	2.5%	25.9%	3.7%	6.1%	13.8%
Completed College	12.3%	8.2%	12.5%	15.7%	15.2%	1.4%
Some College / Tech school	30.5%	29.7%	32.1%	54.9%	15.8%	31.5%
Graduated High School/GED	26.2%	38.4%	24.5%	8.9%	26.2%	29.3%
Some High School or Less	12.0%	21.1%	5.1%	16.7%	36.7%	24.0%

Data from Attachment 7 further indicates that:

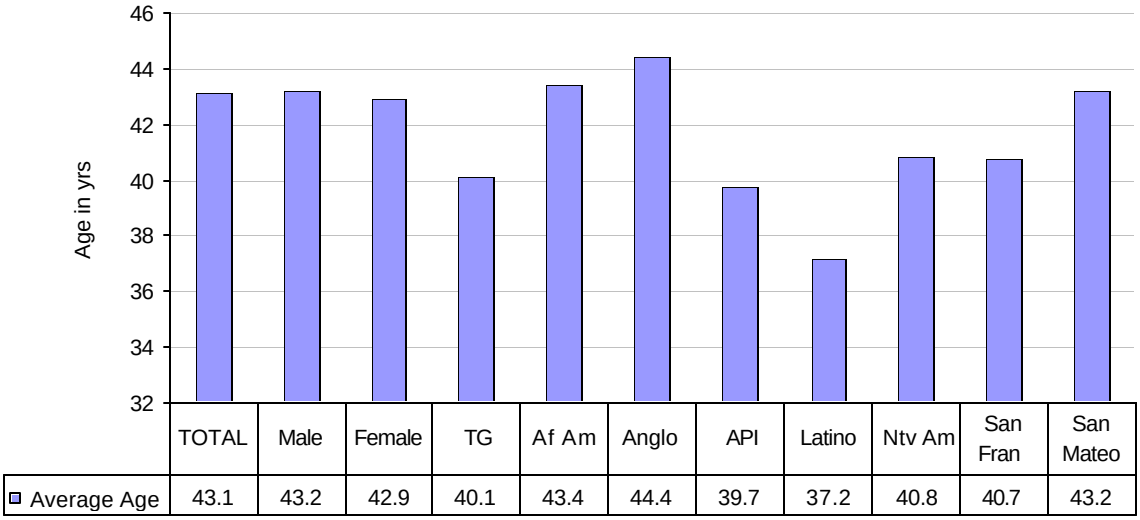
- Persons in-care have a higher education level. Persons who are currently out-of-care are more likely to have completed high school (39%) than persons who are in care (28%), but persons in care are more likely to have received a four year college degree (11%) than persons who are out-of-care (5%).
- Among special populations, the undocumented have the lowest level of education, and about a third of the undocumented, recently incarcerated and currently homeless report having a high school education.

Age Distribution

The average age of PLWH/A is 43 years, and 86% of the PLWH/A are between the ages of 25 and 54 years old, with 12% being over 55. Figure 3-6 shows the average age by gender, race/ethnicity, and location and Figure 3-7 shows the average age by mode and race/ethnicity. The data indicates:

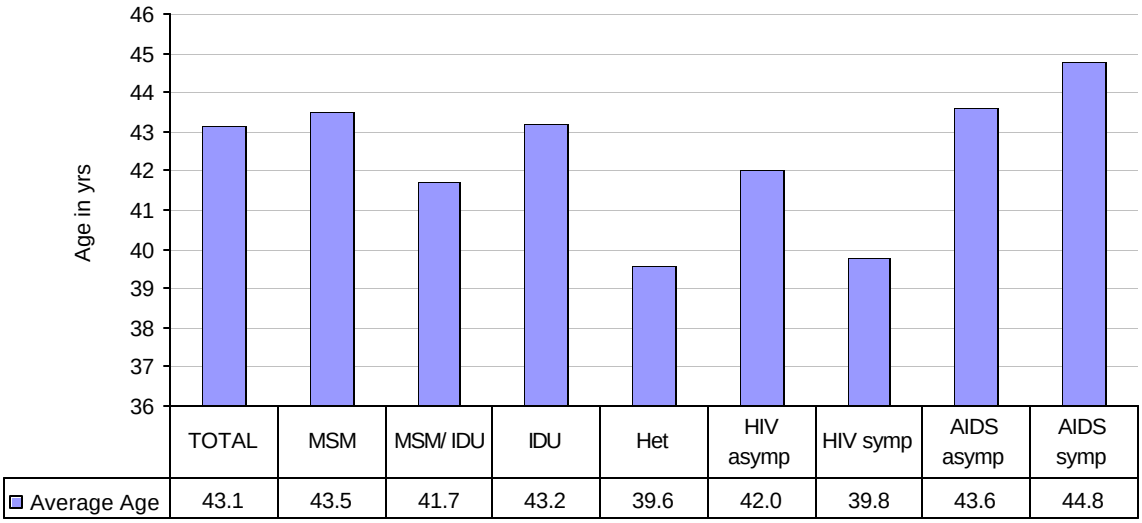
- Among the ethnic populations, Latinos are the youngest, with 6% below the age of 24.
- Amongst risk groups, heterosexuals are the youngest, averaging 40 years old.
- Persons living with AIDS who are symptomatic are older than those living with AIDS who are asymptomatic and those living with HIV who are either symptomatic or asymptomatic.

Figure 3-6 Average Age by Gender, Ethnicity and Location



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	San Fran	San Mateo
Average Age	43.1	43.2	42.9	40.1	43.4	44.4	39.7	37.2	40.8	40.7	43.2

Figure 3-7 Age by Mode and Stage of Infection



	TOTAL	MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
Average Age	43.1	43.5	41.7	43.2	39.6	42.0	39.8	43.6	44.8

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. Those who are married or living with partners often have a caregiver, but also may have larger financial needs if the partner is not working or disabled. Those PLWH/A with families also have particular needs, including day care and services for children when seeking care.

As shown in Attachment 7, 51% of PLWH/A report living alone, with 49% reporting living with others, either adults or children. More females live with others (79%) compared to males (47%)

and transgender persons (42%). Over 60% of PLWH/A are living with another HIV positive person in their household.

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 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 3% of the sample reports making over $35,000, making the vast majority eligible for Ryan White care services including ADAP.

Figure 3-8 shows income levels by gender and mode. It indicates that:

- In general, the participating PLWH/A have low incomes, with about 75% reporting earning less than $16,500 and approximately 36% reporting earning less than $8,600.
- Females report significantly lower income than males. Transgender persons report the lowest income of any gender group with 69% earning $8,600 or less per year compared to 34% of males and 47% of females.
- Among risk groups, the vast majority of IDUs (93%) and MSM/IDU (87%) have incomes of $16,500 or less per year. MSM have the highest income with 21% making more than $23,000 followed by heterosexuals (15%) MSM/IDU (11%,) and IDU (6%). While MSM living with HIV/AIDS are at every income level, heterosexuals tend to be very poor or have incomes above $16,500. However, even among MSM, less than 3% report earning more then $35,000 – the usual limit to qualify for ADAP.

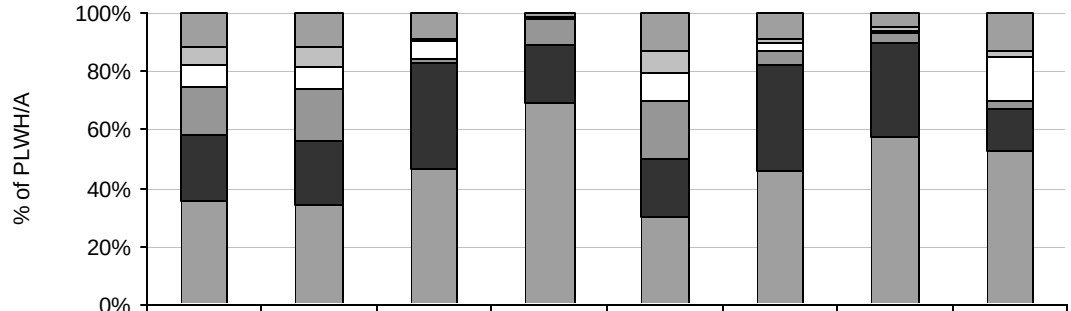
Figure 3-9 shows income by ethnicity. This graphic indicates that:

- Over half the Latinos and African Americans report earning $8,600 per year or less.
- Asian/Pacific Islanders and Anglos report the highest income of any group, with 17% of API's and 13% of Anglos earning $26,000 or more per year.

Data in Attachment 7 further indicate:

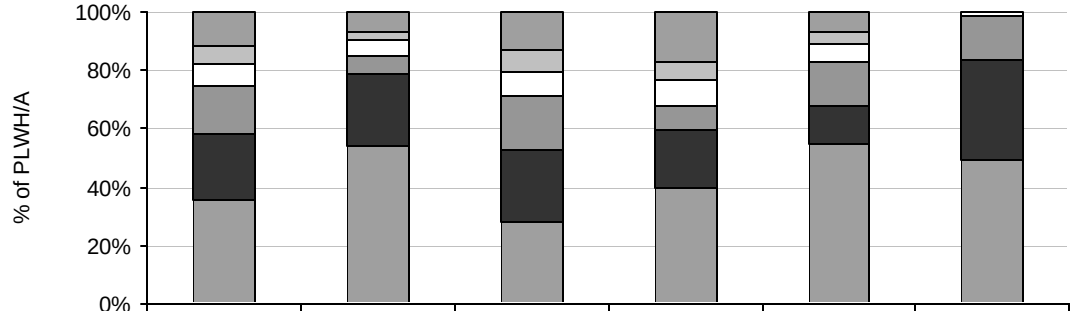
- Over 90% of the homeless and recently incarcerated report earning less than $11,600 a year with over two-thirds reporting earning less than $8,600 a year.
- HIV asymptomatic report the lowest income, suggesting that the newly infected are from the lowest socio-economic brackets, and are coming into the epidemic with a high level of need of social and medical services.
- Persons who are currently out-of-care have a lower income that persons in care.

Figure 3-8 Income by Gender and Mode



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het
$26,001 or more	11.6%	12.0%	9.1%	1.1%	13.0%	8.8%	5.0%	13.1%
$23,201 - $26,000	5.9%	6.4%	0.8%	1.1%	7.5%	1.7%	1.3%	2.2%
$16,501 - $23,200	7.7%	8.0%	6.1%	0.0%	9.4%	2.2%	0.3%	15.1%
$11,601 - $16,500	16.2%	17.3%	1.1%	8.6%	20.3%	5.2%	3.9%	2.7%
$8,601 - $11,600	22.9%	22.2%	36.0%	20.4%	19.7%	35.9%	32.0%	14.3%
$8,600 or less	35.6%	34.3%	46.8%	68.9%	30.0%	46.2%	57.4%	52.7%

Figure 3-9 Income by Ethnicity



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
$26,001 or more	11.6%	6.7%	13.3%	17.3%	7.2%	0.0%
$23,201 - $26,000	5.9%	2.9%	7.0%	5.8%	3.7%	0.0%
$16,501 - $23,200	7.7%	5.3%	8.5%	8.9%	6.2%	1.4%
$11,601 - $16,500	16.2%	6.6%	18.8%	8.4%	15.4%	14.9%
$8,601 - $11,600	22.9%	24.6%	24.5%	19.7%	12.8%	34.7%
$8,600 or less	35.6%	53.9%	27.9%	40.0%	54.8%	49.0%

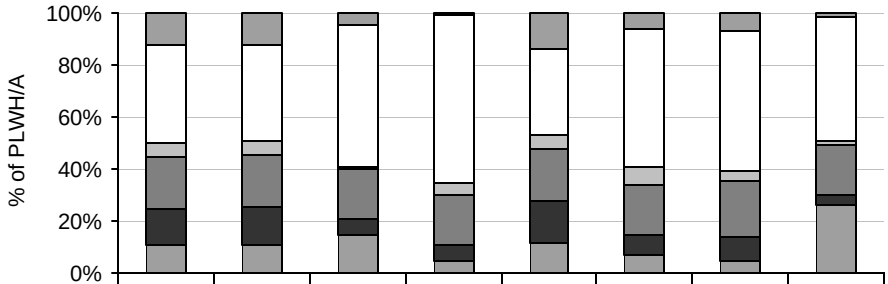
Employment Status

Figure 3-10 and Figure 3-11 show employment status by gender and mode and by ethnicity. The figures show the following:

- The majority of PLWH/A are not currently working (63%). Twenty percent (20%) of those not working are actively looking for work, 5% are students or homemakers, and 38% are not looking for work. Twelve percent of the sample is retired and 25% are either employed part- or full-time.
- More women (55%) and transgender persons (64%) are not working and not looking for work than are men (36%), and more women are employed full time (14.5%) than men (10.4%).
- Among risk groups, heterosexuals have the highest percent of persons employed full-time (27%), followed by MSM (11%), MSM/IDU (7%), and IDUs (5%).
- Among ethnic populations, APIs have the highest percent of PLWH/A who are currently employed full-time at 33%. Native Americans have the lowest percent of persons employed full-time at 3%.
- More Latinos (29%) report looking for work than any other ethnic group.

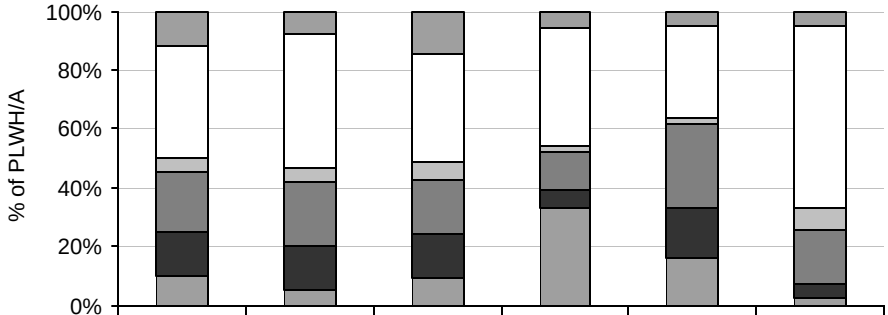
Data from Attachment 7 further indicates that persons homeless and those recently incarcerated are more likely to be unemployed and not looking for work. Interestingly, being symptomatic is a better indication being out of work and not looking for work than having AIDS. Over 40% of HIV symptomatic (43%) and AIDS symptomatic (46%) report not working and not looking for work. Slightly more HIV symptomatic individuals are employed full time (10%) than AIDS symptomatic individuals (6%). Among asymptomatic individuals, those with AIDS are slightly more likely to be looking for work and working than those with HIV.

Figure 3-10 Employment Status by Gender and Mode



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het
Retired	12.0%	12.6%	4.3%	1.1%	14.1%	6.2%	7.1%	1.3%
Not working - not looking for work	37.8%	36.3%	54.6%	64.2%	32.5%	53.2%	53.5%	47.9%
Not working - student/homemaker	5.3%	5.6%	1.4%	4.3%	5.4%	6.4%	4.3%	1.6%
Not working - looking for work	20.2%	20.3%	18.5%	19.5%	20.2%	19.3%	20.9%	19.2%
Employed part-time	14.2%	14.8%	6.6%	6.5%	16.3%	8.1%	9.6%	3.6%
Employed full-time	10.5%	10.4%	14.5%	4.3%	11.4%	6.8%	4.6%	26.5%

Figure 3-11 Employment Status by Ethnicity



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
Retired	12.0%	7.7%	14.7%	5.2%	4.6%	4.6%
Not working - not looking for work	37.8%	45.7%	36.8%	40.4%	32.0%	62.4%
Not working - student/homemaker	5.3%	4.9%	6.3%	2.6%	1.5%	7.7%
Not working - looking for work	20.2%	21.7%	18.6%	12.5%	29.0%	18.1%
Employed part-time	14.2%	14.6%	14.1%	6.3%	17.3%	4.5%
Employed full-time	10.5%	5.4%	9.6%	33.0%	15.6%	2.8%

4. CO-MORBIDITIES

The co-morbidities of homelessness, mental illness, STD's, TB, and drug use are discussed in this section.

Housing & 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 and inconsistent access to food and proper nutrition further aggravates the difficulty adhering to medications.

The 2000 US Census reports that San Francisco is one of the most densely populated large cities in the United States, second only to New York. With market rate rent levels increasing over recent years, San Francisco is considered one of the most expensive areas of the country in which to live. In addition, the scarcity of affordable housing and the very low vacancy rate for any type of housing make it very difficult for low income individuals to find suitable housing.

Federal affordability guidelines consider housing to be "affordable" if households spend no more than 30% of their gross monthly income on all housing costs, including utilities. According to the 1990 Census, 38% of San Francisco households at all income levels expended 30% or more of their gross income on housing costs. Rents greater than 30% of income are a greater burden for low-income households. The Census reports that among extremely-low income households, three quarters paid more than 30% of their income for housing, and 55% paid more than 50% of their income for housing. In the 2001 Needs Assessment survey, among participants within the 400% poverty level, over 55% report paying more than 30% of their income for housing. On average, the PLWH/A report paying about 33% of their income for housing. Almost five percent reporting rent expenses exceeding their annual income, and while this may indicate inaccurate reporting of annual household income, it does suggest that for many living with HIV, rent is their main expense.

According to the 2000 AIDS Surveillance Report, the proportion of PLWA who are homeless at the time of diagnosis has continued to increase since 1990. In 2000, fifteen percent (15%) of the individuals newly diagnosed with AIDS were homeless. The 2002 Needs Assessment survey further supports this finding and indicates that among the PLWA diagnosed in 2000 or later, 19% are currently homeless and an additional 37% report living in some form of transitional housing. Transitional housing includes living in a single room occupancy (SRO) with or without tenancy, living in a group home or residence including residential drug therapy, a half-way house, or transitional housing. The survey data further indicates that the newly diagnosed PLWA are more likely to be homeless, as the newly infected are more concentrated among lower income individuals.

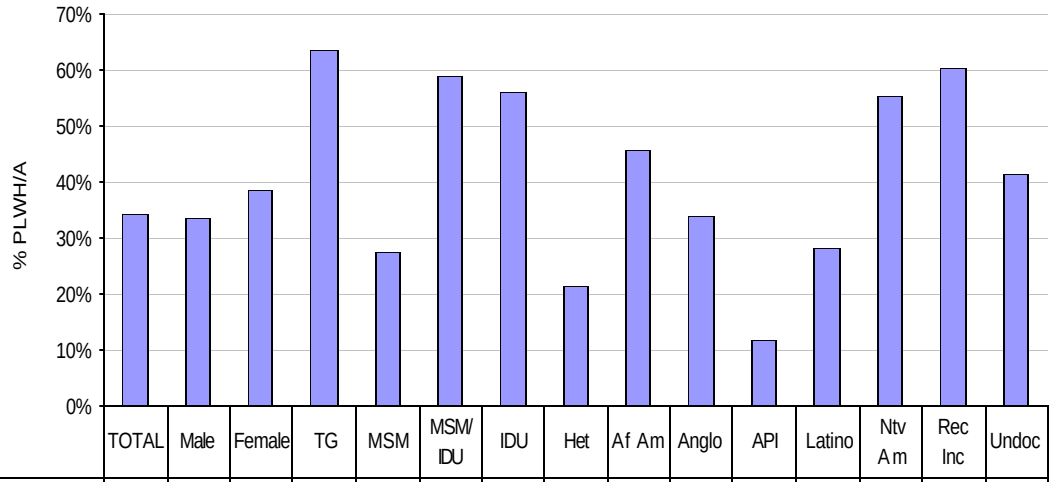
The Section 8 housing waiting list offers some hope for many PLWH/A of finding housing. However, it is difficult to predict how long a person will have to wait. Section 8 housing is often closed for enrollment, then there is a lottery for all those needing housing when it opens. Once enrolled, there can be a substantial wait. For instance if a person is ranked in the first 5000

positions on the list, that person can expect to hear from the SFHA within one year. After that, the waiting time will be an average of six months for each 500 additional families on the list. For example, number 6000 on the list can expect to wait a minimum of two years.
As a result, housing continues to be needed for people living with HIV/AIDS in the city.

The Housing Opportunities for Persons with AIDS (HOPWA) program, enacted as part of the National Affordable Housing Act in 1990, distributes funds based on a federal formula to jurisdictions with the largest number of reported AIDS cases. In 2001, San Francisco received approximately $9,600,000 in HOPWA funds. HOPWA funds can be used for various housing activities, including capital, supportive services, rental assistance, and technical assistance. Capital activities include acquisition, rehabilitation, conversion, new construction, or leasing. In the 2001 needs assessment, about 17% of the PLWH/A report receiving HOPWA subsidy or some other type of subsized housing.

Figure 4-1 shows that among all PLWH/A, transgender persons, African Americans, recently incarcerated, IDUs, and those out-of-care for six months or longer are more likely to be currently homeless. Attachment 7 further indicates that, transgender persons, Native Americans, MSM/IDU, under 24 year olds (Youth), those living in the Tenderloin and those diagnosed with AIDS outside of the EMA are more likely to live in transitional housing than other populations.

Figure 4-1 Currently Homeless or In Transition



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het	Af Am	Anglo	API	Latino	Ntv Am	Rec Inc	Undoc
Homeless/Transitional	34.3%	33.5%	38.5%	63.5%	27.5%	59.0%	56.0%	21.3%	45.8%	34.1%	11.7%	28.1%	55.5%	60.4%	41.3%

The instability of housing becomes more evident when PLWH/A are asked if they have been homeless or in transitional housing in the last two years. Of the PLWH/A interviewed, 29% have been homeless sometime in the last two years, and 20% have lived in some form of transitional housing.

Figure 4-2 and Figure 4-3 confirms:

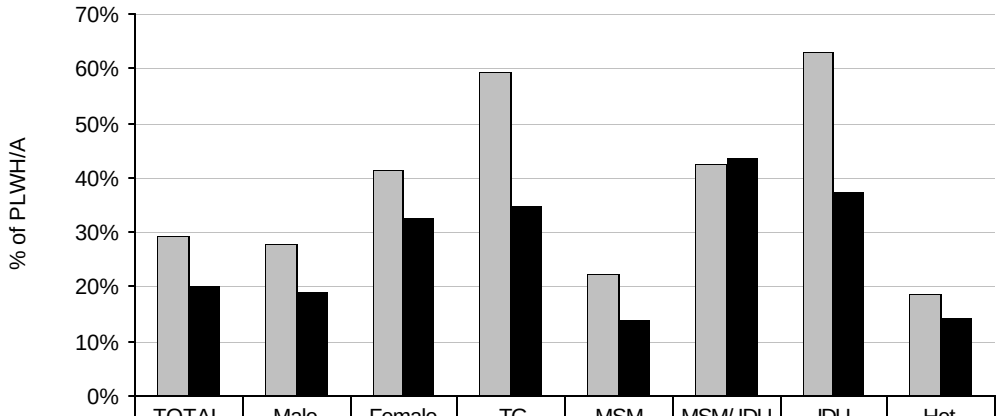
- Men are less likely to have a history of homelessness or living in transitional housing than women or transgender persons.

- African Americans are more likely to have a history of unstable housing and live in transitional housing than other ethnic groups.
- Among risk groups, IDUs and MSM/IDU are much more likely to have been homeless or lived in transitional housing than MSM or heterosexuals.
- Recently incarcerated PLWH/A are far more likely to experience a period of homelessness than other populations. Nineteen percent (19%) of all PLWH/A report having a history of being homeless compared to 77% of those who have been incarcerated in the last two years. This may reflect the financial challenges and rules and regulations of public housing one faces after being released from the jail system.
- APIs (8%) and Latinos (17%) report a much lower incidence of homelessness.

Attachment 7 further indicates that:

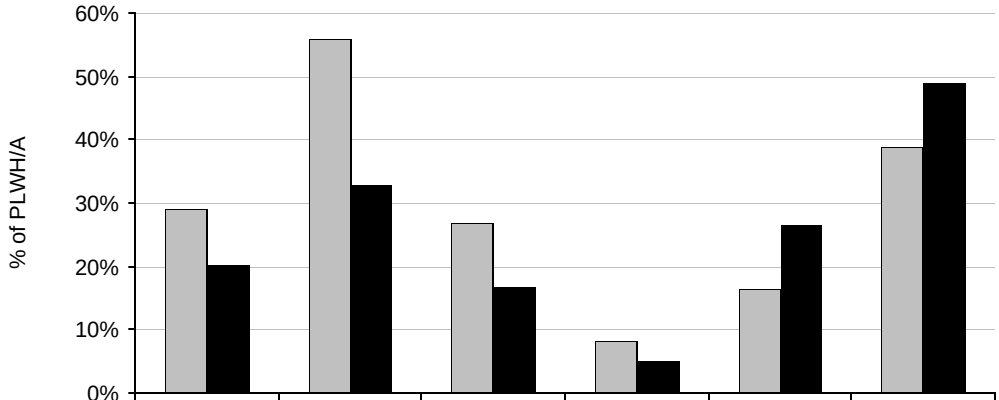
- About half (52%) of the out-of-care and symptomatic PLWH (49%) report being homeless in the last two years.
- Almost half of the newly diagnosed PLWA have been homeless for some length of time since being diagnosed. This again highlights the heightened vulnerability of and greater need of this population.

Figure 4-2 Homelessness & Transitional Housing by Gender and Mode



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het
% w/ homeless history	29.2%	27.8%	41.5%	59.2%	22.4%	42.5%	63.0%	18.8%
% w/ transitional history	20.1%	19.0%	32.5%	35.0%	13.8%	43.6%	37.4%	14.4%

Figure 4-3 Homelessness & Transitional Housing by Ethnicity



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
% w/ homeless history	29.2%	55.8%	26.9%	8.3%	16.6%	38.9%
% w/ transitional history	20.1%	32.9%	16.7%	4.9%	26.4%	48.8%

Substance Abuse

The co-morbidity of substance use and HIV includes drugs that are typically injected such as heroin and crystal meth, but also includes non-injecting substances such as marijuana and "party drugs" such as ecstasy and poppers that have been related to unsafe sexual practices that place individuals at high risk for HIV infection.

The First Quarter 2002 AIDS Surveillance Report indicates that in 2000, over 20% of the living AIDS cases, including MSM and heterosexual IDU, are attributable to injection drug use. The survey data confirm that IDU and MSM/IDU account for about 23% of PLWH/A. The survey data of self-reported drug use indicate that while PLWH/A have a history of high drug use, current use has substantially decreased. About one quarter (23%) of the PLWH/A who were interviewed report a history of injecting drugs, but frequent use of heroin and crystal meth is low.

The gray bar in Figure 4-4 shows the percentage of PLWH/A who ever used a drug, and the black bar shows the percentage of all PLWH/A who use the drug relatively frequently.

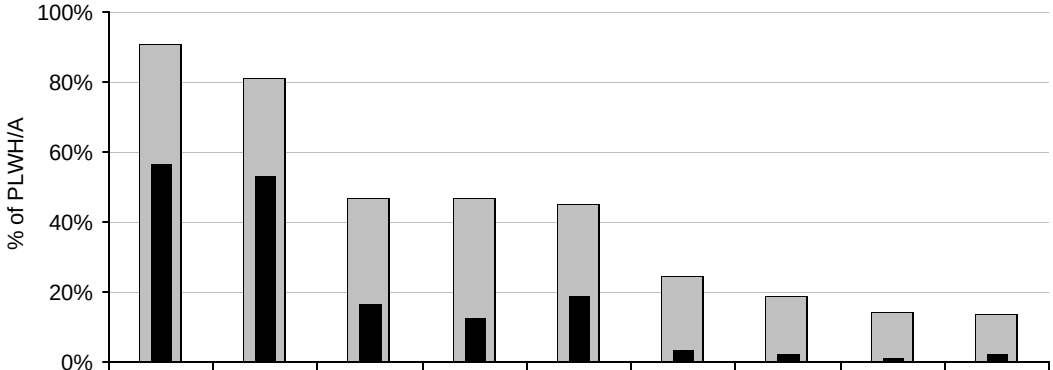
- Over 80% of PLWH/A report ever using alcohol and marijuana, but use in the past six months is lower – 57% of those who ever used alcohol and 53% of those who ever used marijuana. In the past week about 30% saying that they use alcohol and about 36% saying they use marijuana more than once. Frequent marijuana use is highest among transgender persons, homeless and PLWH/A living in the Tenderloin District.
- Of the opiates, 47% of the PLWH/A report ever using crack/cocaine and 19% report ever using heroin. About 13% have used crack/cocaine in the last six months and 9% of PLWH/A who use crack or cocaine say they continue to use the drugs more than once a week. About 2% of those who every used heroin have used it in the last 6 months. The recently incarcerated (22%), out-of-care (27%) and the currently homeless PLWH/A are more likely to use crack than other populations. The recently incarcerated, homeless, symptomatic

PLWH and women are among the highest current users of heroin, indicating the high level of co-morbidities among these populations.

- While almost half (45%) of PLWH/A in San Francisco say they have used crystal meth, less than 10% report using it frequently (once a week or more).
- "Party drugs" include poppers, ecstasy, and Gamma Hydroxybutyrate (GHB). Nearly half (47%) of the PLWH/A report using poppers, with more than 20% saying they use it monthly. One quarter (24%) of all PLWH/A say they have used ecstasy, but it is not frequently used. MSM/IDU, API and symptomatic PLWH tend to use GHB more used than other populations, with more than 40% of the API reporting monthly usage.

Figure 4-4 Substance Use Among PLWH/A

(frequent use is use in the last 6 months)



	Alcohol	Marijuana	Poppers	Crack / cocaine	Crystal meth	Ecstasy	Heroin	Speedball	GHB
Ever used	90.9%	81.0%	47.0%	46.9%	45.3%	24.5%	18.8%	14.0%	13.9%
Used frequently	56.8%	53.0%	16.8%	12.6%	18.7%	3.7%	2.1%	1.4%	2.0%

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 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.

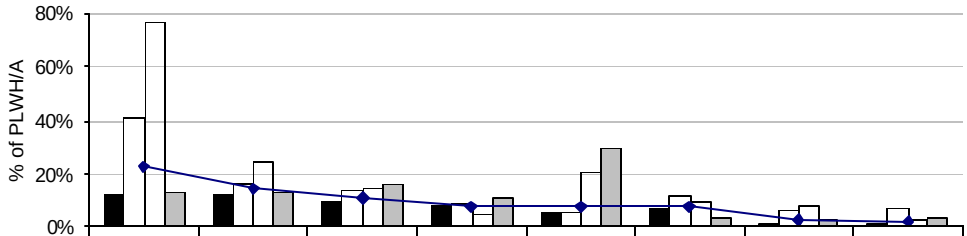
Figure 4-5 and Figure 4-6 show the percentage of PLWH/A who report being diagnosed with STDs in the last year. They indicate that:

- Nearly one quarter of the PLWH/A report having been diagnosed with hepatitis C in the last year. The high hepatitis rates reported by survey participants are consistent with the recent

UCSF study that also reports high rates in the Bay area.[7] Predictably, the incidence of hepatitis is significantly higher among IDUs (76%) and MSM/IDU (41%).

- Among ethnic communities, the incidence of hepatitis C is highest among African Americans (50%). An alarming 61% of the women report having been diagnosed with hepatitis C over the past year. This again is consistent with the UCSF study that found that low-income women in San Francisco, particularly young women, are infected with hepatitis C more than double the national average. This alarming finding highlights the heightened vulnerability of female PLWH/A in San Francisco. This is particularly true for 78% of the African American women who report having hepatitis C. Half of recently incarcerated PLWH/A and over 60% of the San Mateo residents report having hepatitis C.
- Next highest incidence of STDs is hepatitis A or B (14%). It is significantly higher among women (25%), Native Americans (34%), and IDUs (25%). Among the special populations, PLWH/A living in the Tenderloin District, undocumented, recently incarcerated and with symptomatic AIDS report the highest incidence of hepatitis A and B.
- Herpes is the third most frequently reported STD (11%). It is highest among transgender, recently incarcerated, and symptomatic PLWA.
- Amongst PLWH/A who have not sought care in six months or more, hepatitis C (38%) and gonorrhea (16%) are the most common STDs reported. Also, about 10% of the Out-of-care report having syphilis, herpes and genital warts.
- Syphilis (13%) and gonorrhea (22%) are significantly higher among transgender persons than any other group.

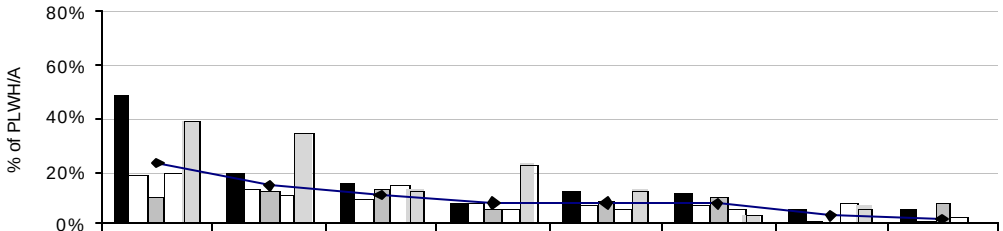
Figure 4-5 STDs among PLWH/A by Mode of Transmission



	Hepatitis C	Hepatitis A or B	Herpes (genital)	Genital warts	Yeast infections	Gonorrhea	Syphilis	Chlamydia
MSM	12.6%	12.2%	9.7%	7.9%	5.5%	6.6%	1.4%	1.1%
MSM/IDU	40.8%	16.2%	13.5%	8.9%	5.5%	11.8%	6.4%	6.8%
IDU	76.4%	24.7%	14.6%	5.1%	20.3%	9.4%	8.4%	3.0%
Het	12.7%	13.3%	15.7%	10.6%	29.6%	3.6%	2.7%	3.7%
Total	22.8%	14.0%	10.9%	7.8%	7.7%	7.5%	2.8%	2.1%

[7] As reported in the *San Francisco Chronicle* - Tuesday, April 2, 2002.

Figure 4-6 STDs among PLWH/A by Ethnicity



	Hepatitis C	Hepatitis A or B	Herpes (genital)	Genital warts	Yeast infections	Gonorrhea	Syphilis	Chlamydia
AfAm	49.5%	19.9%	15.3%	7.6%	12.4%	11.6%	5.2%	6.1%
Anglo	18.4%	13.2%	9.1%	8.2%	7.0%	6.8%	1.4%	0.9%
API	10.2%	12.3%	13.7%	6.3%	8.4%	10.0%	0.0%	7.8%
Latino	19.7%	11.3%	14.5%	5.5%	5.7%	6.3%	8.0%	2.8%
Ntv Am	39.0%	34.4%	13.2%	22.4%	13.2%	3.1%	6.1%	0.0%
Total	22.8%	14.0%	10.9%	7.8%	7.7%	7.5%	2.8%	2.1%

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 service needs. For the purpose of this needs assessment mental illness was defined as having a diagnosis of anxiety, dementia, or depression. More than half of PLWH/A (57%) reported having been diagnosed with one of these conditions.

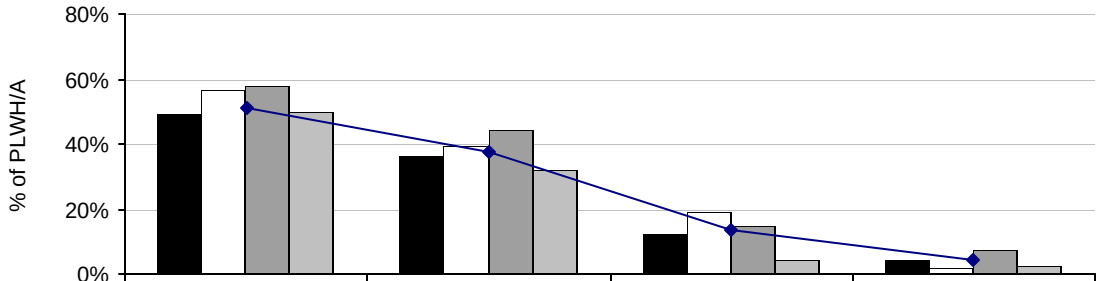
Serious mental illness is defined as having received inpatient mental health services or receiving medication for psychological or behavioral problems. Over one third (34%) report serious mental illness.

The types of mental disorders that have been diagnosed are shown in Figure 4-7 and Figure 4-8. They indicate that:

- Depression has been diagnosed among 51% 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 Native American (57%) and IDU (58%) PLWH/A. API (42%) report less than the average incidence of depression. Attachment 7 further indicates that PLWH/A in San Mateo (69%), women (69%), and transgender persons (65%) have the highest incidence of depression. Asymptomatic PLWA (40%) report the lowest.
- More than one third of PLWH/A (38%) report a diagnosis of anxiety in the past two years. Native Americans (52%), Anglos (40%) and IDU (44%) tend to have received a diagnosis of anxiety more than any of the other race and risk groups. Attachment 7 further indicates that PLWH/A who have been out-of-care for more than six months and asymptomatic PLWH tend to report the lowest incidence of anxiety. This may reflect actual incidence or that they are less likely to see mental health professionals for a diagnosis.

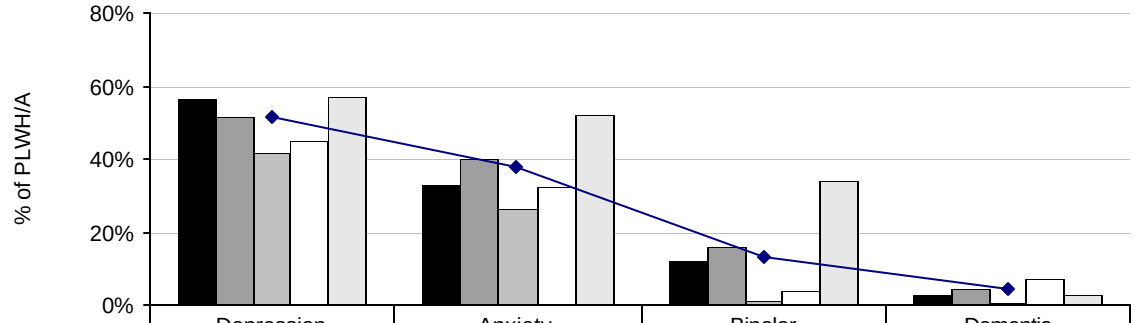
- Thirteen percent of PLWH/A report bipolar disease, with Native Americans (34%) reporting a significantly higher incidence than any of the other populations. Attachment 7 further indicates that Youth (29%) also report an incidence of bipolar disease much higher than the average.
- Less than five percent of the participants report the more acute diagnosis of dementia. Serious dementia may be undercounted because they would not have been able to complete the survey.

Figure 4-7 Mental Illness Among PLWH/A by Risk Group



	Depression	Anxiety	Bipolar	Dementia
MSM	49.4%	36.5%	12.4%	4.4%
MSM/IDU	56.8%	39.4%	18.8%	1.9%
IDU	57.9%	44.0%	14.9%	7.1%
Het	49.7%	32.1%	4.2%	2.5%
Total	51.2%	37.6%	13.2%	4.3%

Figure 4-8 Mental Illness Among PLWH/A by Race/Ethnicity



	Depression	Anxiety	Bipolar	Dementia
Af Am	56.4%	33.0%	12.1%	2.7%
Anglo	51.7%	40.1%	15.7%	4.4%
API	41.9%	26.2%	1.1%	0.5%
Latino	45.2%	32.1%	4.1%	6.9%
Ntv Am	57.1%	51.9%	34.2%	2.9%
Total	51.2%	37.6%	13.2%	4.3%

More than 60% of PLWH/A reported having received mental health counseling or treatment since having been infected with HIV. Among those, half have received medication for psychological or behavioral problems and 30% have been hospitalized for their mental illness.

PLWH/A living in San Mateo (75%), IDUs(72%), female (71%), and Native American (70%) tend to have the greatest need for mental health services. A much higher percent (88%) of PLWH/A report receiving individual counseling than group counseling (58%). Consistent with their medical care health practice, the out-of-care PLWH/A tend to receive less treatment than other populations analyzed.

5. STAGES OF DISEASE

Understanding the number of PLWH/A who are at different stages of infection is an important input for planning. Antiviral treatment is recommended for those individuals with acute viral syndrome or who have seroconverted within six months of infection, and those who exhibit symptoms of acute HIV syndrome. Recently the guidelines to start retroviral treatment were changed from a CD4 count of 500 to 350 cells/uL. Treatment should be considered for HIV infected persons whose CD4 counts are above 350 cells/uL and their viral load level rises above 30,000 copies. Previous guidelines would have called for treatment if the viral load rose above 10,000 copies. All symptomatic HIV infected persons are recommended for treatment, regardless of CD4 count or viral load level.

Those with more progressed AIDS often have a need for buddy and companion services, home health care, hospice care, permanency planning, and other end-stage services.

For others in early stages of infection, case management, monitoring, medical case management, early treatment, and mental health services can be critical for controlling the infection. In addition, all those infected with HIV, regardless of stage may be eligible for food, dental, and a variety of other services noted in the continuum of care provided they meet income and geographic criteria.

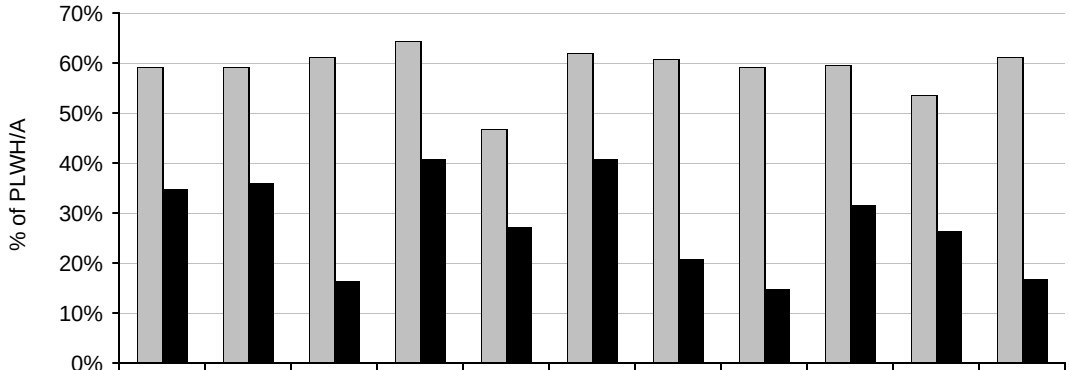
Given these criteria, the survey asked respondents to note if they are symptomatic or asymptomatic and if they have been diagnosed with AIDS. The survey also asks for self-reported highest and most recent CD4 and viral load counts as well as any history of opportunistic infections (OIs) since finding out that they were HIV positive.

Diagnosed with AIDS

Figure 5-1 and Figure 5-2 show that 59% of the PLWH/A who were surveyed reported that they were told by their doctor, nurse or other health care team member that their HIV had progressed to AIDS.

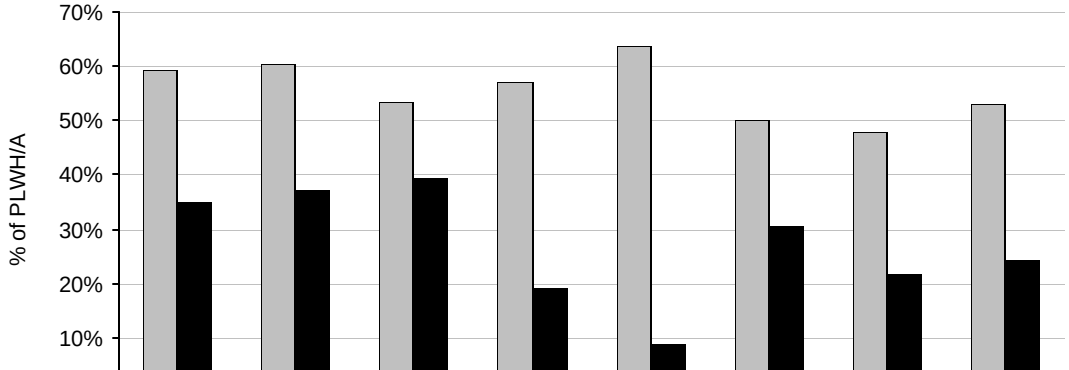
Generally there is a clear relationship between the length of time a person knows they were HIV positive and an AIDS diagnosis. Typically, those who know their status longest are most likely to have been diagnosed with AIDS. However, the sample indicates that in 2002, female, API, Latinos, heterosexuals and Anglo MSM are almost equally likely to be diagnosed with AIDS,. This high incidence of reported AIDS among these populations may in fact suggest a greater vulnerability to progression to AIDS, testing at a later stage of infection and/or entering the care system at a later stage of infection. It may also reflect a bias in the recruiting and participation of the needs assessment sample.

Figure 5-1 AIDS Diagnosis and Time Known HIV+ by Gender, Ethnicity, and Geo



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	San Fran	San Mateo
AIDS Diagnosis	59.3%	59.0%	61.3%	64.6%	46.9%	61.8%	60.7%	59.1%	59.6%	53.4%	61.1%
12+ yrs HIV+	34.8%	35.8%	16.4%	41.0%	27.4%	40.9%	20.7%	14.7%	31.6%	26.4%	16.7%

Figure 5-2 AIDS Diagnosis and Time Known HIV+ by Mode and Special Pops



	TOTAL	MSM	MSM/ IDU	IDU	Het	Undoc	Rec Inc	Homeless
AIDS Diagnosis	59.3%	60.4%	53.3%	57.0%	63.7%	50.0%	47.7%	53.0%
12+ yrs HIV+	34.8%	37.2%	39.4%	19.2%	8.8%	30.4%	21.6%	24.2%

In addition, Table 5-1 shows that transgender persons, MSM/IDU, and IDUs are more likely to have been diagnosed in the last three years than any other time. Over 70% of the women have been diagnosed in the past six years. And while over 70% of the heterosexuals were diagnosed in the past 6 years, only 13.6% were diagnosed within the past 3 years, a very different pattern from the women. In addition, a greater proportion of the males, MSM and Anglos were diagnosed with AIDS over 12 years ago, longer than other populations, reflecting the early impact of the epidemic among these populations. Taken at face value, it suggests that transgender persons, women, MSM/IDU, IDUs, and heterosexuals are likely to progress to AIDS earlier than men, MSM and Anglos. It also suggests that HIV is being detected among these vulnerable populations at a later stage of infection.

Table 5-1 Time of AIDS Diagnosis

	Male	Female	TG	MSM	MSM IDU	IDU	Het	Af Am	Anglo	API	Latino	Ntv Am
Less than 3 years	25.2%	31.9%	52.7%	22.8%	39.2%	39.2%	13.6%	35.8%	26.0%	14.9%	20.7%	30.2%
3 to 6 years	27.9%	42.0%	16.9%	28.2%	19.4%	32.8%	58.5%	18.0%	29.8%	50.6%	25.5%	12.1%
6 to 12 years	36.0%	20.7%	28.7%	37.3%	34.7%	20.4%	26.5%	39.5%	31.8%	34.4%	48.0%	47.7%
More than 12 years	10.9%	5.4%	1.7%	11.7%	6.7%	7.6%	1.4%	6.8%	12.4%	0.0%	5.8%	10.1%

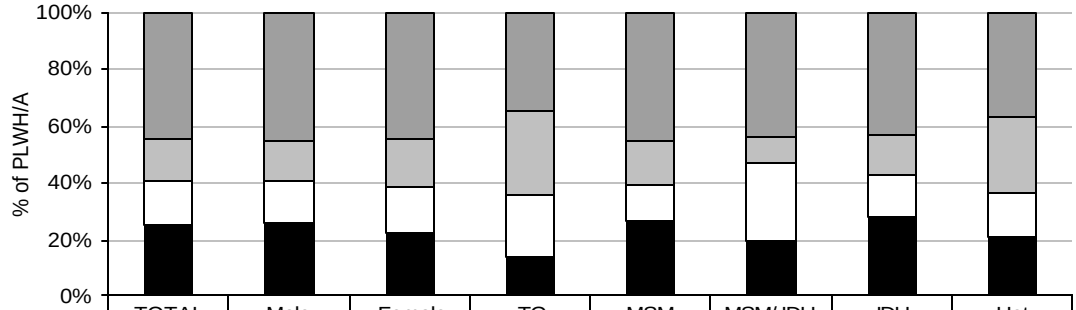
Symptomatic

The data indicate that more than 60% of PLWH/A surveyed currently have symptoms associated with their HIV infection. Of those diagnosed with AIDS, three quarters (76%) report being symptomatic. Among HIV positive non-AIDS diagnosed respondents, 38% report symptoms.

Figure 5-3 and Figure 5-4 show the percentage reporting symptoms by gender, mode of transmission and ethnicity. The graphs show:

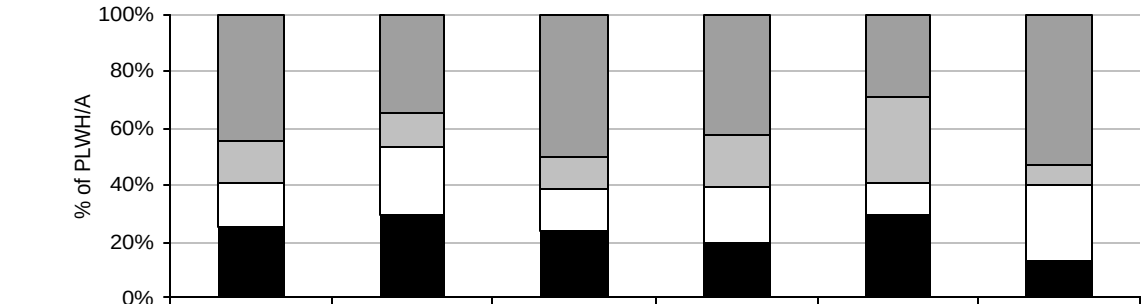
- Overall, the participants are more likely to have progressed to AIDS (59%) than to be living with HIV.
- However, African Americans are more likely to be HIV positive and have not progressed to AIDS, and they are slightly more likely to be asymptomatic.
- Native Americans and Anglos are the populations most likely to have symptomatic AIDS.
- Among the special populations, not shown in the graph, youth, the out-of-care and recently incarcerated PLWH/A are more likely than any other population to be HIV positive without an AIDS diagnosis.

Figure 5-3 % With and Without Symptoms by Gender and Mode



	TOTAL	Male	Female	TG	MSM	MSM/ IDU	IDU	Het
PLWA symp	44.9%	45.1%	44.9%	35.0%	45.6%	44.1%	43.2%	37.1%
PLWA asymp	14.3%	13.9%	16.4%	29.6%	14.8%	9.2%	13.8%	26.6%
PLWH symp	15.6%	15.4%	16.4%	21.5%	13.6%	27.6%	15.3%	15.0%
PLWH asymp	25.2%	25.6%	22.3%	14.0%	26.0%	19.1%	27.7%	21.3%

Figure 5-4 % With and Without Symptoms by Ethnicity



	TOTAL	Af Am	Anglo	API	Latino	Ntv Am
PLWA symp	44.9%	35.0%	50.1%	42.2%	29.0%	53.5%
PLWA asymp	14.3%	11.9%	11.7%	18.6%	30.1%	6.1%
PLWH symp	15.6%	23.2%	14.5%	19.4%	11.0%	27.3%
PLWH asymp	25.2%	29.9%	23.7%	19.9%	29.9%	13.1%

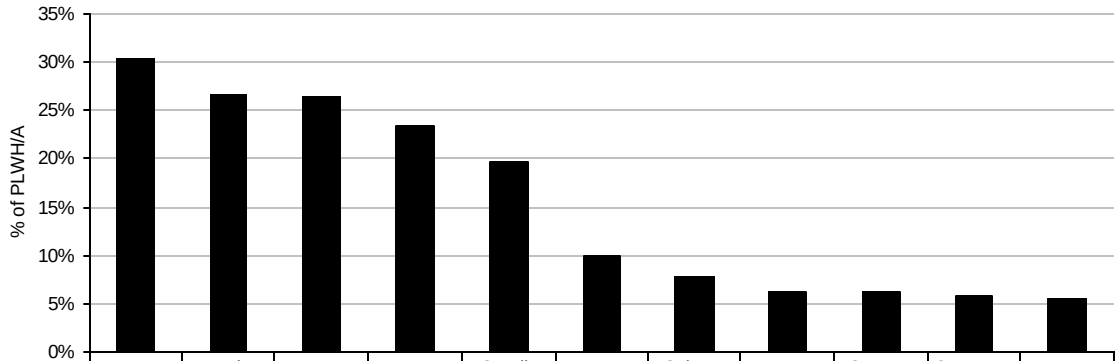
Opportunistic Infections

Along with CD4 counts and viral load, an HIV-infected person receives a diagnosis of AIDS after developing one of the CDC-defined AIDS indicator illnesses or opportunistic infections (OIs). In the early years of the AIDS epidemic, OIs caused a lot of sickness and deaths. However, in the recent years, once PLWH/A started taking combination antiviral therapy, fewer got OIs or have been better treated for their OIs.

In the survey, PLWH/A were asked if they have been diagnosed with any of several OIs since learning of their HIV status. Figure 5-5 shows the top OIs reported by the PLWH/A.

- More than one quarter of the PLWH/A report having had PCP (27%), wasting syndrome (27%), and non-genital herpes (30%).
- While the tuberculosis (TB) rate in San Francisco ranks among the top five in the United States, less than six percent of the participants indicated having had TB since learning about their HIV status.

Figure 5-5 Opportunistic Infections



	Herpes	Wasting Syndrome	PCP	Shingles	Candi-diasis	KS	Salmo-nella	Lym-phoma	Crypto-sporidiosi	Cytomeg-alovius	TB
OIs	30.4%	26.7%	26.5%	23.4%	19.7%	10.0%	7.7%	6.2%	6.2%	5.9%	5.6%

Table 5-2 shows that among the top ten OIs reported by PLWH/A a greater proportion of men tend to have herpes, KS, salmonella, lymphoma, cryptosporidiosis, and cytomegalovirus disease than women or transgender persons. It further shows that:

- Among the ethnic populations a higher proportion of the Anglo PLWH/A tend to have had an OI. However, APIs are more likely than any other ethnic population to have had herpes and wasting syndrome.
- Among the risk groups, heterosexuals are more likely than any of the other groups to have wasting syndrome, shingles, candidiasis, lymphoma, and cryptosporidiosis.
- The proportion of transgender persons, MSM/IDU, Latinos, and African Americans with TB is significantly greater than the average among the PLWH/A, although these reflect small sample sizes and may be unreliable.

Table 5-2 Opportunistic Infections by Gender, Ethnicity and Mode of Transmission

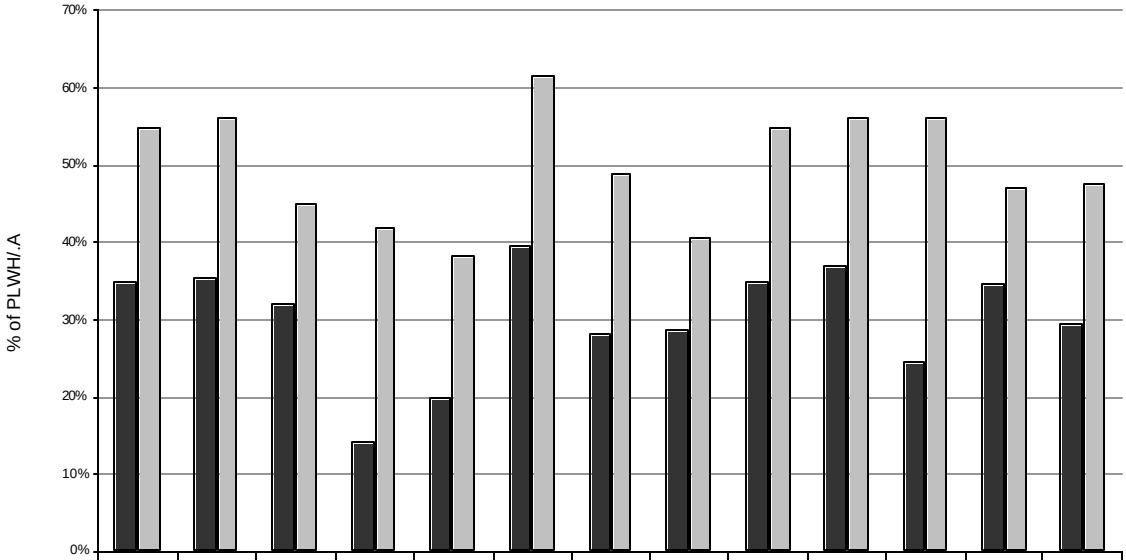
Opportunistic Infections	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	MSM	MSM IDU	IDU	Het
Herpes (not genital)	31.3%	19.6%	18.2%	21.0%	32.5%	34.3%	28.9%	25.5%	30.0%	35.9%	26.8%	27.8%
Wasting Syndrome	26.4%	32.1%	21.5%	19.9%	28.8%	31.7%	21.9%	17.4%	26.7%	24.9%	26.0%	35.7%
Pneumonia or PCP	26.4%	30.8%	18.2%	23.6%	29.4%	17.6%	16.6%	26.4%	25.3%	29.4%	32.2%	22.0%
Shingles	22.8%	33.5%	18.9%	21.3%	25.5%	21.9%	13.9%	37.5%	24.2%	21.3%	19.0%	28.5%
Candidiasis	19.1%	26.1%	27.5%	9.5%	22.4%	14.9%	17.9%	15.1%	20.3%	16.2%	16.9%	29.7%
Kaposi's Sarcoma (KS)	10.7%	0.0%	3.2%	3.5%	12.1%	0.0%	8.4%	9.1%	12.3%	3.6%	3.7%	1.0%
Salmonella	8.2%	1.9%	1.2%	3.1%	9.6%	7.8%	2.9%	7.7%	8.9%	6.3%	2.9%	0.7%
Lymphoma	6.3%	5.9%	2.2%	3.2%	7.2%	0.0%	6.0%	2.8%	6.8%	0.9%	6.5%	14.3%
Cryptosporidiosis (Chronic intestinal)	6.3%	5.7%	3.2%	2.2%	7.5%	0.0%	5.5%	3.1%	6.8%	4.8%	2.1%	11.5%
Cytomegegalovius	6.2%	1.6%	2.2%	2.7%	7.0%	0.5%	4.6%	9.1%	7.2%	1.7%	2.6%	0.7%
TB	5.4%	5.4%	13.9%	10.1%	3.7%	7.4%	10.2%	2.8%	4.7%	10.4%	6.7%	2.5%

Eligible for Medical Care

As shown in Figure 5-6, currently the majority (65%) of PLWH/A report t-cell counts above 350 cells/uL, yet, more than half report having had T-cell counts drop below 350 cells/uL at some point in their disease progression. Consistent with the length of time of infection and the trend in the epidemic, currently Anglos (39%), MSM (37%), Native Americans (35%), and IDUs (35%) are more likely than other populations to have T-cell counts below 350 cells/uL.

Based on the criteria for antiviral treatment, 61% of the HIV positive population report symptoms and would be recommended for treatment. In addition, based on survey data, there are nine percent of all PLWH/A who report an AIDS diagnosis, are asymptomatic, and report a current T-cell count below 350. Using these criteria, it is estimated that 70% of PLWH/A are likely to need medical treatment for their infection.

Figure 5-6 Current and Lowest T-Cell Counts



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	MSM	MSMIDU	IDU	Het
Most Recent Tcell <350	34.8%	35.4%	32.0%	14.3%	19.9%	39.3%	28.1%	28.7%	34.9%	36.8%	24.5%	34.6%	29.5%
Lowest Tcell - < 350	54.9%	55.8%	44.9%	41.9%	38.5%	61.6%	48.9%	40.6%	54.7%	56.2%	55.8%	47.1%	47.5%

6. INSURANCE AND BENEFITS

Access to Health Care

Ryan White funds should assure that all persons living with HIV/AIDS have access to care, 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 and wrap around services through a number of clinics in San Francisco. Based on the Reggie database, the primary outpatient clinics, and the number of Ryan White funded clients seen in 2002 are shown in Table 6-1. Ward 86 serves almost half of all the clients reported to receive outpatient care in the Reggie system. They also account for over 40% of the duplicated client encounters. The San Francisco Department of Health is the second most common provider of outpatient medical care accounting fro almost one third of the unduplicated clients reported by Reggie.

Not shown in this chart are the non-Ryan White funded PLWH/A receiving medical care from private doctors and clinics. These PLWH/A have private insurance or pay for medical care themselves. They may, however, access other wrap-around services, including case management.

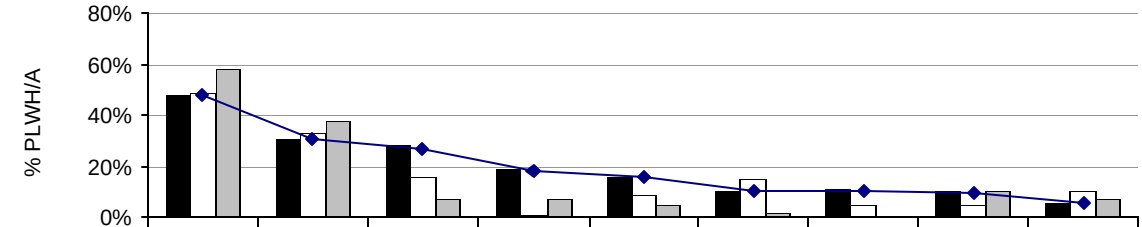
Table 6-1 Medical Care Providers

Medical Care Provider	Unduplicated Clients	Percent of Total Unduplicated Clients Served	Duplicated Client Contacts	Percent of Total Duplicated Clients Served
UCSF AIDS Program SFGH Ward 86 (inc. BAPAC)	1,867	43.8%	15,871	43.5%
SFDPH Community Health Network	1,287	30.2%	6,214	17.0%
St. Mary's Medical Center	344	8.1%	2,904	8.0%
Forensic AIDS Project	303	7.1%	1,389	3.8%
Mission Neighborhood Health Center (CCC)	252	5.9%	1,900	5.2%
Continuum Tenderloin Care (Integrated Services)	150	3.5%	407	1.1%
SFDPH City Clinic	141	3.3%	885	2.4%
SFGH-Department of Psychiatry (SACS, STOP, Ward93)	133	3.1%	1,770	4.8%
UCSF Women's Specialty Clinic	124	2.9%	641	1.8%
South of Market Health Center (CCC)	79	1.9%	419	1.1%
San Francisco AIDS Foundation	75	1.8%	2,254	6.2%
Lyon-Martin Women's Health Svcs (Intg Svcs)	50	1.2%	503	1.4%
Native American Health Center (CCC)	49	1.2%	291	0.8%
UCSF-Women and Children's Specialty Program	42	1.0%	579	1.6%
SFGH-General Medical Clinic/Early Access Clinic	38	0.9%	63	0.2%
HAFCI/Haight Ashbury Free Clinic, Inc	31	0.7%	402	1.1%
Baker Places, Inc.	30	0.7%	30	0.1%
TOTAL	4,259	100.0%	36,522	100.0%

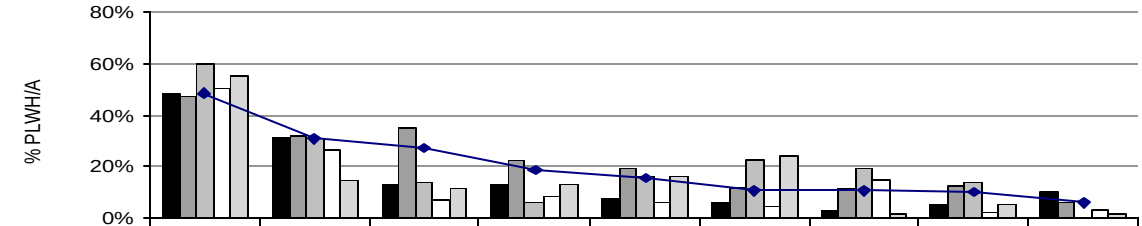
In the survey participants were asked where they received their medical care most often. Figure 6-1 displays the sites for the total sample, sex/gender subpopulations, race/ethnicity, and risk group. They are not mutually exclusive – PLWH/A can report more than one site where they usually receive their medical care. Overall:

- Slightly less than half the PLWH/A receive medical care from community clinics such as the SFDPH, Mission Neighborhood Medical Center or Tom Waddell Clinic. Community clinics are used more by transgender persons, APIs, and heterosexuals.
- About 31% of PLWH/A report using San Francisco General – Ward 86 (SFG). It s used more by transgender persons, and IDUs.
- About a fourth of the PLWH/A say they use private doctor or private clinic. Males, MSM, and Anglos are much more likely to use private facilities.
- About 18% of PLWH/A say they receive their medical care from a private hospital. Like those that receive care from a private doctor, they are more likely to be male, Anglo, and MSM.
- About 15% of PLWH/A receive their medical care from alternative treatment facilities. Of those reporting alternative care, about half also report going to a community clinic, over a third say they use SF general, and about 30% use private doctors, clinics or hospitals. Alternative treatments are used more by males, Anglos and APIs, and MSM. .
- About 10% of PLWH/A report using UCSF and Kaiser. UCSF sees proportionately more women and APIs, while Kaiser is used more by males, MSM, and Latinos. Like UCSF, Kaiser also sees a relatively large proportion of APIs.
- Emergency rooms are visited by about 10% of PLWH/A. Men say they are more likely to go to the emergency room than women.
- About 6% of PLWH/A report using the VA. Surprisingly, women are more likely to report using the VA then men and this suggests further research. They are also more likely to be African American, and IDUs.

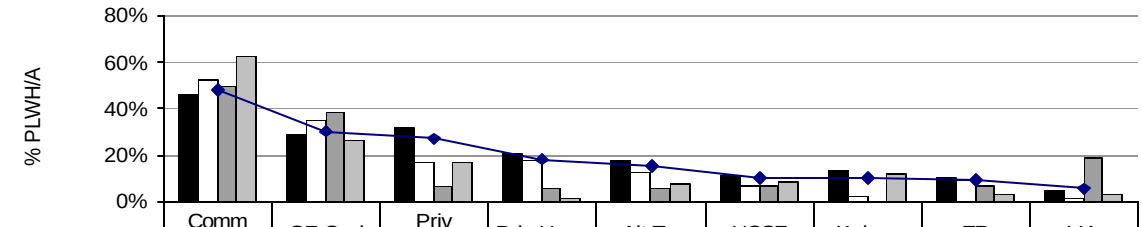
Figure 6-1 Medical Care Sites



	Comm Clinic	SF Gnrl	Priv Dr/Clinic	Priv Hosp	Alt Tx	UCSF	Kaiser	ER	VA
Male	47.9%	30.4%	28.0%	19.2%	16.0%	10.3%	10.9%	10.0%	5.4%
Female	48.6%	33.2%	15.4%	0.9%	8.6%	15.1%	4.8%	5.0%	10.5%
TG	57.8%	37.5%	7.2%	7.1%	4.4%	1.4%	0.0%	10.1%	7.2%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%



	Comm Clinic	SF Gnrl	Priv Dr/Clinic	Priv Hosp	Alt Tx	UCSF	Kaiser	ER	VA
Af Am	48.5%	31.2%	12.7%	12.7%	7.6%	5.7%	2.4%	4.7%	9.6%
Anglo	47.1%	31.6%	34.6%	21.7%	19.0%	11.9%	11.1%	12.4%	5.6%
API	59.9%	30.5%	13.5%	5.7%	15.8%	22.3%	19.0%	13.5%	0.0%
Latino	49.9%	26.6%	6.8%	7.7%	5.7%	4.4%	14.5%	1.8%	3.3%
Ntv Am	55.0%	14.1%	11.1%	12.9%	16.2%	23.7%	1.5%	4.9%	1.5%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%

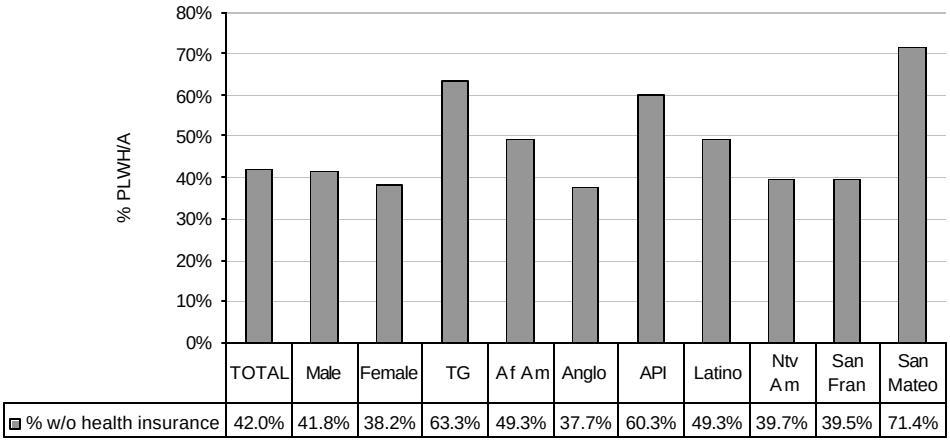


	Comm Clinic	SF Gnrl	Priv Dr/Clinic	Priv Hosp	Alt Tx	UCSF	Kaiser	ER	VA
MSM	46.6%	28.9%	32.0%	20.5%	17.6%	11.5%	13.4%	10.4%	4.4%
MSM/IDU	53.1%	35.0%	17.1%	17.2%	12.6%	7.1%	2.6%	9.9%	1.8%
IDU	49.3%	38.2%	6.5%	5.7%	5.6%	7.4%	0.1%	7.3%	19.1%
Het	62.7%	26.1%	17.0%	1.8%	8.2%	9.0%	11.8%	3.1%	3.3%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%

Insurance Coverage

In the survey participants were asked where they received their medical care most often. More than 40% of the PLWH/A who were surveyed reported having no form of insurance. As shown in Figure 6-2, transgender persons (63%), APIs (60%) and PLWH/A in San Mateo (71%) are most likely to report not having insurance than other populations of PLWH/A.

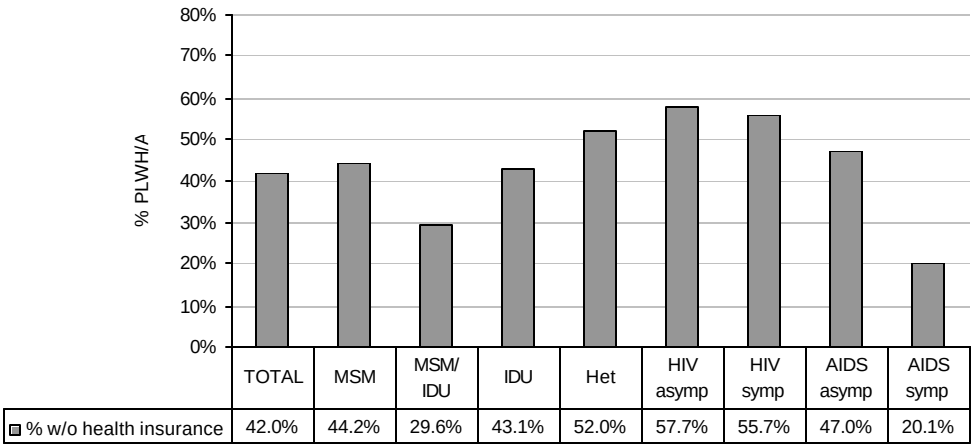
Figure 6-2 No Insurance by Gender, Race and Region



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	San Fran	San Mateo
% w/o health insurance	42.0%	41.8%	38.2%	63.3%	49.3%	37.7%	60.3%	49.3%	39.7%	39.5%	71.4%

As shown in Figure 6-3, heterosexuals are more likely than any of the other exposure groups to not be insured. Over 55% of the PLWH report not having any form of insurance, while fewer PLWA (47% asymptomatic and 20% symptomatic) report no insurance.

Figure 6-3 No Insurance by Exposure Category and Stage of Disease



	TOTAL	MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
% w/o health insurance	42.0%	44.2%	29.6%	43.1%	52.0%	57.7%	55.7%	47.0%	20.1%

A slightly larger percentage of women (62%), on the other hand, report having insurance than men (58%). This is the usual pattern for EMAs because of the various Medicaid programs for families and single mothers with children, such as WIC and TANF, and may explain the higher rate of insurance coverage among women. If anything, a larger proportion of women living with HIV and AIDS should be insured.

Among the various ethnic/racial groups Anglos tend to be insured more than African Americans and Latinos because they often have higher incomes to purchase insurance, or are more likely to qualify for SSDI because of past work history. Sixty-two percent (62%) of Anglo PLWH/A report having insurance compared to about 50% of African Americans and Latinos. Interestingly, MSM/IDU (70%) are the group most likely to be insured while heterosexuals (48%) are the group least likely to report having any form of health insurance.

Attachment 7 also indicates that certain special populations are likely to be uninsured, including young PLWH/A under the age of 24 (71%), homeless (64%), and PLWH/A out of care for more than 6 months (64%). On the other hand, symptomatic PLWA report the highest levels of insurance (80%).

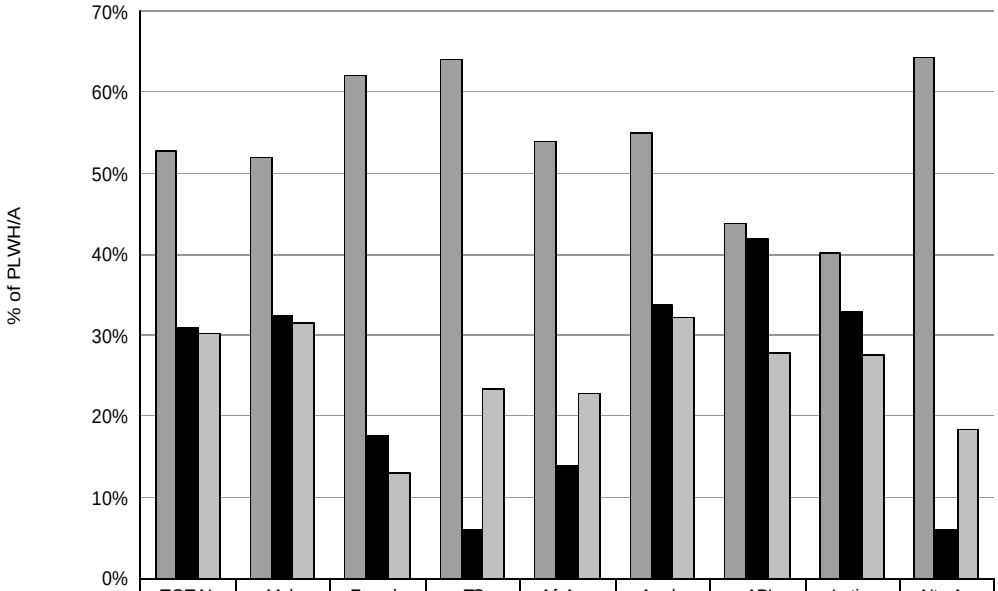
As shown in Figure 6-4 and Figure 6-5 several types of insurance are reported by PLWH/A. Figure 6-4 and Figure 6-5 indicate that the different types of coverage vary by population.

- Medi-Cal/ Medicaid are by far the most common form of insurance for all populations infected with HIV/AIDS in the San Francisco area, with transgender persons, Native Americans, and MSM/IDU being the groups most likely to have this type of insurance.
- Overall, an equal number of PLWH/A report having private insurance and Medicare. However, a greater proportion of the transgender persons, African Americans, Native Americans, MSM/IDU, IDU and PLWH/A living in San Francisco are more likely to receive Medicare than to have private insurance. APIs are more likely to have private insurance than any other group.

Further analysis of the data indicate that:

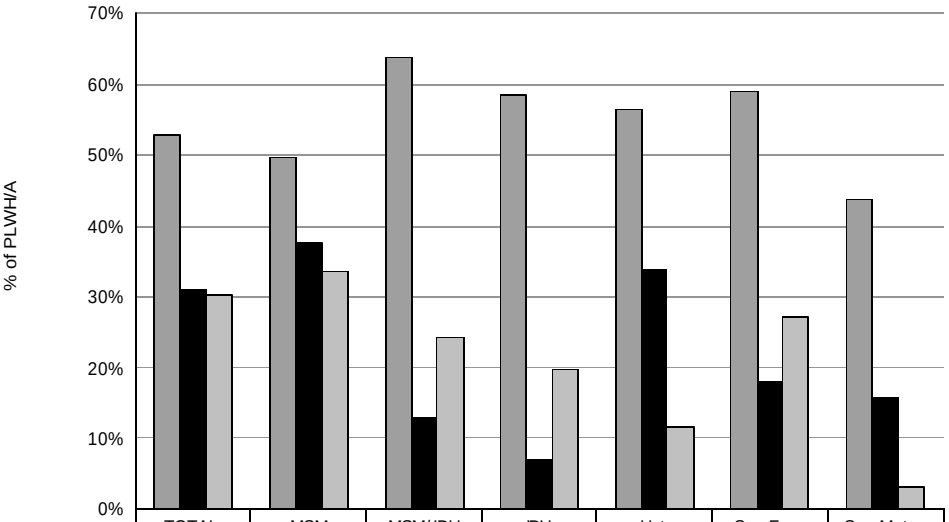
- 40% of all those with insurance report Medi-Cal/Medicaid as their sole form of insurance. Medi-Cal/Medicaid is the sole insurer for more than half of the women, transgender persons, African Americans, IDUs, and heterosexuals
- One third of the insured PLWH/A report having some form of private insurance as their only source of insurance. Men are much more likely to report having private insurance and about 40% of the APIs, MSM and asymptomatic PLWA report having private insurance as their sole coverage.
- Twenty-two percent of the insured PLWH/A report Medicare as their sole coverage. Medicare is the primary insurer for PLWH/A Youth and over 55 years of age. Also, more than one third of the API report Medicare as their sole insurer.

Figure 6-4 Insurance Coverage – Gender and Race/Ethnicity



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am
Medi-Cal / Medicaid	52.8%	51.9%	62.0%	64.1%	53.8%	55.0%	43.6%	40.1%	64.3%
Private Ins/Cobra	30.9%	32.4%	17.6%	5.9%	13.9%	33.8%	41.9%	33.0%	5.9%
Medicare	30.2%	31.5%	13.0%	23.4%	22.7%	32.2%	27.8%	27.7%	18.4%

Figure 6-5 Insurance Coverage - Risk Group and Region



	TOTAL	MSM	MSM/ IDU	IDU	Het	San Fran	San Mateo
Medi-Cal / Medicaid	52.8%	49.6%	63.6%	58.4%	56.4%	59.0%	43.8%
Private Ins/Cobra	30.9%	37.7%	13.0%	7.1%	33.9%	18.1%	15.8%
Medicare	30.2%	33.7%	24.2%	19.8%	11.7%	27.2%	3.3%

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. Drug reimbursement programs like ADAP can be the only form of drug assistance or it can supplement existing insurance coverage.

VA and Public Health Services

About four percent of the PLWH/A report VA benefits and an additional two percent report receiving CHAMPUS, a form of VA Assistance for non-military personnel.
Among the recipients of VA benefits, about 50% report having no insurance.

About one percent of the PLWH/A report receiving public health services, Bureau of Indiana Affair benefits. However, as expected a substantially higher (11%) of the Native Americans report receiving this benefit. Confirming the earlier demographic analysis showing several transgender Native Americans it is not surprising to note that 17% of the transgender persons report receiving this benefit.

Drug Reimbursement

The data suggest that PLWH/A do not have a clear sense of how their medication is purchased. While up to 61% and 57% of the PLWH/A report that ADAP or Medi-Cal/Medicaid paid for their medications, respectively, up to 20% report not knowing the amount of prescriptions paid for by any of their sources of drug reimbursement.
In addition, 45% of the PLWH/A report that their medication was reimbursed by private insurance, 30% report out of pocket medication cost and nine percent report receiving VA benefits to cover their medications.

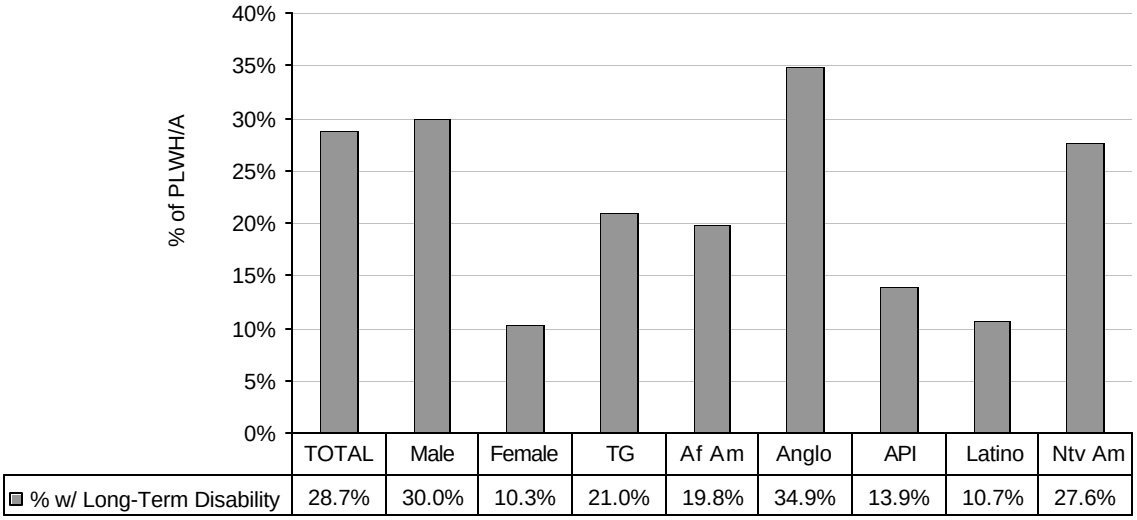
Other Benefits

PLWH/A receive a variety of other services, 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, nine percent report not being eligible for benefits with an additional 11% not knowing whether they qualify or not.

Disability

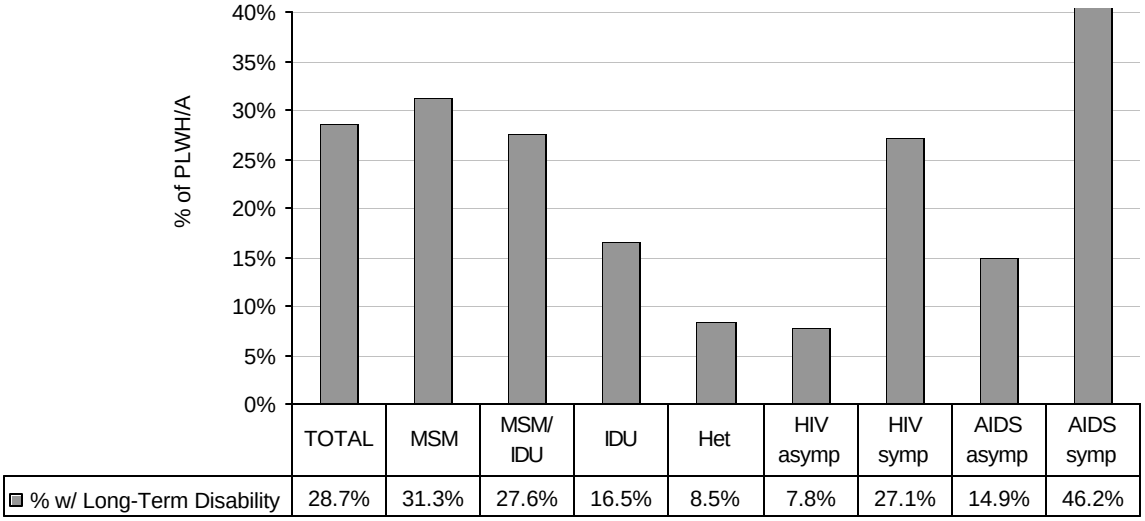
As shown in Figure 6-6 and Figure 6-7, about 29% of PLWH/A report being on long term disability. As expected the rate of disability is higher among those infected earlier, such as males, Anglos, MSM, and symptomatic PLWA. Latinos, heterosexuals, women and youth are the least likely to receive long term disabilities.

Figure 6-6 Long-Term Disability by Gender and Ethnicity



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am
% w/ Long-Term Disability	28.7%	30.0%	10.3%	21.0%	19.8%	34.9%	13.9%	10.7%	27.6%

Figure 6-7 Long-Term Disability by Exposure Category and Stage of Disease



	TOTAL	MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
% w/ Long-Term Disability	28.7%	31.3%	27.6%	16.5%	8.5%	7.8%	27.1%	14.9%	46.2%

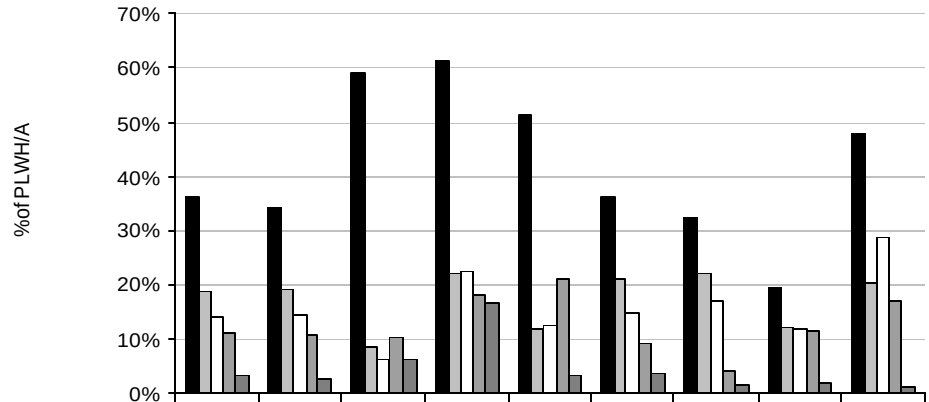
Supplementary Income

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. Social Security Income (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, although there is a waiting period. Ryan White funds direct emergency assistance, and PLWH/A have to demonstrate need. The program has limited funds and allows limited payments each year.

The proportion of PLWH/A reporting supplemental sources of income is shown in Figure 6-8 and Figure 6-9. The data show that:

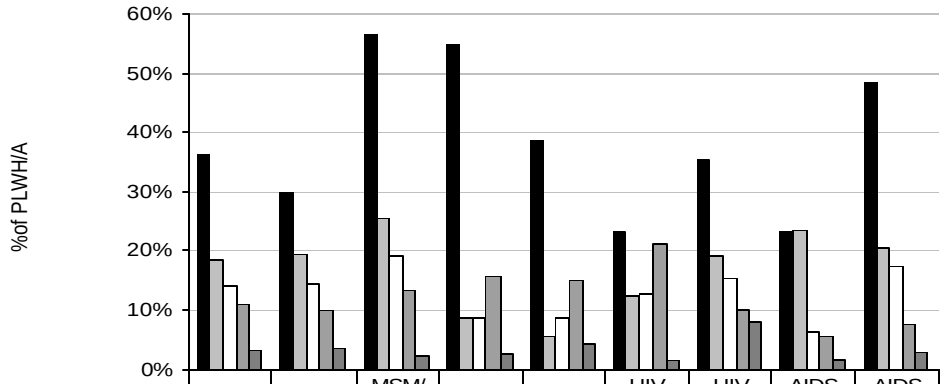
- Indicative of the low income of PLWH/A, more than one-third (36%) report receiving SSI and 17% report receiving housing subsidy. Females, transgender persons, MSM/IDU and IDUs, African Americans, the over 55 years old, and PLWA are more likely to receive SSI. However, these same groups are not necessarily more likely to receive rental subsidies. Males and transgender persons are more likely than females to receive rent supplements; APIs and Native American and APIs are more likely to receive rent subsidies than other ethnic populations; and MSM/IDU and MSM are more likely to receive rental subsidies than other risk groups.
- About 19% of the PLWH/A report receiving direct emergency financial assistance (DEFA), usually used for utilities, rent, or emergency medical treatment. However, women, African Americans, Latinos, and heterosexuals, PLWH/A living in San Mateo, homeless, the out of care, youth and PLWH are the least likely to receive DEFA.
- Surprisingly, only 11% report receiving food stamps and three percent report receiving TANF/CalWorks. Transgender persons (18%), African Americans (21%), youth (32%), recently incarcerated (31%), homeless (33%), the out of care (30%) are much more likely to receive food stamps than any other group. Further investigation is necessary to determine why more transgender persons (17%) report receiving TANF than men (3%) or women (6%).

Figure 6-8 Supplemental Income – Gender and Ethnicity



	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am
SSI	36.2%	34.2%	59.2%	61.4%	51.4%	36.2%	32.3%	19.5%	47.8%
Emergency Financial Assistance	18.7%	19.2%	8.7%	22.1%	11.8%	21.2%	22.1%	12.2%	20.6%
Rent Supplement	14.2%	14.5%	6.4%	22.6%	12.5%	14.8%	17.3%	11.8%	28.6%
Food stamps	11.1%	11.0%	10.4%	18.2%	21.1%	9.2%	4.2%	11.4%	17.1%
TANF / CalWorks	3.2%	2.8%	6.4%	16.9%	3.4%	3.5%	1.6%	2.0%	1.4%

Figure 6-9 Supplemental Income - Exposure Category and Stage of Disease



	TOTAL	MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
SSI	36.2%	29.8%	56.4%	54.9%	38.6%	23.2%	35.3%	23.3%	48.5%
Emergency Financial Assistance	18.7%	19.4%	25.5%	8.7%	5.6%	12.4%	19.1%	23.5%	20.6%
Rent Supplement	14.2%	14.4%	19.2%	8.6%	8.8%	12.6%	15.3%	6.3%	17.4%
Food stamps	11.1%	9.9%	13.4%	15.6%	15.1%	21.0%	10.0%	5.4%	7.6%
TANF / CalWorks	3.2%	3.4%	2.3%	2.5%	4.4%	1.3%	8.0%	1.7%	3.0%

7. OUT-OF-CARE

Estimate of Out-of-Care

There are about 21,000 PLWH/A in the San Francisco EMA. It is estimated that 75% of those who are positive in the San Francisco EMA know their status leaving 15,750 PLWH/A that might seek some services, and based on a 300% poverty level, about 14,648 would be eligible for Ryan White funded services. The REGGIE system, combined with reports from Marin and San Mateo, show about 11,000 clients receive care eligible services. For all services that would suggest that 25% of PLWH/A with 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).

When the concept of out-of-care is more carefully defined, however, it becomes much more complex. Care seeking is a dynamic process and might be seen along a continuum where one extreme is unconnected to care and the other is regular monitoring for HIV infection. Between those two extremes are those who have:

- 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.

In San Francisco, "not in care" is defined as people living with HIV who know their HIV status and have not seen a clinician for HIV-related medical care in more than six months. However, in developing a more precise definition there are four factors that should be considered:

5. Stage of infection
6. Time from diagnosis to initial primary care visit
7. Length of time between visits
8. Adherence to scheduled visits

Operational Definition of Delayed Care Seeking and Unconnected to Care

The following are the definitions used for the analysis of the delayed care and unconnected or out-of-care PLWH/A. In all instances seeking emergency room care does not qualify as seeking primary care for HIV infection.

<u>Delayed Care Seekers</u>

- A newly diagnosed PLWH/A, diagnosed on after 1995[8], who does not see a physician after three months, but starts care within 6 months, is considered a delayed care seeker, regardless

[8] 1995 is used as this was the first year when effective antiviral treatments were widely available.

of stage of disease. The 2002 Needs Assessment found 17 PLWH/A who would be considered delayed care seekers.

- Any PLWH/A would be considered a delayed care seeker if he or she visited a physician, is in the early stages of HIV infection (learns they have a CD4 cell count, viral load, and OI profile that are above the threshold to start HAART), and misses two consecutive appointments or, if he or she does not have a physician or clinic, does not seek care for an additional six months after an appointment. In the needs assessment ten additional PLWH/A were identified that fit this criteria.
- Any PLWH/A would be considered a delayed care seeker if he or she visited a physician, learns his/her health status is in the more advanced stages of HIV (CD4 count, viral load, and OI profile meets the standard to start HAART), and misses an appointment or, if he or she does not have a physician or clinic, does not seek care for an additional three months after an appointment. An additional twenty-four PLWH/A are considered delayed care seekers under this definition.

Unconnected to or Out of Care

- A newly diagnosed PLWH/A who has not seen a primary care physician within six months is considered to be unconnected to care. Thirty-four PLWH/A report waiting more than six months to see a physician after receiving their HIV diagnosis, or about 6% of the sample.
- Any PLWH/A who knows his/her infection for over 6 months, and has not seen a physician in over a year, regardless of previous care practices, would be considered unconnected to care. Nine PLWH/A report not seeing a doctor in more than 12 months and are considered to be currently out of care, or less than 2% of the sample would be considered currently out-of-care. Notably the sample is mostly recruited from providers of HIV/AIDS care services.

The following section presents the profile of the 51 PLWH/A who are considered delayed care seekers and the 43 who have had a history of being out of care.

Demographic Profile

Table 7-1 presents the gender, ethnic and risk group distribution for the delayed care seekers and those with a history of being out-of-care. It indicates that:

- The majority of the delayed care seekers (78%) as well as the unconnected to care (67%) are men. However, a greater proportion of the women are more likely to delay or to be unconnected to care than the proportion of women in care. Also, women are more likely to be unconnected to care than to be delayed care seekers.
- African Americans are disproportionately represented among those out-of-care. While the same proportion of Anglos and African Americans delay care, Native Americans, Latinos and African Americans are proportionately much more likely to delay care.
- African Americans participants in the survey were much more likely than other ethnic groups to be unconnected to care. This may not be generalizable due to the small sample size and nonrandom sample.

- Among the risk groups, heterosexuals are the smallest group among those that delay or are unconnected to medical care. However, MSM/IDU, IDU and heterosexuals are disproportionately represented among those unconnected to and delaying medical care.

Table 7-1 Delayed Care Seekers and Out-of-care: Demographic Profile

	Total (wt)		Delayed		Unconnected	
	N =572	%	N=51	Col %	N=43	Col %
Gender						
Male	529	92.5%	40	78.4%	29	67.4%
Female	32	5.7%	7	13.7%	9	20.9%
Transgender	10	1.8%	4	7.8%	5	11.6%
Race/Ethnicity						
African Am	83	14.5%	15	29.4%	23	53.5%
Anglo	392	68.5%	15	29.4%	8	18.6%
API	20	3.6%	6	11.8%	4	9.3%
Latino	73	12.8%	10	19.6%	6	14.0%
Native Am	4	0.6%	5	9.8%	0	0.0%
Mode						
MSM	423	74.0%	16	31.4%	18	41.9%
MSMIDU	73	12.8%	16	31.4%	9	20.9%
IDU	60	10.5%	14	27.5%	10	23.3%
Hetero	16	2.7%	5	9.8%	6	14.0%

Data not shown in the table further shows that:

- Sixty-seven percent (67%) of the delayed care seekers and 61% of the unconnected to care have less than a high school education. This is a substantially lower level of education than the 39% of the total sample of PLWH/A who report less a high school education or lower.
- Six delayed care seekers and seven unconnected to care report currently being employed in some capacity. This is much lower than 24% percent employment level reported by the overall sample. The delayed care seekers and unconnected to care are also much more likely than the PLWH/A in care to live in poverty. More than 60% of both groups report annual incomes of $8,600 or less.
- Three of the delayed care seekers and three of the unconnected to care live with children. None report having HIV positive children. Yet, five of the delayed care seekers and six of the unconnected to care live with a partner/spouse who is also HIV positive.

Stage of Infection

In terms of stage of infection and length of time of infection, delayed care seekers are not very different than other PLWH/A in care. More than half of all the PLWH/A who completed the survey (59%) as well as more than half of the delayed care seekers (55%) have been given an AIDS diagnosis. However, as expected, fewer of the unconnected to care (40%) have been told their infection has progressed to AIDS. On average, PLWH/A, whether in care, delayed care or unconnected to care report having had on opportunistic infection since being diagnosed with HIV. However, the maximum number of OIs reported by the unconnected to care is three, compared to a high of six among the delayed care seekers. Those in care report up to 17 OIs

probably because they are more likely diagnosed through their contact with the medical care system.

Table 7-2 shows that about one third of the delayed care seekers (31%) and the unconnected to care (35%) have known their HIV status for less than three years compared to less than 20% of the total sample of PLWH/A. A greater proportion of the unconnected to care (53%) report being asymptomatic compared to the delayed care seekers (35%) or the overall sample of PLWH/A.

Table 7-2 Length of HIV Infection

	TOTAL		Delayed Care		Unconnected	
	N	Percent	N	Percent	N	Percent
Less than 3 years	106	18.5%	16	31.4%	15	34.9%
3 to 6 years	104	18.2%	22	43.1%	19	44.2%
6 to 12 years	163	28.5%	13	25.5%	9	20.9%
More than 12 years	199	34.8%	0	0.0%	0	0.0%

Surprisingly, the majority of the delayed care seekers and the unconnected to care indicate an awareness of their CD4 count. In addition, 95% of the unconnected to care report current CD4 counts above 350 cell/uL, compared to 65% of the PLWH/A in the sample. However, close to 40%of the delayed care seekers report CD4 counts of 200 cell/uL or lower. This is likely to reflect their last known CD4 cell counts.

The delayed care seekers and the unconnected to care are more likely than all PLWH/A to say that their physical and emotional health is less than good (i.e., fair or poor). Yet, more than 60% of the delayed care seekers and more than 70% of the unconnected to care feel that their physical and emotional health has remained the same or improved since they first sought treatment for their HIV infection.

Medication Adherence

Delayed care seekers are slightly less likely (70%) to take medication than all PLWH/A in care (77%). Those unconnected to care a much less likely to take medication (49%). Delayed care seekers report similar adherence levels (35%) as PLWH/A in the overall sample. However, more than 79% of the unconnected to care report problems taking their medications as prescribed.

Table 7-3 shows the top reasons reported by the PLWH/A for not adhering to medication regimens. Among all PLWH/A, whether in care or not, forgetting to take the medications was the number one reason for not adhering to medications. For the delayed care seekers and the unconnected to care running out of medicines was also among the top reasons for not adhering. For the unconnected to care, difficult scheduling was also an important factor.

Table 7-3 Top Reasons for Skipping Medications

	TOTAL		Delayed Care		Unconnected	
	N	%	N	%	N	%
Forgot	150	69.4%	16	84.2%	8	72.7%
Side effects	94	43.9%	8	47.1%	5	45.5%
Difficult schedule	95	41.5%	9	50.0%	7	63.6%
Didn't want to take them	53	24.9%	8	42.1%	6	54.5%
Hard to coordinate with food	50	23.2%	7	38.9%	4	36.4%
Doctor advised me to stop	50	23.1%	4	21.1%	0	0.0%
Ran out	47	22.0%	9	50.0%	5	45.5%
Homeless	35	16.6%	7	38.9%	4	36.4%
Feel that medications didn't work	29	13.4%	2	11.8%	3	27.3%
Felt didn't need meds anymore	27	12.5%	5	27.8%	2	18.2%
Didn't want others to see the meds	14	6.6%	5	27.8%	4	36.4%
Didn't understand directions	8	3.5%	4	22.2%	2	18.2%
Affordability	6	2.9%	4	23.5%	2	18.2%

Co-Morbidities

A higher proportion of the delayed care seekers and the unconnected to care report high incidence of hepatitis C compared to the overall sample of PLWH/A. About 30% of the unconnected to care and 47% of the delayed care seekers have had hepatitis C since being diagnosed with HIV. Delayed care seekers and those unconnected to care report a higher incidence of syphilis than other PLWH/A.

As shown in Table 7-4, the delayed care seekers and the unconnected to care are much more likely to currently be using substances that other PLWH/A. More than half report using alcohol, crack/cocaine, and marijuana.

Table 7-4 Current Substance Use

	TOTAL		DELAYED		UNCONNECTED	
Substance	**N**	**%**	**N**	**%**	**N**	**%**
Alcohol	274	57.7	31	70.5	22	68.8
Crack/cocaine	119	35.7	19	55.9	16	64.0
Marijuana	247	59.2	24	58.5	24	75.0
Heroin	49	20.4	10	38.5	3	20.0
Crystal meth	112	38.6	16	48.5	8	42.1
Speed	26	12.8	4	17.4	2	15.4
GHB	24	16.1	4	22.2	2	28.6
Poppers	70	28.9	10	40.0	7	46.7
Ecstasy	30	16.7	6	30.0	1	16.7
Other pills	50	25.6	6	27.3	7	53.8

Housing

As previously noted in this report, housing is a major need among all PLWH/A. Delayed care seekers and the unconnected to care are much more likely than all PLWH/A to have unstable housing and be recently released from a correctional facility. Nearly one quarter of the delayed care seekers and 30% of the unconnected to care are currently homeless, living either in the street or in a homeless shelter. In addition, more than half of both groups have a history of being homeless, with 30% of the unconnected to care, and 51% of the delayed care seekers have been in transitional housing during the past two years. Over 30% of the unconnected to care and the delayed care seekers do not feel that their housing is safe, stable, nor habitable. Delayed care seekers and the PLWH/A unconnected to care pay substantially less than other PLWH/A for housing. More than 40% of all the PLWH/A are on the housing waiting list (HWL). With 47% reporting being on the HWL, delayed care seekers are more likely than the unconnected to care to be on the waiting list. Much fewer unconnected to care have received referrals from the HWL and even far less have had a housing placement resulting from a referral. However, with the exception of supportive housing, the delayed care seekers and the unconnected to care report needing less housing service than all of the other PLWH/A. Nonetheless, for the delayed care or unconnected to care, rental assistance is the greatest housing need.

Delayed care seekers and those unconnected to care are much more likely to have been in jail. Forty percent (40%) of the delayed care seekers and 30% of the unconnected to care have been in jail for some length of time over the past two years while about 15% of all PLWH/A report some contact with the correctional system in the past two years.

Need for Care

While more than 80% of all the PLWH/A report seeing a physician on a regular basis during the past year, a much lower proportion of the delayed care seekers (54%) and unconnected to care (40%) report having on-going care. Delayed care seekers are slightly more likely than other PLWH/A and those unconnected to care to have had the same physician since finding out their HIV status.

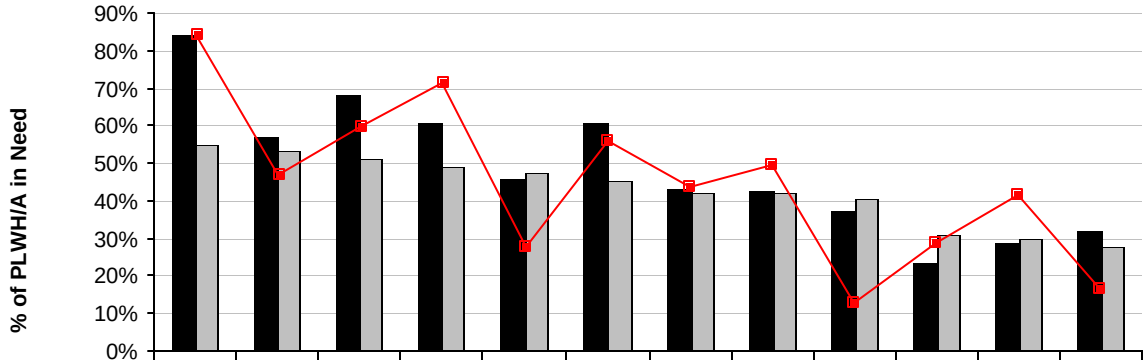
Comparable to the other PLWH/A, the most common places where the delayed care seekers and the unconnected to care have received care are San Francisco General and local neighborhood clinics. As expected, the delayed care seekers and the unconnected to care are much less likely than other PLWH/A to seek care from a private doctor.

Top Service Need

Figure 7-1 shows the top service needs for the delayed care seekers and the unconnected to care, ranked by the need reported by the unconnected to care. Overall, the unconnected to care report much lower service needs than other PLWH/A. However, consistent with the general PLWH/A population, the delayed care and unconnected to care ranked outpatient medical care as their number one need. The ranks for dental care, food pantry, and case management shifted from one

population to the next. However, these services generally remained among the top six service needs. Food vouchers, rental assistance, taxi vouchers, and outpatient substance abuse counseling represent a much higher need among the unconnected to care and the delayed care seekers than for the other PLWH/A.

Figure 7-1 Top Service Needs for the Delayed Care Seekers and Unconnected to Care



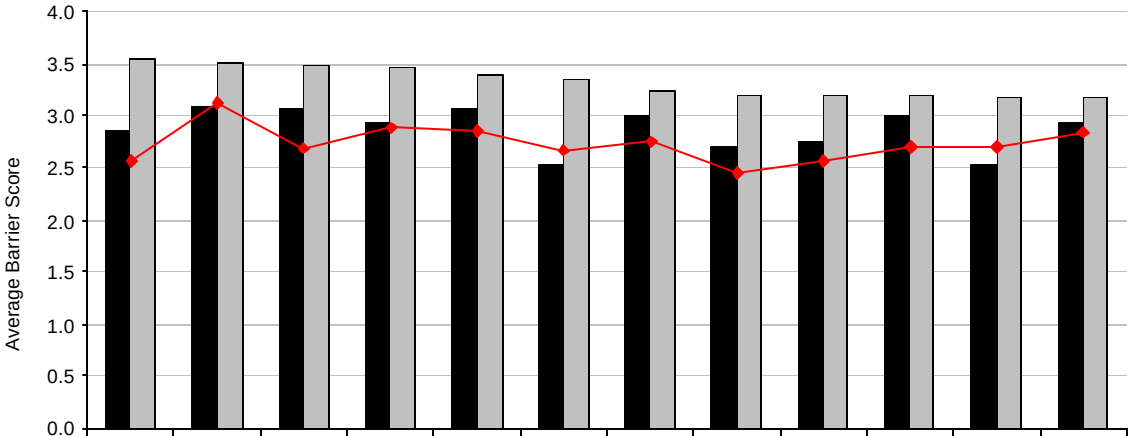
	Outpt med	Food Vouch	Food pantry	Dental care	Rental asst	Case mangnt	Housng Info Srvcs	DEFA	Taxi Vouch	Peer Adv	Benefit counsl ng	Outpt subs counsl
Delayed Care	84.3%	56.9%	68.0%	60.8%	46.0%	60.8%	43.1%	42.9%	37.3%	23.5%	28.6%	32.0%
Unconnected	54.8%	53.5%	51.2%	48.8%	47.6%	45.2%	41.9%	41.9%	40.5%	31.0%	30.0%	27.9%
Total	84.0%	46.7%	59.4%	71.5%	27.7%	56.1%	43.6%	49.8%	12.7%	28.9%	41.5%	16.7%

Barriers to Care

The criteria for delayed care or being unconnected to care allowed for the inclusion of PLWH/A who have returned to care after some disruption in their care. By definition all of the delayed care seekers had sought treatment at some point since being diagnosed with HIV, and 31 out of the 43 unconnected to care had returned to care. For most, the main reason for seeking care or returning to care was that they got sicker. Obtaining stable housing was the second most common event that caused delayed care seekers or unconnected to care to seek treatment.

Overall, PLWH/A feel that services are relatively easy to access and feel that, even when they face barriers, on average, these barriers are between small to moderate. However, not surprisingly, the unconnected to care report higher barriers, with an average barrier score between moderate to big (score 3.10). Figure 7-2 shows that the fear of lack of confidentiality is a major concern for the unconnected to care; and was more of a barrier than for the delayed care seekers and other PLWH/A.

Figure 7-2 Top Barriers - Delayed Care and Unconnected to Care



	Lack of confi-dentiality	Not knowing service	Lack of insu-rance	Not knowing who to	Cost of the service	Not knowing med serv	Not elig for serv	Communi cating w/ provider	Navigate the system	Rules and regs	Not knowing location	Wait for an appointm
DELAYED	2.9	3.1	3.1	2.9	3.1	2.5	3.0	2.7	2.8	3.0	2.5	2.9
UNCONNT	3.5	3.5	3.5	3.5	3.4	3.3	3.2	3.2	3.2	3.2	3.2	3.2
Total	2.6	3.1	2.7	2.9	2.9	2.7	2.8	2.4	2.6	2.7	2.7	2.8

Out-of-Care – Qualitative Comments

A separate focus group was conducted among PLWH/A who have currently been out of care for more than six months or who report a history of being out of care for more than twelve months since finding out their HIV positive status. The group consisted of six individuals, five men, one woman, one African American, one Latino, and four Anglos. While not generalizable to the population of PLWH/A out of care, the comments from the focus group participants help elucidate some of the factors influencing the decision to seek care.

For instance, an Anglo MSM shared his opinion on why PLWH/A may choose not to go to the doctor. He said, *"I do think that judgment, cultural sensitivity, and language sensitivity have all played a part in that. Also people are worried about the fact that there may be a push for medications instead of looking for alternative choices such as strategic treatment interruptions. I know a lot of people that don't want to do the medications at all, because of the history of what they've seen happen to people or the fact that we already now know that they may have direct correlations to things like the lipids. They may lead to things like lipodystrophy. They may create that at a much higher rate for people so people don't even want to go on them until you can give them a test that shows what's the likelihood of that happening to them and it can be cured, altered, or stop the results of that ever happening to our body image and also toxicities in the first place people don't want to go in there. When they go in to their providers the message is your lab work says we need to get you on meds or I've had friends that have had the reverse who are feeling that their body is really on some level in an 8 to 10 year period HIV positive starting to breakdown something they feel internally, but their lab work doesn't support. They're keeping their virus at check and the CD4's are okay and they're fighting with their caregivers now to try and get on meds. So I see it from both places. People that don't want to be told to get on meds*

until we have more clear reality of fine tuning the test so we know what to do or people who are feeling internally and emotionally, 'I think maybe I need to,' and the doctor is going, 'Well according to the new CDC standards we shouldn't be doing this,' and fighting them back. So that's also happening. I've seen both sides of the coin and it's making people not want to go in. And if I were to ever not have insurance again I think I would be in some other place."

For some PLWH/A who have delayed care, denial was a major reason for not seeing a doctor within six months of their diagnosis.

An African American IDU female explained, *"Yeah it took me a long time after my diagnosis to see a doctor. It took me almost a year. After I got out of jail I was like, 'I don't need that.' It was about my own denial knowing that I did everything that was possible in the book while using needles and everything. Thinking I was more cautious than I was or as careful as I should have been. I thought people couldn't get that from me, because I kept the needles I used to get high. But that was just my denial. So I looked around and I saw people that I used to see that I don't see anymore. They're dead. I had to realize this is what I have to do. They didn't take care of themselves. I must take care of myself, because I do want to live."*

Another African American IDU female also had to face her own denial. She said, *"I was in denial too. I was devastated when I found out and I got heavier in my addiction. I didn't tell my family. I went on for about two years until I got really, really sick with pneumonia. All that time I just got into my addiction. I was in denial. I didn't care. I was just doing everything known to man, and I got really sick with pneumonia. That's when I finally woke up and said, 'I need help. I need to get a doctor,' and I started medication, AZT and all of that. But it took me about two years after my diagnosis."*

For an African American MSM the diagnosis was more than he could handle at the time. He said, *"It was kind of devastating so it was several years until I decided this is reality so I then started seeking medical care."*

This was a similar experience for a homeless male who said, *"It took about three years because it was just hard to believe. It was hard for me to accept it."*

In addition, current substance use and unstable housing were reasons for PLWH/A postponing or foregoing treatment.

A homeless participant talked about his experience with substances. He said, *"It took me four years. It was drugs. I couldn't get myself together enough to go in. My life means something to me now. The drugs are always going to be there. We're not going to be there if we are on dope."*

A San Mateo African American female was particularly vulnerable being homeless and actively using drugs. She said, *"'I was homeless for a while and didn't see the doctor for a year in San Francisco. I couldn't see the doctor because I was doing drugs. I got back on methadone and started seeing a doctor because I got tired of being sick."*

A San Mateo African American male was also more committed to using drugs than to his own medical care. He described his struggle as follows, *"I've had a period of six months or longer without seeing a doctor and that's because of my addiction and my relationship with the streets. I just didn't go in. I was on a mission and then once I got picked up and then once I got out of prison again then I went back [to the doctor]. We're known for that. I always went back to the same doctor and his response would be that I needed to change my lifestyle, because all I was doing was driving myself to the grave. [Each time I was released, on my mind was] to get back on medications and also get an overall view of my health because in prison they have resources for people with HIV, but the resources are very scarce and hard to find. They just have minimal treatment there and I needed a lot more treatment. I was having a lot of other problems and they weren't treating it at all. I mean they were giving me pills and that was it. They didn't evaluate my physical status at all. As long as I was alive that's all they wanted. When I left them then I would go to the doctor."*

An IDU Latina had to seek drug treatment prior to feeling comfortable seeing a medical provider. She said, *"I didn't see the doctor because of my drug usage. I was ashamed and didn't want to see anybody so I didn't go. They would call me but I wouldn't come in."* She returned to her doctor six months ago after starting a drug treatment program for fear that her children would be taken away from her.

Shame was also a factor for a transgender who said, *"I did it (stayed out of care), because I was embarrassed, because when I was on drugs I didn't want anybody to see me like that, because there were people trying to help me and here I am using. I didn't feel right."*

In the focus groups PLWH/A often spoke about the need to stay mentally positive in order to manage their HIV. For some staying mentally positive meant staying away from doctors and clinics.

For instance a Latino MSM said, *"I just started going now to the doctor but I had not gone for two years because hospitals and medicine stress me out a lot. I believe that if you keep yourself mentally positive you can stay well. But one never knows what's going on inside."*

Another Latino MSM said, *"Three years ago I stopped going to the clinic and one of the reasons was that I wanted to feel conscious of being alive. Sometimes it's because I don't have anytime because I work six days a week. When I go to the clinic, I'm confronted with the reality that I have the disease and I get very depressed. I rather just go to church because either way I know that I'm going to die one day so I prefer to enjoy my life. Going to the clinic means confronting a part of me that I want to hide, while going to church heals my soul. I found myself in a very bad situation and had to take medication and again I found myself confronting that I'm ill and I don't like that. I like to live, not think about death."*

Other reasons for not seeking care, as discussed below were not feeling sick enough to require treatment, feeling scared and not knowing what to do or where to go for help, not wanting to take medications or not having medical insurance.

An African American MSM said, *"Once I found out I didn't immediately go. I didn't go for about a year because I couldn't find a doctor that I wanted to go to, and I wasn't sick. I wasn't dying. It wasn't like I was going to drop off and die the next day after I found out. Once I found out I just started drinking and stuff. I started feeling better about living with this."*

An African American MSM who hasn't seen a doctor in six months and has no scheduled appointment coming up said he is not concerned that once he develops symptoms that he may have a wait to see the doctor. He said, *"No not really because I'm thinking you can see any doctor then. I could probably go to the clinic and I could go back to Bay View and see a doctor. So no if I got sick I'm sure they would take me in."*

A heterosexual Latina who did not see a doctor for the first seven years after her diagnosis explained, *"I was real scared and I did not want to get treated. People started influencing me by asking who was I going to leave my daughters with and [pointing out] that I had to get a lawyer. I told them 'No, I'm not dying.' Honestly I was real scared because I didn't know where it came from."*

An Anglo MSM suggested he would stop seeing his doctor if he chose to stop following his medication regimen. His doctor is resistant to that idea and suggested to him that he should find another doctor if he wants to stop meds.

An Anglo MSM discussed his not seeing a doctor for several years because he didn't have health insurance. He changed jobs and didn't have the funds to maintain COBRA. He said, *"I didn't have any insurance for several years. I didn't seek any care for close to 2 years and I needed asthma medication. Someone suggested a free clinic in Haight Ashbury and I went to get my asthma prescription. At that point they went through their questions and I said I was positive. They asked if I had been getting engaged in care and I said I hadn't. They said they actually had an HIV program and I got involved in my initial care through them. Probably for about the first 20 months after I was positive I didn't receive much care, I guess for the first two years and the majority of that time I didn't have insurance."*

Focus group participants also discussed barriers faced by those in care that may lead PLWH/A to discontinue care.

For instance, the perceived quality of services may affect a PLWH/A's decision to discontinue care. A Latino MSM said, *"I've never stopped going to the doctor, but I know that there are a lot of people that leave because of the services they get. Sometimes some of the doctors do not speak Spanish while others do not understand. The secretaries they have do not care one bit that we are not understood. The paper work that has to be done and the service is not bad, but it could be a lot better."*

The fear of loss of confidentiality was among one of the top barriers faced by the unconnected to care. A Latino MSM described this as follows, *"You asked why don't we go to the clinics and I'm telling you that this is why…because being a Latino one does not want to advertise that one is ill."*

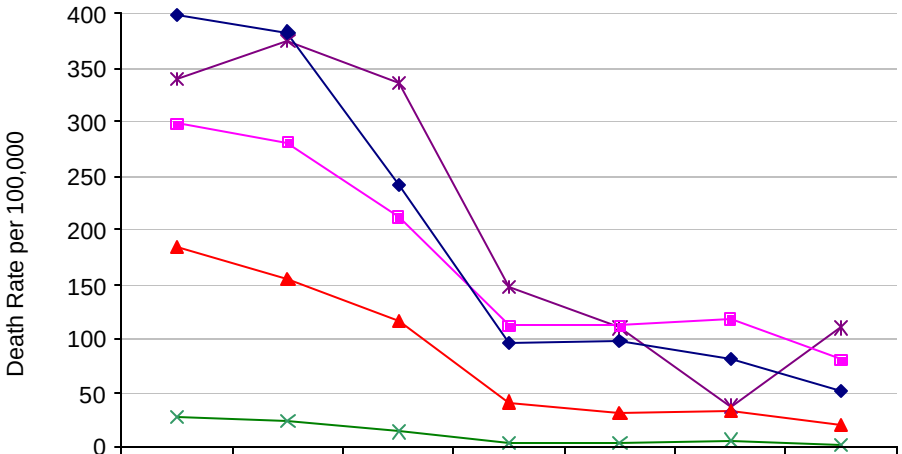
8. OUTCOMES

Fewer people dying of AIDS and improved quality of life for those living with HIV and AIDS are two outcomes measured in this needs assessment.

Mortality

As a decline in diagnosed AIDS cases and increase in those living with AIDS is observed, it is not surprising to see that the overall death rate (defined by the crude death rate per 100,000[9].) has declined. As shown in Figure 8-1, a sharp decline in death rates has occurred among all ethnic populations since 1995. However, the death rate among the African American population has remained higher than that of the Anglo, Latino, and API populations. At the end of 2000, the death rate among African Americans was almost twice as high as that of Anglos and over four times the death rate among Latinos.

Figure 8-1 HIV/AIDS Deaths by Ethnicity per 100,000 of San Francisco County Population



	1994	1995	1996	1997	1998	1999	2000
Ntv Am*	339	375	335	148	111	37	110
Af Am	299	281	213	113	111	118	80
Anglo	399	381	242	97	98	81	51
Latino	184	156	116	42	31	33	19
API	27	23	13	5	5	6	2

This large discrepancy between African Americans and other ethnic populations is somewhat moderated by the fatality rates shown in Figure 8-2. The "case fatality rate" measures the death rate among a cohort diagnosed with AIDS during a certain calendar year. This "fatality rate" measures the death rate among a cohort diagnosed with AIDS during a certain calendar year and tracked to determine year of death. For instance, in 1994, 2022 were diagnosed with AIDS of

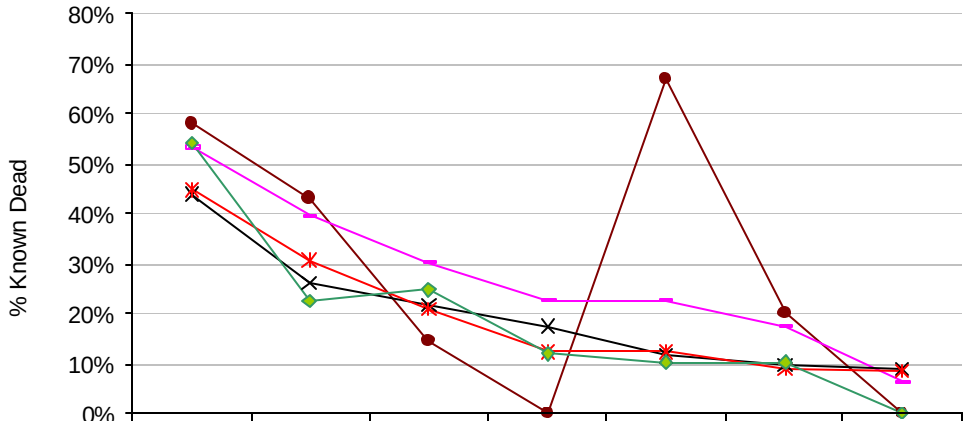
[9] The mortality rate, or rate of death per 100,000 reflects everyone who was recorded by a doctor on the death certificate as dying of AIDS-related disease for a specific year. .

which as of this date 923 have died, indicating a fatality rate of 46%. For the cases diagnosed in 2000 (n=559) the fatality rate is 8%. Case fatality rates are expected to decline for more recently diagnosed cases because of improved care and shorter periods of time with AIDS, but they are useful for comparing between groups how lethal it was over time to be diagnosed with AIDS.

Figure 8-2 indicates that from 1994 to 1997, fatality rates declined at about the same pace for Anglos, Latinos and African Americans. However, from 1997 to 2000 the difference in rate among these three ethnic groups broadened, with the Anglo and Latino fatality rate decreasing at a faster pace than the rate for African Americans. In 1999, the fatality rate among African Americans (18%) was almost double the rate for Anglos (10%) and Latinos (9%).

Caution should be taken when looking at the sharp decline noted from 1999 to 2000. While the rapid decline in fatality rate for African Americans may suggest the dramatic success of the medications and/or an improvement in treatment adherence, it may be too soon to consider this a trend

Figure 8-2 % Fatality Rate - Deceased by Year of Diagnosis



	1994	1995	1996	1997	1998	1999	2000
Ntv Am	57.9%	42.9%	14.3%	0.0%	66.7%	20.0%	0.0%
Af Am	53.1%	39.4%	30.1%	22.8%	22.7%	17.7%	6.3%
Anglo	43.7%	26.1%	21.9%	17.6%	11.6%	9.6%	9.0%
Latino	44.7%	30.8%	20.9%	12.5%	12.5%	8.8%	8.7%
API	54.1%	22.7%	24.5%	11.8%	10.3%	10.3%	0.0%

Physical and Mental Health

Other outcomes measured for the system of care are current and changed physical and mental health. While no baseline physical or mental health measures are available for PLWH/A, survey participants rated their current physical and emotional health and then compared it to "when they first sought treatment for their HIV infection" (questions 23 through 24a, Attachment 3). The assumption tested is that access to care, and in particular to new HIV drug therapies, have a

positive impact on the physical and mental health of PLWH/A seeking care. Consequently, improved physical or emotional health after seeking treatment would suggest the care system is meeting one of its major objectives.

Drug therapies, however, may not have the same beneficial affect across all populations, and some PLWH/A may experience severe side-effects that compromise both physical and mental health. Additionally, there are disparities in access to care and treatment that may also impact quality of life. As a result of these factors, it is expected that some of the survey respondents will report decreasing physical and emotional health regardless of the quality of the treatment.

Figure 8-3 and Figure 8-4 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. Not shown in the figures is that of those living with AIDS, nearly three quarters (71%) said they were symptomatic, and 29% said they were asymptomatic.

- Over 90% of PLWH with no symptoms rate their physical health as good or excellent. Thirty-eight percent (38%) say that their physical health is better now as compared to when they first sought treatment and another third say their health is the same.
- In contrast, about 50% of symptomatic PLWH report that their health is good or excellent. About 45% report their physical health as fair . Twenty-nine percent (29%) say their health is a little better now that when they first sought treatment, and about 40% say that their health is a little worse.
- While PLWA have a higher number reporting poor health (15%), over 70% say they have fair to good health. They report the greatest improvement in health compared to those at other stages of infection since they started treatment (53%). In comparison to symptomatic PLWH, symptomatic PLWA are currently doing better with 14% reporting poor health compared to 20% of the symptomatic PLWH. PLWA say that their physical health is better now than it was when they started treatment (53%) compared to symptomatic PLWH (29%).
- PLWH/A 24 years old or younger, APIs, and African Americans report the best physical health whereas transgender persons, Native Americans, and those diagnosed with AIDS outside the EMA report the worst current health.

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.

- The large percent of asymptomatic PLWH reporting poor emotional health (11%) may be connected to concern of their recent diagnosis. But a majority (52%) report better emotional health than their initial diagnosis.
- Surprisingly, PLWA have a higher number reporting excellent emotional health (16%). They also report the greatest improvement in health compared to those at other stages of infection since they started treatment (55%).

- Females, APIs, Native Americans, and San Mateo residents report the greatest improvement in their emotional health, while Transgender and PLWH/A 24 years or younger report the poorest improvement in emotional health.

Overall, based on improvement in both physical and emotional health, the care system is making an impact. Those with AIDS appear to show the greatest improvements. HIV symptomatic populations are having the worst outcomes.

Figure 8-3 Quality of Life – Physical Health

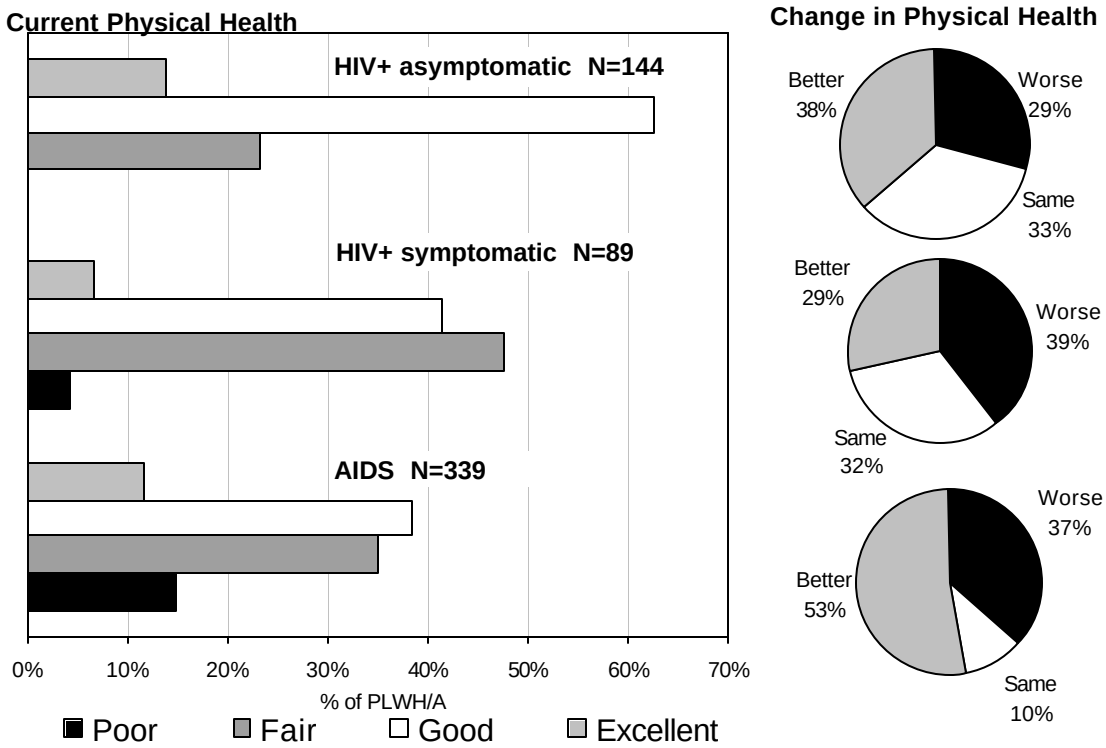
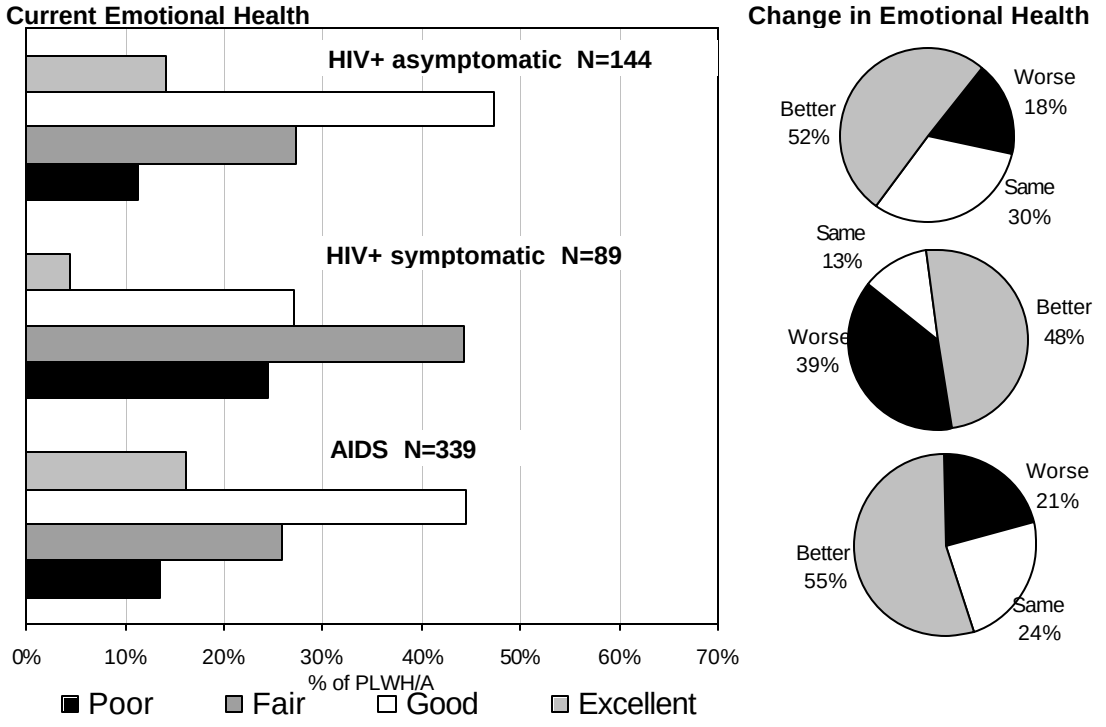


Figure 8-4 Quality of Life – Emotional Health



Quality of Life – Qualitative Comments

The participants' comments in the focus groups highlight the importance for PLWH/A to not only stay physically healthy but also to maintain a positive outlook on their lives.

A Latino MSM described the quality of his life as follows, *"I've been living in San Francisco for 18 years and I'm from Havana. I'm 56 years old and I know how to take care of myself. Sometimes I live a very happy life as well as a bitter one because I'm not having any sex. Sex does not exist for me anymore. What I do is share my life with my family and friends and educate others so that they do not get infected."*

And another Latino MSM said, *"In 1990 I had pneumonia and I realized that I had AIDS. At the time people were dying much faster than now and I feel that there is a lot of health in my life, in a certain way I feel very lucky and proud that I have not been consumed by the symptoms and illnesses."*

Others, however, in addition to living with HIV/AIDS, have also had to face other life challenges. For instance, a homeless man struggles living with HIV. He describes his experience as follows, *"I'm 37 years old and I've had HIV for 7 years. I'm asymptomatic but I have neuropathy. I was only homeless for three months out on the streets living with the rats, and then I finally got into an SRO here for two years now. My health, I've been getting infections easily now so I'm kind of scared and it's not easy living here in San Francisco. It's not easy because it's too expensive and a lot of our programs have been taken away from us and it's really hard."*

9. MEDICATION AND ADHERENCE

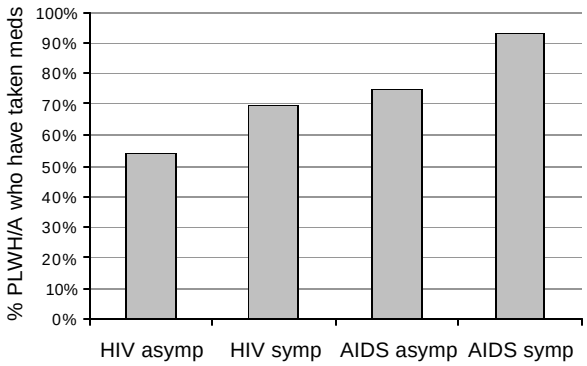
Medication and Adherence

Taking Medication

The use of combination therapy and prophylactics to prevent opportunistic infections has greatly improved the length and contributed to the quality of life of PLWH/A. Continued and improved health status outcomes will depend, in part, on the availability, access, and adherence to properly prescribed medical regimens.

Seventy-seven percent of all PLWH/A report taking medicines to treat their HIV infection, but as shown in Figure 9-2, there is a linear relationship with stage of disease, with 93% of symptomatic PLWA reporting taking medication.

Figure 9-1 Medication by Stage of Infection



Of those taking medication, 82% are currently on combination drug therapy. 92% of PLWA who are asymptomatic are taking combination drug therapy, while 85% of PLWA who are symptomatic report taking combination therapy.

Females are more likely to have taken HIV medications (82%) than either males (77%) or transgender persons (56%). Undocumented, out-of-care, recently incarcerated, and homeless report a much lower use of medication. Over two-thirds (67%) of undocumented persons, 62% of the recently incarcerated, and 51% of the homeless, and fewer than 50% of people who are currently out-of-care have a history of taking medications to treat their HIV.

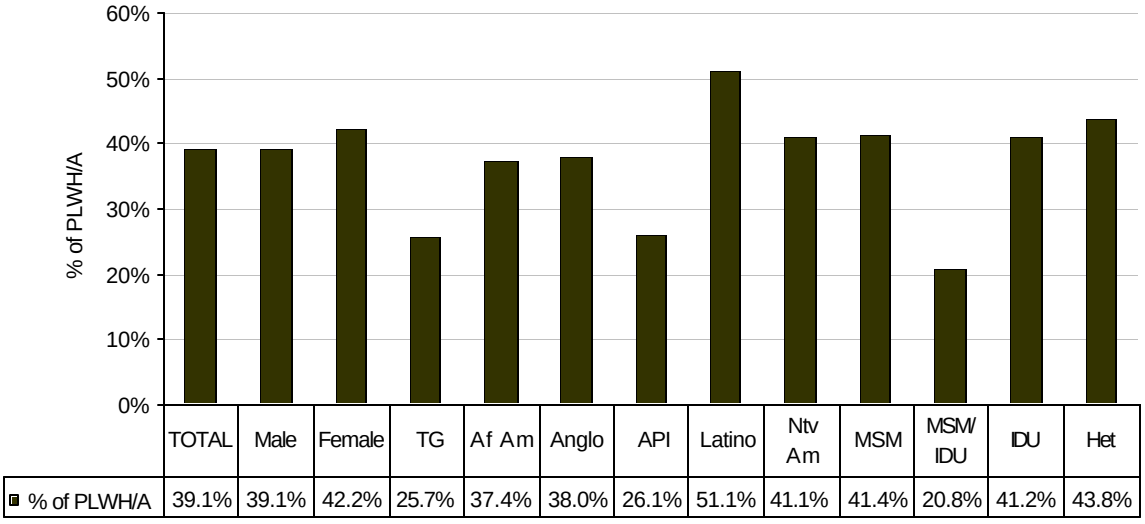
Adherence

Thirty-nine percent of PLWH/A report never skipping their medications, and at the other extreme, seven percent have stopped taking their medicines.

- Among gender groups, transgender persons are far more likely to have stopped taking their meds (31%) than either males at 6% and females at 13%.
- Latinos adhere substantially more than other ethnic populations.
- Persons 24 years old or younger have a very high rate of stopping medications at 20% compared to all PLWH/A.
- Notably, symptomatic PLWH/A are more likely to stop taking their medication than asymptomatic PLWH/A.

Figure 9-2 shows adherence to medications across different sub-populations. Groups that appear to have the most trouble adhering to medication schedules include MSM/IDU (21%), Asian/Pacific Islanders (26%) and transgender persons (26%).

Figure 9-2 PLWH/A Who've Never Skipped Their Medications



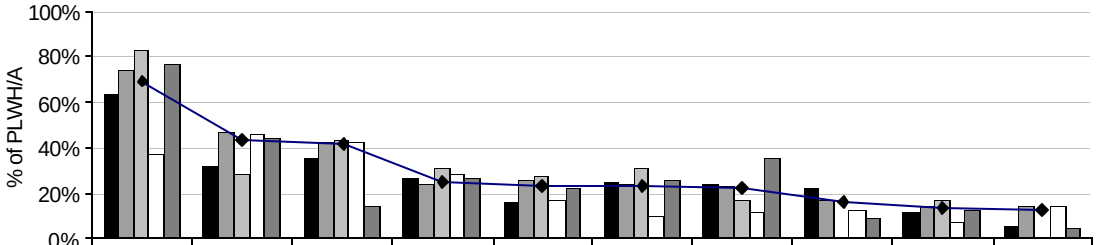
	TOTAL	Male	Female	TG	Af Am	Anglo	API	Latino	Ntv Am	MSM	MSM/ IDU	IDU	Het
% of PLWH/A	39.1%	39.1%	42.2%	25.7%	37.4%	38.0%	26.1%	51.1%	41.1%	41.4%	20.8%	41.2%	43.8%

Figure 9-3 and Figure 9-4 indicates that the top reasons for discontinuing medications for all PLWH/A.

- Among all groups, forgetting to take them (69%) is typically the major reason for skipping medication, with Asian/Pacific Islanders (83%), Native Americans (77%), and MSM (72%) the most likely to forget.
- PLWH/A who are symptomatic and PLWH who are symptomatic also have higher rates of forgetting than those who are asymptomatic.
- The next two most common reasons cited for skipping doses were side effects of medications (44%) and the difficult medication schedules (42%). Anglos (47%), Latinos (46%), and Native Americans (44%) appear to have a greater problem with side effects than other ethnic groups. Native Americans (14%) report the least trouble with the medication schedule. MSM (46%) and IDUs (44%) cite side effects as a reason for skipping more frequently than do other risk groups.

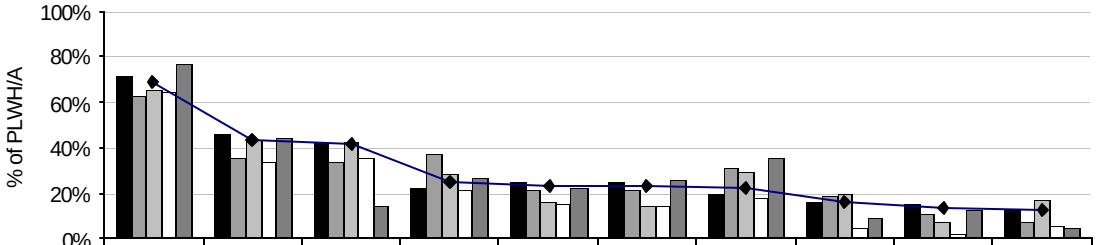
- Attachment 7 and focus groups indicated that Native Americans (35%) and recently incarcerated PLWH/A (36%) cited running out of medications far more frequently than did any other group.
- The two least cited reasons include medications did not work (13%) and did not need meds (13%).

Figure 9-3 Reasons for Skipping or Stopping Medications by Ethnicity



	Forgot	Side effects	Difficult sched	Didn't want to take them	Hard to coor-dinate	Doctor's advice	Ran out	Homeless	Meds didn't work	Didn't need meds
AfAm	63.0%	31.7%	35.3%	26.2%	16.0%	25.0%	24.3%	22.5%	12.0%	5.7%
Anglo	74.1%	47.1%	42.5%	23.6%	25.3%	23.9%	23.3%	17.3%	14.3%	14.6%
API	83.0%	28.6%	43.9%	30.8%	27.1%	30.6%	17.1%	0.0%	17.0%	0.0%
Latino	37.8%	46.1%	43.1%	28.5%	16.9%	10.3%	11.6%	12.7%	7.4%	14.3%
Ntv Am	77.0%	44.1%	14.4%	26.1%	22.1%	25.4%	35.1%	9.0%	13.1%	4.5%
Total	69.4%	43.9%	41.5%	24.9%	23.2%	23.1%	22.0%	16.6%	13.4%	12.5%

Figure 9-4 Reasons for Skipping or Stopping Medications by Mode of Transmission



	Forgot	Side effects	Difficult sched	Didn't want to take them	Hard to coor-dinate	Doctor's advice	Ran out	Homeless	Meds didn't work	Didn't need meds
MSM	71.7%	46.2%	43.1%	21.9%	24.9%	25.1%	19.2%	16.1%	15.1%	13.2%
MSM/IDU	62.3%	34.8%	33.5%	36.5%	21.6%	21.2%	30.7%	19.2%	11.2%	7.7%
IDU	65.7%	44.0%	42.9%	28.0%	16.4%	14.8%	29.0%	19.4%	8.0%	16.8%
Het	64.1%	33.6%	36.2%	21.7%	15.7%	14.2%	17.7%	5.5%	1.9%	6.0%
Ntv Am	77.0%	44.1%	14.4%	26.1%	22.1%	25.4%	35.1%	9.0%	13.1%	4.5%
Total	69.4%	43.9%	41.5%	24.9%	23.2%	23.1%	22.0%	16.6%	13.4%	12.5%

Overall, 23% of PLWH/A report they stopped taking their medications under advice from a doctor. Asian/Pacific Islanders, PLWH/A in San Mateo County and persons who are HIV-symptomatic cited this reason more frequently than other groups.

10. SERVICES

Funding Sources for HIV/AIDS Services

Based on the 2001 Title I application, the San Francisco EMA has $203,676,646 in public funding for HIV/AIDS care. That includes about $38.7 million in Ryan White Title I funds, $20.3 million in ADAP (Title II), over $75 million in Medi-Cal and Medicare, $45 million in local funds, and about $9 million allocated from HOPWA.

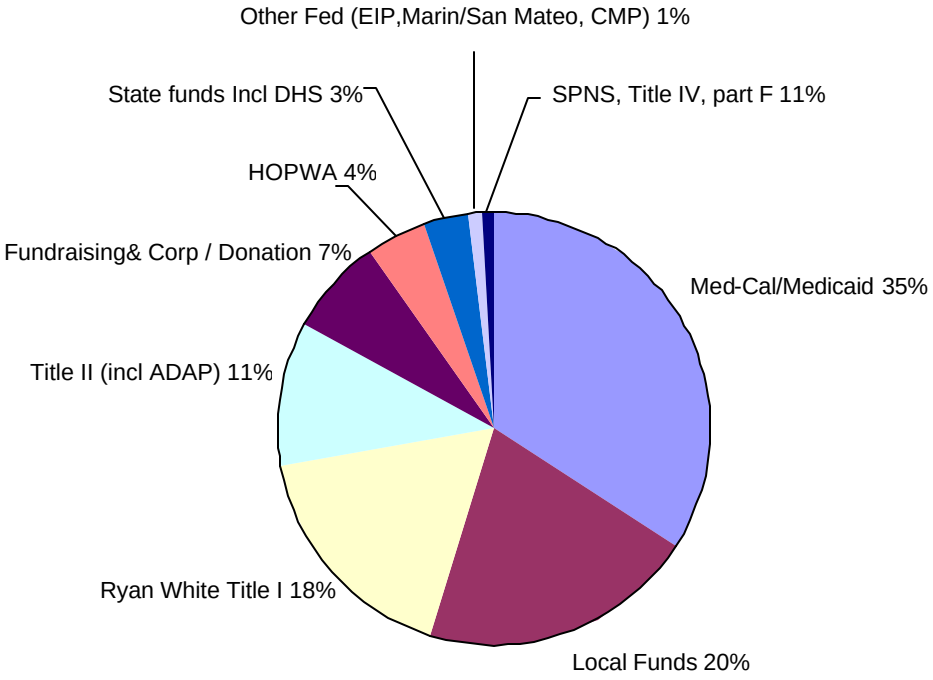
Provider Information Forms were sent to all recipients of Ryan White Title I funding. Forty-four out of 53 returned their survey (83%) and reported accounting for about 64% of all Title I funding based on the Title I application. In addition, 47% of the HOPWA funds were reported, under 4% of Medicaid/Medi-Cal, and less than 5% of Title II (mostly ADAP dollars). In short, providers were unable to accurately report substantial amount of funding they received. In addition the reported services account for only a fraction of the overall services provided in the continuum of care because of limited participation by many Title II, SPNS, Medi-Cal and Medicaid, and housing providers. While the provider forms are a beginning to building a comprehensive provider database, the use of the data for funding would be misleading.

Based on secondary data collected by the DPH plus the reported funds from fundraising, corporate donors, and donations reported in the Provider forms there is an estimated $219.9 million to fund and administer services in the HIV/AIDS continuum of care. Figure 10-1 shows the percentage distribution of funds by source. The largest source of funding in the system is Medi-Cal and Medicaid (combined both Federal and State contributions). Next is local funding that includes general funds, in-home support, housing, funds allocated to San Mateo and Marin counties, Memorandums of Understanding (MOUs) for various services, funds for incarcerated programs, and child welfare funds. Ryan White Title I funds account for 18% of all funds, followed by Title II funds, including ADAP.

In this figure, the 7% shown from private donations and corporate contributions is likely to be low. It was derived from the provider survey, and not every provider completed the survey.

In future needs assessments it would be useful to calculate the funding by service category, but this is not possible with the current data.

Figure 10-1 Care Funding Sources for HIV/AIDS



Service Categorization

Consumers were asked to rank their awareness of, need, demand, and utilization for thirty-five services, representing nine service categories shown in Table 10-1. The nine service categories are shown in order of the Council's 2002 service priorities. Some subservices such as dementia care and hospice care were not asked because those needing the services are under-represented in the sample, and they are proportionately a very small segment of all those living with HIV/AIDS. Information for priority and funding levels for these services are not provided in this needs assessment. Note that the Council does not prioritize subservices.

Table 10-1 Service Categories 2002 Priorities
(subcategories do not have priorities)

1. HEALTH CARE
- 1.1 Outpatient Medical Care
- 1.2 Medication Reimbursement
- 1.3 Dental care
- 1.4 Adherence Support
- 1.5 Home Health Care
- 1.6 Treatment Advocate
- 1.7 Complementary Care
- 1.8 Health Insurance Continuation*

2. HOUSING
- 2.1 Housing Info Services
- 2.2 Rental Assistance
- 2.3 DEFA
- 2.4 Supportive Housing

3. FOOD
- 3.1 Food Pantry
- 3.2 Food Vouchers
- 3.3 Home Delivered Meals
- 3.4 Nutrition Education

4. MENTAL HEALTH
- 4.1 Psychiatric Assessment
- 4.2 Residential Mental Health Services
- 4.3 Crisis Intervention
- 4.4 Peer Counseling

5. SUBSTANCE ABUSE TREATMENT
- 5.1 Outpatient Substance Counseling
- 5.2 Residential Substance Counseling
- 5.3 Detox/Methadone Maintenance

6. CLIENT ADVOCACY
- 6.1 Consumer Advocate
- 6.2 Benefits Counseling
- 6.3 Legal Services
- 6.4 Money Management

7. CASE MANAGEMENT
- 7.1 Case Management
- 7.2 Peer Advocate
- 7.3 HERR*
- 7.4 Employment Assistance *

8. TRANSPORTATION
- 8.1 Van Transportation
- 8.2 Taxi Vouchers

9. DAY/RESPITE CARE
- 9.1 Adult Day Care**)
- 9.2 Child Day Care

* not RWTI funded in SF

** Not RWTI funded as separate exhibit

Health care has remained the number one priority for the past eight years. Between 2001 and 2002, client advocacy was moved up to 6th priority, while case management fell to the 7th priority. Client advocacy includes legal assistance, benefits counseling, and money management. Based on consumer input, it was felt that consumer advocacy and peer advocacy served to draw people into care.

Most Needed Services

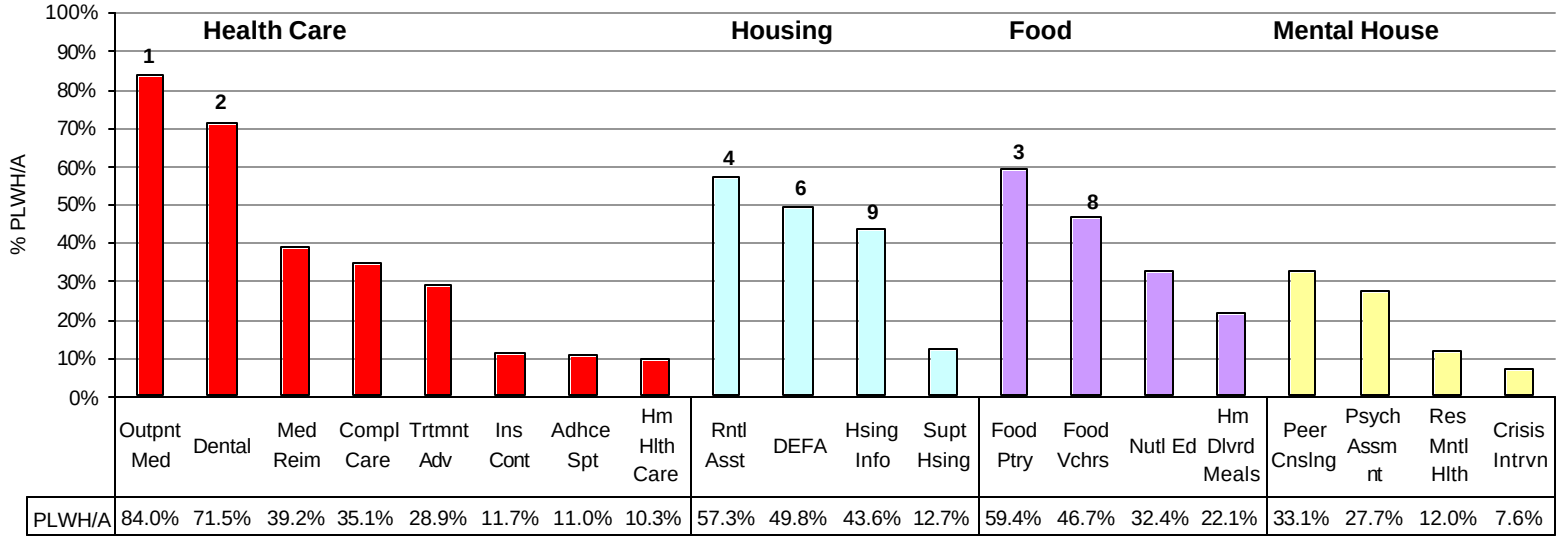
Top Rated Needs

Each PLWH/A who participated in the survey was asked if "you needed the service in the past year." The percentage needing the service is shown in Figure 10-2 on the next page. The graph is presented by the 2002 Service Priorities of the Council. Within the nine service priorities, sub-services are ranked by the percentage of PLWH/A who report they needed the service in the past year. The numbers on top of some bars represent the ranking of the top ten sub-services, regardless of overall service category.

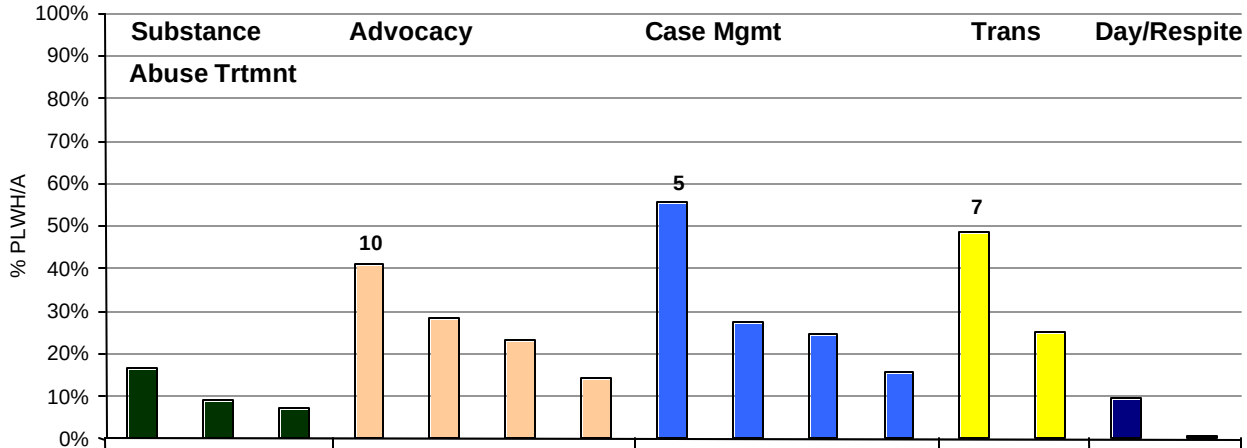
Figure 10-2 indicates that:

- The top two most needed services are within health care: 1) outpatient medical care and 2) dental care.
- Food pantry service is ranked third by PLWH/A. Food vouchers, one of the subservices within the food service category, are ranked 8th by the PLWH/A.
- Three of the top ten services are within Housing. Rental assistance is ranked 4th by PLWH/A, DEFA is ranked 6th, and housing information is ranked 9th.
- Case management, ranked 7th by the Council, is ranked fifth by PLWH/A, just below rental assistance.
- Taxi vouchers are ranked 7th by consumers.
- Under client advocacy, benefits counseling is ranked 10th by PLWH/A.
- Notably, the perceived need for substance abuse treatment is relatively low even though it is ranked 5th out of nine service categories by the Council. While ranked higher among IDUs, it is not near their top needs that include outpatient medical care, food pantry, rental assistance, and case management.
- PLWH/A do not rank any of the mental health sub-services as a top need, while mental health is ranked 4th out of nine by the Council.

Figure 10-2 Ranked Service Needs



	Outpnt Med	Dental	Med Reim	Compl Care	Trtmnt Adv	Ins Cont	Adhce Spt	Hm Hlth Care	Rntl Asst	DEFA	Hsing Info	Supt Hsing	Food Ptry	Food Vchrs	Nutl Ed	Hm Dlvrd Meals	Peer Cnslng	Psych Assm nt	Res Mntl Hlth	Crisis Intrvn
PLWH/A	84.0%	71.5%	39.2%	35.1%	28.9%	11.7%	11.0%	10.3%	57.3%	49.8%	43.6%	12.7%	59.4%	46.7%	32.4%	22.1%	33.1%	27.7%	12.0%	7.6%



	Outpnt Sub Abs	Detox/ MM	Res Sub Abs	Bene-fits Cnslng	Legal	Money Mgmt	Consu mer Adv	Case Mgmt	Peer Adv	Emply mnt Asst	HERR	Taxi Vchr	Van Transp	Ad Day Care	Child Day Care
PLWH/A	16.7%	9.1%	7.2%	41.5%	28.8%	23.4%	14.3%	56.1%	27.7%	24.4%	16.1%	48.8%	25.2%	9.5%	0.7%

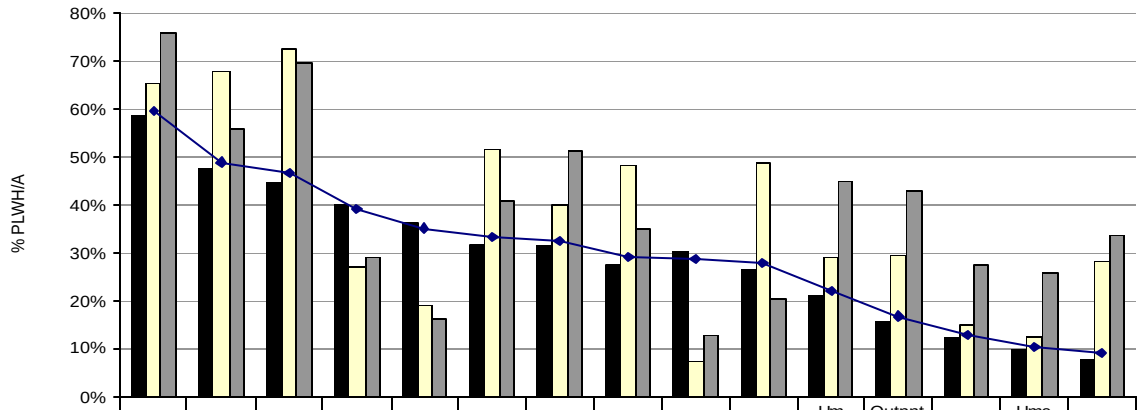
Top Service Needs: Sex and Gender Differences

As noted in detail in the following service templates, there are significant differences in the ranking between gender, risk group and ethnicity.

Selected services indicate a large gender difference. As shown in Figure 10-3, women place a higher priority on taxi and food vouchers than all PLWH/A.

- Women are more likely than men to report a need for taxi and food vouchers. They say they need more interaction with peers for peer counseling or peer advocacy, and also have a greater need than men for treatment advocacy.
- Women and transgender PWLH/A are much more likely than men to report a need for detoxification and methadone maintenance and crisis intervention. Women report the highest need for food vouchers.
- Transgender persons rank food services (food pantry, food vouchers, nutritional education, and home meals) higher than men, and with the exception of food vouchers, than women. They also say they have a greater need for residential mental health, and home health care. In addition they report a greater need for substance abuse outpatient counseling.
- Men are more likely to say they need medication reimbursement, complementary treatment, legal services, and employment assistance than women or Transgender persons. They are more likely to need insurance continuation than women.

Figure 10-3 Top Service Needs by Gender



	Food Bank	Taxi Vchr	Food Vchrs	Med Reim	Compl Care	Peer Cnslng	Nutri Ed	Tx Adv.	Legal	Peer Adv	Hm Dlvrd Meals	Outpnt Sub Abs	Supt Hsing	Hme Hlth Care	Detox/ MM
Male	58.7%	47.5%	44.7%	40.1%	36.4%	31.9%	31.6%	27.6%	30.4%	26.6%	21.2%	15.5%	12.3%	9.8%	7.5%
Female	65.2%	67.8%	72.8%	27.3%	19.0%	51.6%	40.1%	48.3%	7.4%	48.8%	29.0%	29.4%	15.0%	12.5%	28.0%
TG	76.1%	56.0%	69.6%	29.0%	16.3%	40.8%	51.2%	35.0%	12.9%	20.4%	45.0%	43.1%	27.5%	25.9%	33.5%
Total	59.4%	48.8%	46.7%	39.2%	35.1%	33.1%	32.4%	28.9%	28.8%	27.7%	22.1%	16.7%	12.7%	10.3%	9.1%

Top Service Needs: Ethnic/Racial Differences

Figure 10-4 shows the ethnic/racial differences among the top ranked services.

Different PLWH/A of different races/ethnicities rate needs differently. In general, African Americans and Native Americans report higher needs for most services, including food pantry, DEFA, taxi vouchers, food vouchers, housing information, peer counseling, psychological assessment, van transportation, money management, outpatient substance abuse treatment, supportive housing, residential substance abuse treatment, and detoxification/methadone maintenance.

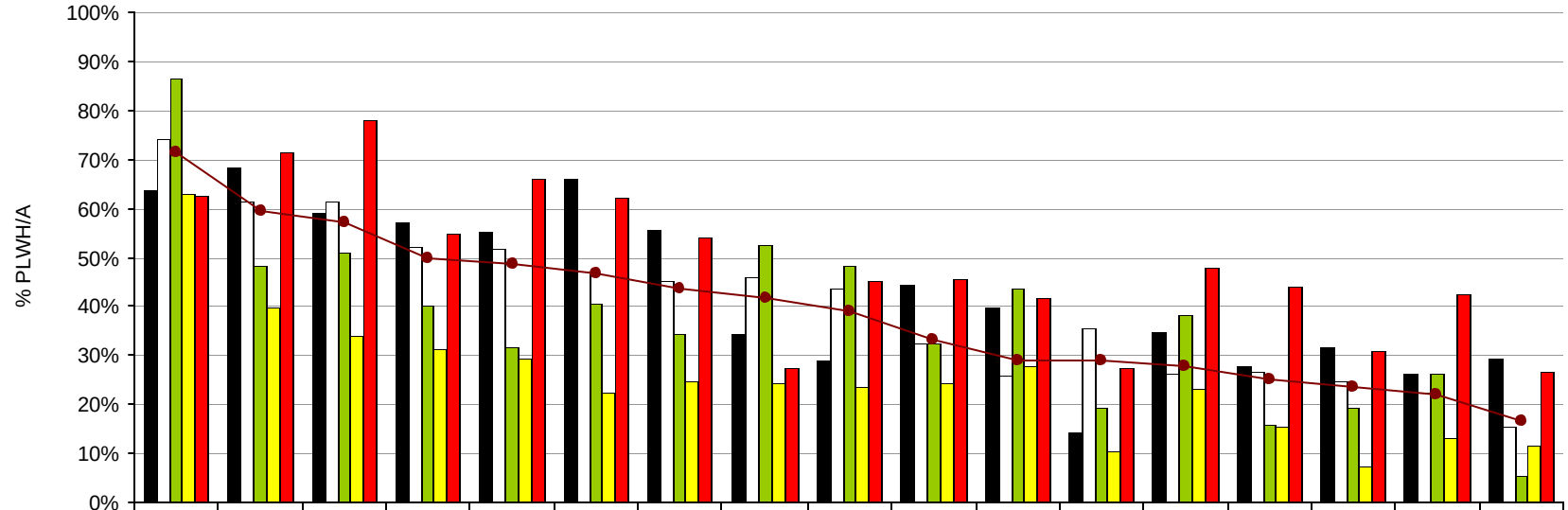
Native Americans express a higher need than other ethnic populations for case management, employment assistance, and health education risk reduction.

Latinos typically report the lowest need for services with the sole exception of reporting they need more heath education and risk reduction information. In surveys of this type Latinos often indicate a lower need for services, and this is likely to be due to lower expectations and the perception of lack of eligibility.

APIs report a greater need than other ethnic groups for dental care, case management, benefits counseling, treatment advocacy, and insurance continuation.

Anglos are more likely to report needing complementary care (along with Native Americans), legal services, psychological assessment (along with African Americans), consumer advocacy, employment assistance, and adult day care.

Figure 10-4 Top Needs by Race/Ethnicity



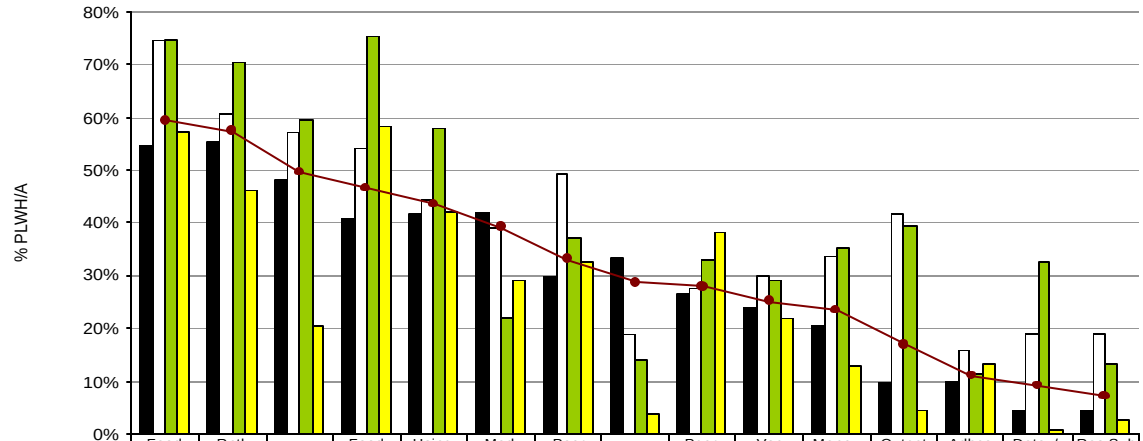
	Dental	Food Bank	Rntl Asst	DEFA	Taxi Vchr	Food Vchrs	Hsing Info	Benefits Cnslng	Med Reim	Peer Cnslng	Tx Adv.	Legal	Peer Adv	Van Transp	Money Mgmt	Hm Dlvrd Meals	Outpnt Sub Abs
Af Am	63.7%	68.5%	58.9%	57.2%	55.2%	65.9%	55.6%	34.3%	28.8%	44.3%	39.6%	14.4%	34.6%	27.9%	31.8%	26.4%	29.3%
Anglo	74.0%	61.5%	61.5%	52.1%	51.9%	47.3%	45.0%	45.8%	43.7%	32.4%	25.9%	35.7%	26.4%	26.7%	24.6%	22.4%	15.6%
API	86.6%	48.4%	50.8%	40.1%	31.5%	40.4%	34.5%	52.6%	48.4%	32.5%	43.8%	19.4%	38.1%	15.6%	19.4%	26.1%	5.5%
Latino	62.9%	39.9%	33.8%	31.5%	29.2%	22.4%	24.5%	24.3%	23.6%	24.2%	27.9%	10.3%	23.2%	15.6%	7.4%	13.2%	11.6%
Ntv Am	62.5%	71.6%	78.0%	54.8%	66.1%	62.3%	53.9%	27.4%	45.2%	45.4%	41.6%	27.6%	47.9%	43.9%	30.7%	42.5%	26.6%
Total	71.5%	59.4%	57.3%	49.8%	48.8%	46.7%	43.6%	41.5%	39.2%	33.1%	28.9%	28.8%	27.7%	25.2%	23.4%	22.1%	16.7%

Top Service Needs: Risk Group Differences

Most risk groups have a similarly high need for outpatient care and dental services. After these, needs differ by risk group. As shown in Figure 10-5 and Attachment 9:

- Heterosexuals and MSM often show the lowest need for many services, with the exception of benefits counseling.
- However, MSM have a higher need for medicine reimbursement and legal services.
- Heterosexuals have a higher need for peer advocates and home health care. They have a somewhat higher need for food vouchers.
- MSM/IDU and IDU have the highest need for food pantry, DEFA, money management, outpatient and residential substance abuse counseling.
- IDUs have the highest need for food vouchers, case management, housing information, rental assistance, and detoxification and methadone maintenance. MSM/IDU have the highest need for peer counseling and adult day care.

Figure 10-5 Needs by Risk Group



	Food Bank	Rntl Asst	DEFA	Food Vchrs	Hsing Info	Med Reim	Peer Cnslng	Legal	Peer Adv	Van Transp	Money Mgmt	Outpnt Sub Abs	Adhce Spt	Detox/ M M	Res Sub Abs
MSM	54.7%	55.3%	48.1%	40.9%	41.5%	41.9%	29.8%	33.4%	26.5%	23.9%	20.3%	9.7%	10.0%	4.4%	4.4%
MSM/IDU	74.5%	60.7%	57.1%	54.0%	44.3%	39.1%	49.3%	18.8%	27.7%	30.1%	33.6%	41.7%	15.7%	19.0%	18.9%
IDU	74.8%	70.2%	59.6%	75.4%	58.0%	22.2%	37.3%	14.1%	33.2%	28.9%	35.4%	39.5%	11.2%	32.4%	13.3%
Het	57.3%	46.1%	20.4%	58.3%	42.2%	29.1%	32.6%	3.8%	38.0%	21.9%	12.9%	4.5%	13.2%	0.7%	2.7%
Total	59.4%	57.3%	49.8%	46.7%	43.6%	39.2%	33.1%	28.8%	27.7%	25.2%	23.4%	16.7%	11.0%	9.1%	7.2%

Top Services by Special Populations

The templates in the following section detail differences by some of the special populations. In summary, some of the significant differences include:

Age

Youth have few needs greater than the average. In general, they express lower needs.

Those over 55, on the other hand, often express higher needs including higher than average needs for outpatient care, food pantry, DEFA, taxi vouchers, peer counseling, nutritional education, treatment advocacy, peer advocates, psychiatric assessment, money management, HERR, supportive housing, and residential mental health programs.

Region

Those living in the Tenderloin tend to report greater than average need for food pantry, food vouchers, and home delivered meals.

Those living in San Mateo report higher than average need for outpatient care, food pantry, case management, taxi vouchers, food vouchers, benefits counseling, nutrition education, treatment advocates, outpatient substance abuse counseling, and HERR.

Undocumented

Undocumented PLWH/A report higher than average needs for peer counseling, outpatient substance abuse counseling, supportive housing, residential mental health services, and residential substance abuse counseling.

Recently Incarcerated

Recently incarcerated PLWH/A report higher than average needs for several services including: food pantry, case management, DEFA, taxi vouchers, food vouchers, housing information services, treatment advocacy, van transportation, home delivered meals, supportive housing, detox and methadone maintenance, and residential substance abuse counseling.

Homeless

Homeless PLWH/A indicate greater than average need for DEFA, housing information services, treatment advocate, outpatient substance abuse counseling, detox and methadone maintenance, and residential substance abuse counseling.

Stage of Infection

Those at a later stage of infection tend to report a greater need for basic services, including food pantry, food vouchers, DEFA, money management, and home delivered meals.

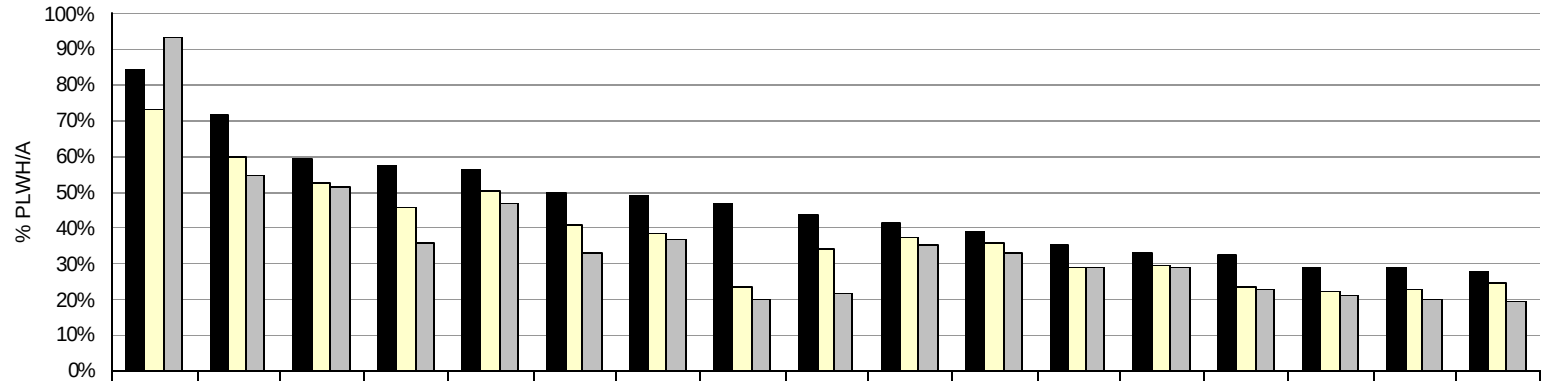
Asking for and Receiving Services

Participants in the survey were instructed to indicate whether they had asked for each of 35 services in the past year, and whether they received the service. As shown in Figure 10-6, perceived need, reported demand (asking for a service), and reported utilization (receiving a service) follow a similar, but not identical pattern. Figure 10-6 indicates that:

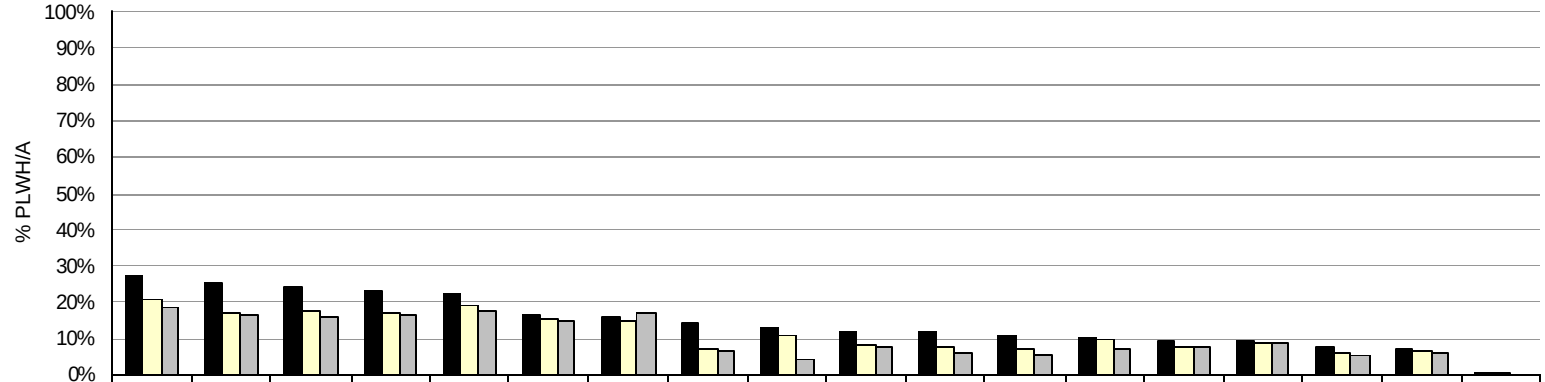
- With the exception of outpatient medical care, perceived need is higher than either the reported demand or utilization for each service.
- Demand is usually greater than utilization, with the exception of outpatient medical care and health education and risk reduction.
- The demand for services follows reported need, with the exception of food vouchers, where PLWH/A are considerably less likely to ask for them than other top ranked services.
- The difference in the rank order of utilization and need reflects the much lower utilization of housing services, including rental assistance DEFA, and housing information. There is also low utilization of food vouchers relative to the high reported need for food vouchers.
- While over 20% of the populations report currently using crystal meth, crack/cocaine, or heroin use, substance abuse services, including outpatient and residential substance treatment, is used by well under 20% of PLWH/A.
- While about 20% of the PLWH/A report significant adherence problems (skipping medication more than twice a month or stopping medications), the demand and utilization of adherence support is under 8% of PLWH/A.

The templates shown in the following chapter discusses need, demand, and utilization for subpopulations.

Figure 10-6 Consumer Need, Demand, & Utilization



	Outpnt Med	Dental	Food Ptry	Rntl Asst	Case Mgmt	DEFA	Taxi Vchr	Food Vchrs	Hsng Info	Benefits Cnsling	Med Reim	Compl Care	Peer Cnslng	Nutl Ed	Tx Adv	Legal	Peer Adv
Need	84.0%	71.5%	59.4%	57.3%	56.1%	49.8%	48.8%	46.7%	43.6%	41.5%	39.2%	35.1%	33.1%	32.4%	28.9%	28.8%	27.7%
Ask	72.9%	60.2%	52.7%	45.7%	50.5%	41.0%	38.6%	23.5%	34.3%	37.4%	35.8%	29.0%	29.5%	23.7%	22.3%	22.6%	24.5%
Receive	93.3%	54.7%	51.8%	35.7%	46.9%	33.2%	36.6%	19.8%	21.4%	35.2%	33.0%	29.1%	28.8%	22.5%	21.1%	19.8%	19.3%



	Psych Assmt	Van Transp	Emply Asst	Money Mgmt	Hm Dlvrd Meals	Outpnt Sub Abs	HERR	Cnsumr Adv	Supt Hsing	Res Mntl Hlth	Ins Cont	Adhce Spt	Hm Hlth Care	Ad Day Care	Detox MM	Crisis Intrvn	Res Sub Abs	Child Day Care
Need	27.7%	25.2%	24.4%	23.4%	22.1%	16.7%	16.1%	14.3%	12.7%	12.0%	11.7%	11.0%	10.3%	9.5%	9.1%	7.6%	7.2%	0.7%
Ask	20.8%	17.2%	17.4%	17.1%	19.2%	15.3%	15.2%	7.1%	11.1%	8.5%	7.7%	7.2%	9.7%	7.7%	8.6%	6.1%	6.9%	0.3%
Receive	18.8%	16.4%	15.8%	16.8%	17.5%	15.2%	16.9%	6.5%	4.1%	7.7%	6.3%	5.9%	7.2%	7.6%	9.0%	5.0%	6.2%	0.2%

Service Gaps

In addition to the ranking of service needs, the difference between what services are needed and what services are asked for ("unmet need") indicates a gap between what PLWH/A believe they need and their expectation of receiving a service. PLWH/A may not ask because they know or perceive they are ineligible, feel that they have no access, or do not know who to ask for in order to obtain the service. These barriers are explored in the next section.

The difference between what is asked for and what is received, "unmet demand", the misperception of the consumer on their eligibility for a service and/or the system's lack of capacity to provide requested services. Organizational barriers are further explored in the following section.

Figure 10-7 displays these gaps ranked by the unmet demand. It includes all services where there was a greater than five percent gap in either unmet demand or unmet need. For greater detail on any service or gap, the service template on each service is in Section 12, SERVICE AND BARRIER TEMPLATES; for page numbers see the table of contents.

Figure 10-7indicates that:

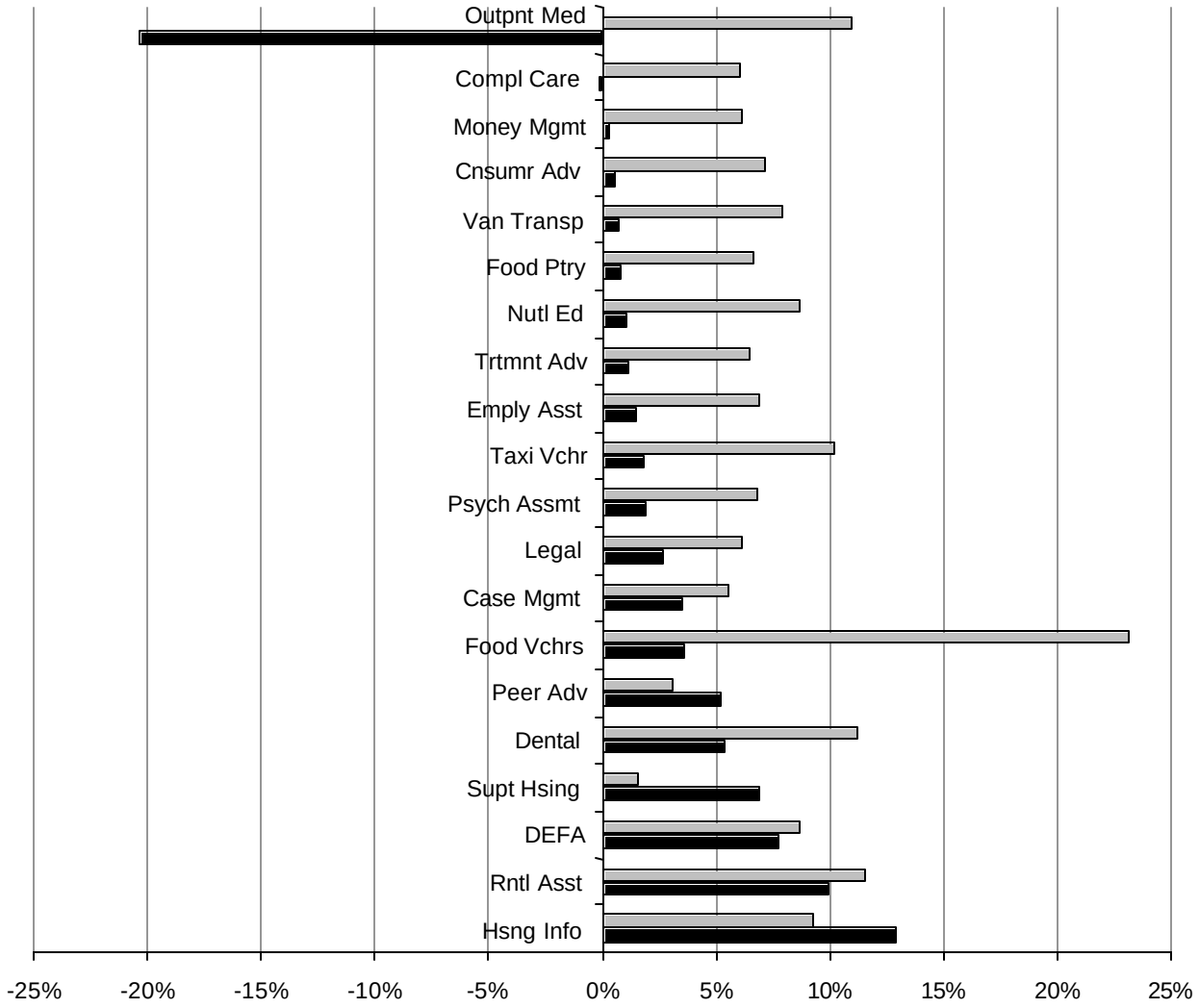
- The overall message is that unmet need and unmet demand is small. With the exception of the large unmet need for food vouchers, other gaps are under 15%.
- Outpatient medical care shows that there is no unmet demand; in fact more people receive the service than ask for it. The likely explanation is that most PLWH/A don't ask for the service; rather appointments are set. That would mean that more people receive services than "ask" for them. There is, however, and unmet need with over 10% of PLWH/A saying they need it, but not asking for it. This could reflect several things. As suggested in the out-of-care section, reasons for not asking for care were discussed in focus groups and include substance abuse issues, problems with confidentiality, access, perceived lack of service for specific subpopulations. See the focus groups comments at the end of the Health Care templates.
- The service with the greatest unmet demand is housing. Thirteen percent (13%) of PLWH/A ask for, but did not receive housing information. Ten percent (10%) asked for, but did not receive, rental assistance, 8% asked for but did not receive DEFA, and 7% asked for, but did not receive, supportive housing. Rental assistance also had a relatively high unmet need, but other housing services has a lower unmet need. This suggests that housing is high on the agenda of PLWH/A and they ask for it when they perceive they need it. As is clear by the survey and focus group responses, however, the demand for housing far exceeds the systems capacity to provide it.
- Dental and peer advocacy are the other two services with a demand gap above 5% suggesting that, with the exception of housing and dental, when PLWH/A ask for service they report receiving it.
- Dental care also is in the top five unmet needs. This may reflect the realization of many PLWH/A that services do not cover some dental needs or that they have used their allocation

of services. It may also reflect difficulty in obtaining appointments or traveling to the dental clinic.

- Taxi and van vouchers show an unmet need of greater than 5% suggesting that, based on focus groups, consumers find the system difficult to use or unresponsive to their needs.
- Other services with a difference of more than 5% between needing and asking for the service, include: case management, legal, psychiatric assessment, employment assistance, treatment advocacy, nutritional education, food pantry, van transportation, consumer advocacy, money management, and complementary care.

To better understand these gaps, the next section discusses general barriers to the system, and the following Section 12, SERVICE AND BARRIER TEMPLATES provides specific gaps and barriers for each service. Section 13, Conclusion draws these finding together and suggests some possible actions to overcome these gaps.

Figure 10-7 Service Gaps



	Hsng Info	Rntl Asst	DEFA	Supt Hsing	Dental	Peer Adv	Food Vchrs	Case Mgmt	Legal	Psych Assmt	Taxi Vchr	Emply Asst	Trtmnt Adv	Nutl Ed	Food Ptry	Van Transp	Cnsum r Adv	Money Mgmt	Compl Care	Outpnt Med
Need - Ask	9.3%	11.6%	8.7%	1.7%	11.3%	3.2%	23.2%	5.7%	6.2%	6.9%	10.3%	7.0%	6.6%	8.7%	6.7%	8.0%	7.2%	6.2%	6.1%	11.0%
Asked - Rec	12.9%	10.0%	7.8%	7.0%	5.5%	5.3%	3.7%	3.6%	2.8%	2.0%	1.9%	1.5%	1.3%	1.2%	0.9%	0.8%	0.6%	0.4%	-0.2%	-20.4%

11. BARRIERS

The PLWH/A participating in the survey were asked about barriers in two ways. In question 43 of the survey, at the end of each major service category, PLWH/A were asked, "what problems did you experience in accessing or using the service?" These service-specific barriers are noted in the templates in the following section.

In the question 44 of the survey, PLWH/A were also asked to rank 30 different potential problems on a scale ranging from "not a problem" to a "very big problem" (see Q. 44, Attachment 3). These barriers were not "linked" to a particular service category. As shown in Table 11-1, the thirty potential problems can be classified into the more general categories of "organizational", "structural, or "individual" barriers.

- Structural barriers refer to "rules and regulations" and levels of access. Rules and regulations include insurance coverage, cost of services, red tape, eligibility, and problems navigating the system of care. On average, more than half the PLWH/A are likely to have a problem with these types of barriers.
- Structural "access" barriers have to do with lack of transportation, access to specialists, or lack of family-oriented services. These are mentioned much less frequently than "rules and regulations" with less than 30% of PLWH/A registering that they had a problem with these types of barriers.
- Individual barriers refer to the individual's knowledge and well-being. Like "rules and regulation" barriers, on average about half the PLWH/A mention knowledge and well-being barriers.
- Organizational barriers refer to provider sensitivity and provider expertise. Sensitivity barriers include the provider's response to the PLWH/A's issues and concerns, making the client feel like a number, and helpfulness of the provider. Provider expertise includes the perceived experience of providers, ability to provide correct referrals, and ability of providers to get along with clients. On average, about 40% of PLWH/A note that they have experienced these types of barriers.

Table 11-1 Types of Barriers

STRUCTURAL 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.	65.0%	21.1%	2.8
2. My ability to find my way through the system.	57.0%	11.7%	2.6
3. There was too much paperwork or red tape.	52.7%	16.9%	2.9
4. There are too many rules and regulations.	51.2%	14.5%	2.7
5. I was not eligible for the service.	48.2%	14.1%	2.8
6. My lack of, or inadequate, insurance coverage.	45.8%	12.8%	2.7
7. I can't afford one or more of the services.	45.7%	14.2%	2.9
Access			
8. There was no specialist to provide the care I needed.	39.1%	9.0%	2.5
9. No transportation.	37.5%	13.7%	2.7
10. I have been denied or have been afraid to seek services due to a criminal justice matter	26.0%	7.1%	2.5
11. I have been terminated or suspended from seeking services.	25.4%	5.5%	2.2
12. No childcare.	17.6%	2.0%	1.9
ORGANIZATIONAL			
Provider Sensitivity			
13. Sensitivity of the organization and person providing services to me regarding my issues and concerns.	54.0%	18.7%	3.0
14. The organization providing the service made me feel like a number.	56.0%	17.8%	2.8
15. The people providing services to me are not helpful.	46.4%	8.6%	2.3
16. Fear of my HIV or AIDS status being found out by others – lack of confidentiality.	41.7%	9.8%	2.6
17. Discrimination I experienced by the persons or organization providing the services.	40.6%	15.5%	3.0
18. Fear that I would be reported to immigration or other authorities.	19.3%	4.2%	2.2
Provider Expertise			
19. Experience or expertise of the person providing services to me.	55.1%	10.5%	2.5
20. The organization did not provide the right referrals to the services of I needed.	51.2%	13.7%	2.5
21. I do not get along with the people providing services.	36.6%	4.6%	2.1
INDIVIDUAL			
Knowledge			
22. Not knowing that service or treatment was available to me	64.8%	23.7%	3.1
23. Not knowing location of the services.	60.9%	15.7%	2.7
24. Not knowing who to ask for help.	57.4%	17.4%	2.9
25. Not knowing what medical services I need to treat my HIV infection or AIDS.	47.3%	12.9%	2.7
26. Not understanding instructions for obtaining service or treatment	45.3%	10.2%	2.4
27. My ability to communicate or interact with the service provider.	35.8%	5.6%	2.4
Well-Being			
28. My state of mind or mental ability to deal with treatment.	54.1%	16.9%	2.9
29. My physical health has not allowed me to get to the place where the service is provided	50.7%	11.5%	2.5
30. I not believe HIV/AIDS is a problem for me that requires assistance (denial)	47.8%	14.7%	2.9

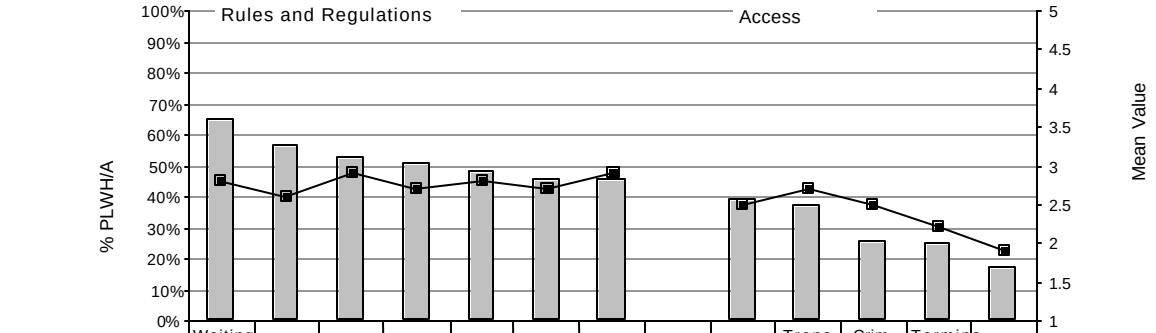
Figure 11-1 graphs the three types of barriers. It shows that:

- Among structural barriers, over 50% of PLWH/A have some problem with waiting for appointments, navigating the system, and red tape. Between 40% and 50% have a problem with eligibility, insurance, and cost.
- For those who considered waiting a problem, 21% said it was a big problem. 17% of those who said red tape was a problem, said it was big problem.

- On average, among structural rules and regulation barriers, none were ranked as a big barrier. Yet, for those naming cost, red tape, waiting, and eligibility, on average, these represented moderate barriers.
- Among organizational barriers, sensitivity of the organization and feeling like a number are reported by over 50% of PLWH/A. Among those naming these barriers, it is considered a moderate barrier, and about 20% say they are a big problem.
- Lack of provider expertise and provider referrals are also named by over 50% of PLWH/A. However, among those reporting these barriers, they say they are small to moderate barriers. Of those who felt they were a problem between 11% and 14% said it was a big problem.
- Forty percent of PLWH/A named discrimination as a barrier and rank it as a relatively high barrier. Sixteen percent (16%) of those with a problem, said it was a big problem.
- Not knowing treatment and not knowing the location of providers were named as barriers by over 60% of PLWH/A. Not knowing treatments is perceived of as a moderate barrier and 24% of those who said it was a problem noted it was a big problem. Not knowing locations is viewed as a small to moderate barrier, with 16% those who said it was a problem noting it was a big problem for them.
- Over 50% of PLWH/A name not knowing who to ask, their own state of mind, and their own physical health as barriers. They are ranked as small to moderate barriers, with fewer than 20% f those saying it was a problem ranking it as a big problem.

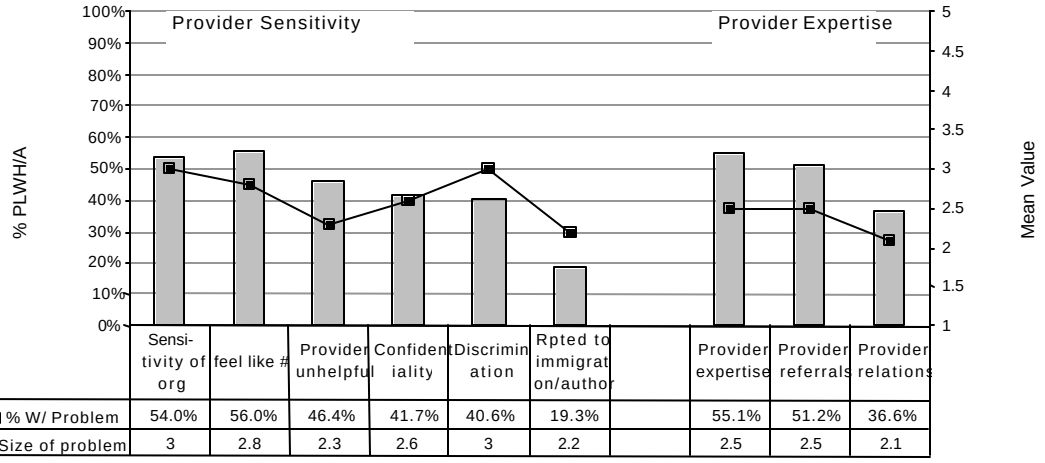
Figure 11-1 Barriers to Services

Structural



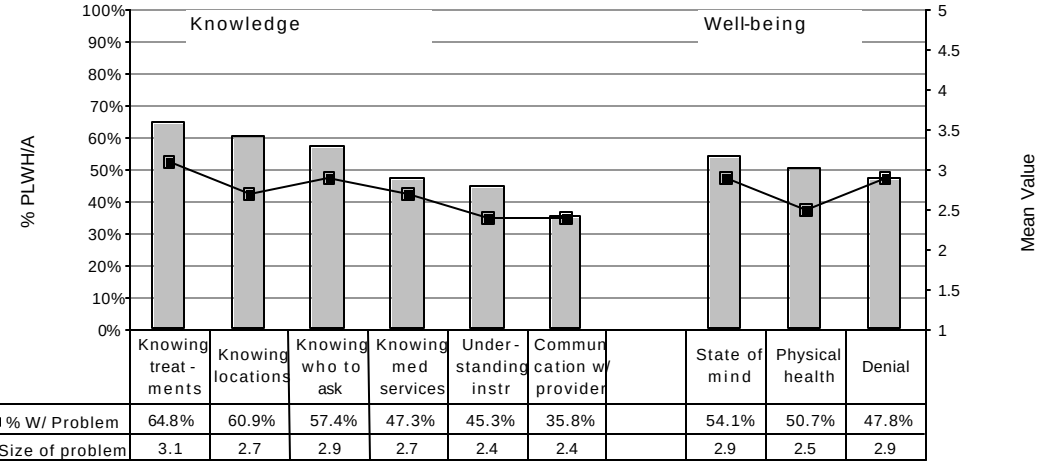
	Waiting for Apt.	Navigating syst	Red Tape	Rules & Regs	Eligibility	Insurance	Cost		Specialists	Transportation	Criminal justice hist	Terminated service	Childcare
% W/ Problem	65.0%	57.0%	52.7%	51.2%	48.2%	45.8%	45.7%		39.1%	37.5%	26.0%	25.4%	17.6%
Size of problem	2.8	2.6	2.9	2.7	2.8	2.7	2.9		2.5	2.7	2.5	2.2	1.9

Organizational



	Sensitivity of org	feel like #	Provider unhelpful	Confidentiality	Discrimination	Rpted to immigration/author		Provider expertise	Provider referrals	Provider relations
% W/ Problem	54.0%	56.0%	46.4%	41.7%	40.6%	19.3%		55.1%	51.2%	36.6%
Size of problem	3	2.8	2.3	2.6	3	2.2		2.5	2.5	2.1

Individual



	Knowing treatments	Knowing locations	Knowing who to ask	Knowing med services	Understanding instr	Communication w/ provider		State of mind	Physical health	Denial
% W/ Problem	64.8%	60.9%	57.4%	47.3%	45.3%	35.8%		54.1%	50.7%	47.8%
Size of problem	3.1	2.7	2.9	2.7	2.4	2.4		2.9	2.5	2.9

Severity of Problem

Although the highest average barrier was rated as a moderate barrier, as shown in Figure 11-2, different populations reported considerably higher barriers. Important differences are highlighted below.

Sex / Gender

Overall, transgender persons report significantly higher barriers than average for most of the 30 problems they ranked. The exception were that Transgender persons tend to be in less denial than other PLWH/A, they are less likely to feel like a number, and do not have greater barriers related to cost than other PLWH/A.

The most significant barriers for males are not knowing what service is available, and then provider sensitivity to issues, and discrimination. The highest barriers for females are different and include red tape, waiting for an appointment, no transportation, and not knowing what services they need to treat their HIV infection.

Females report greater problems than males with their physical health, state-of-mind, understanding instruction, not getting along with their providers, communicating with providers, getting bad referrals from providers, finding specialists, fear of losing confidentiality, no childcare, and lack of or inadequate insurance.

Risk Groups

MSM tend to rank barriers lowest among the risk groups with the exception of discrimination by providers, which they rank as a moderate barrier.

Among the risk groups, IDUs report higher barriers than other groups. Their highest barrier is transportation, which they rank as a moderate to large problem. They are more likely to name red tape, being treated like a number, and not accessing specialists as a barriers than other risk groups.

Heterosexuals also cite transportation as one of their highest barriers. They are more likely than other risk groups to report their own physical health, not knowing what medical services are available, red tape (along with IDUs), and rules and regulations as barriers.

MSM/IDU rate most barriers as quite low, but are more likely to say that they have been denied or have been afraid to seek services due to a criminal justice matter, and along with IDUs are more afraid than other risk groups of being reported to authorities.

Ethnic Populations

African American populations rate most barriers higher than other risk groups. Among top barriers, they are more likely to say they don't know where to go for services than other ethnic

populations. Also, African Americans are more likely than other ethnic populations to say they face the barriers of transportation, lack of confidentiality, ability to communicate with their provider, and denial of services due to criminal justice history.

Latinos are more likely than other risk groups to report higher barriers related to fear of being reported to authorities, lack of insurance coverage, and red tape. They are also more likely to note communication problems and that rules and regulations are problems for them in obtaining care.

APIs say that lack of insurance coverage is a moderate to big problem, and say that cost of services is a moderate problem. They also cite a lack of childcare as a relatively high barrier. Along with Latinos, they say that getting along with providers is more a problem for them than for Anglos or African Americans.

Native Americans rank feeling like a number and denial of services based on their criminal justice history as their top barriers. They are more likely than other ethnic populations to give a higher barrier score to their own physical health, expertise of providers, lack of helpfulness by providers, navigating the system, and lack of specialists.

Age Groups

Among those over 50 the highest barriers are denial and the sense they are not eligible of services.

The Youth population reports that knowledge of services and lack of expertise by providers are higher barriers for them than for other PLWH/A.

Out-of-Care

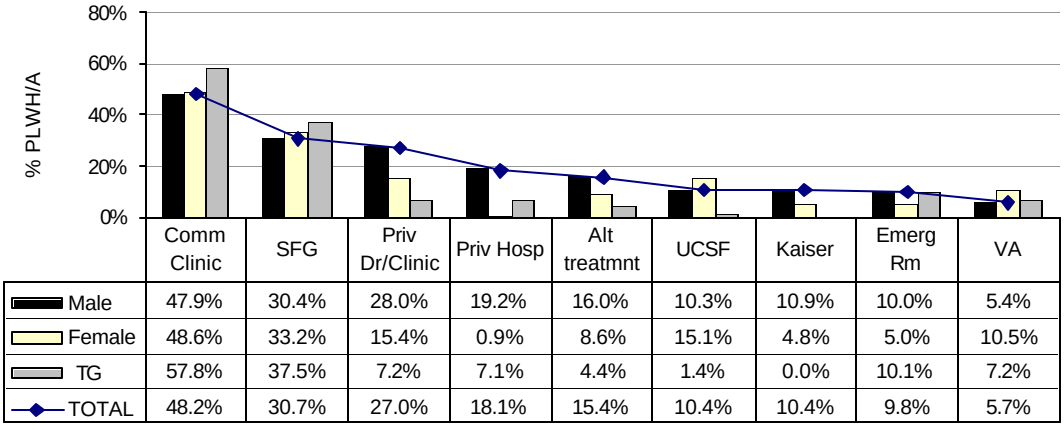
Those Out-of-care between 6 months and year say that not knowing who to ask for help and feeling like a number are moderate to big barriers for them. They also are more likely to say that sensitivity to their issues and denial are barriers for them.

For the few PLWH/A who reported being Out-of-care for a year or more, lack of insurance and cost of the service, not knowing the service was available, and lack of confidentiality are the main barriers cited.

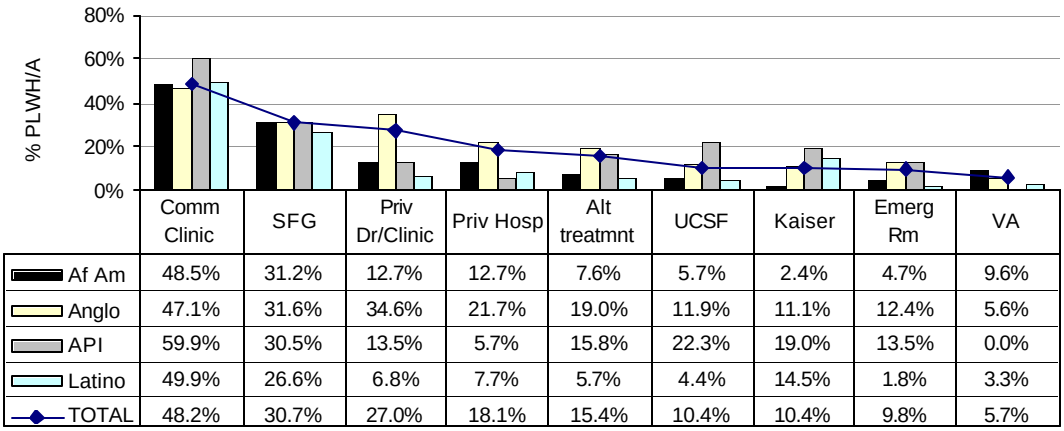
Stage of Infection

HIV and AIDS symptomatic participants reported higher barriers than asymptomatic persons. AID symptomatic reported moderate to big barriers for their own physical health and were more likely to say denial was a barrier to receiving care.

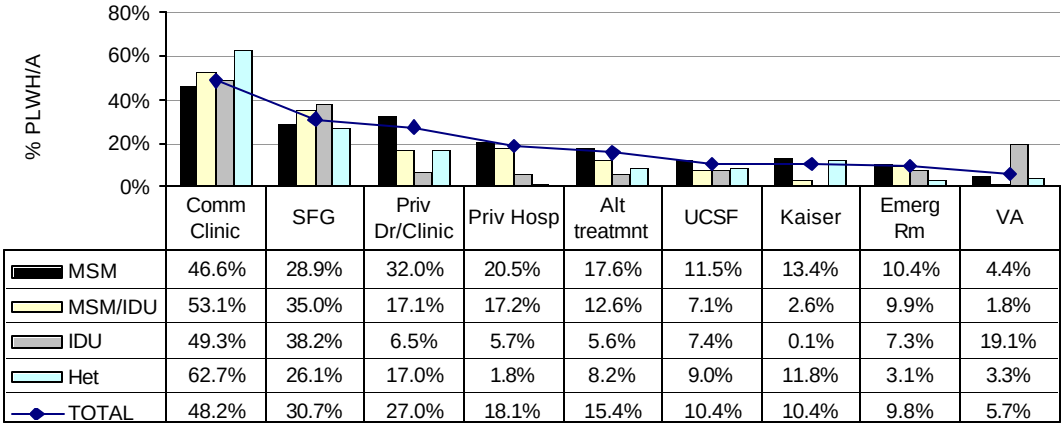
Figure 11-2 Barriers by Subpopulations



	Comm Clinic	SFG	Priv Dr/Clinic	Priv Hosp	Alt treatmnt	UCSF	Kaiser	Emerg Rm	VA
Male	47.9%	30.4%	28.0%	19.2%	16.0%	10.3%	10.9%	10.0%	5.4%
Female	48.6%	33.2%	15.4%	0.9%	8.6%	15.1%	4.8%	5.0%	10.5%
TG	57.8%	37.5%	7.2%	7.1%	4.4%	1.4%	0.0%	10.1%	7.2%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%



	Comm Clinic	SFG	Priv Dr/Clinic	Priv Hosp	Alt treatmnt	UCSF	Kaiser	Emerg Rm	VA
Af Am	48.5%	31.2%	12.7%	12.7%	7.6%	5.7%	2.4%	4.7%	9.6%
Anglo	47.1%	31.6%	34.6%	21.7%	19.0%	11.9%	11.1%	12.4%	5.6%
API	59.9%	30.5%	13.5%	5.7%	15.8%	22.3%	19.0%	13.5%	0.0%
Latino	49.9%	26.6%	6.8%	7.7%	5.7%	4.4%	14.5%	1.8%	3.3%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%



	Comm Clinic	SFG	Priv Dr/Clinic	Priv Hosp	Alt treatmnt	UCSF	Kaiser	Emerg Rm	VA
MSM	46.6%	28.9%	32.0%	20.5%	17.6%	11.5%	13.4%	10.4%	4.4%
MSM/IDU	53.1%	35.0%	17.1%	17.2%	12.6%	7.1%	2.6%	9.9%	1.8%
IDU	49.3%	38.2%	6.5%	5.7%	5.6%	7.4%	0.1%	7.3%	19.1%
Het	62.7%	26.1%	17.0%	1.8%	8.2%	9.0%	11.8%	3.1%	3.3%
TOTAL	48.2%	30.7%	27.0%	18.1%	15.4%	10.4%	10.4%	9.8%	5.7%

12. SERVICE AND BARRIER TEMPLATES

Summary statistics for each service are shown graphically in this section. Readers may go to the service of interest (page numbers are in the Table of Contents) and quickly assess the awareness, need, demand, utilization, and gaps for each service. Services are presented by 2002 priorities.

Each service is shown using the same page layout. At the top of each template the name of the service and service definition is provided. The next measure is the unit of service that is reported in the REGGIE system. Notably, several services are categorized differently by different service providers and are not always categorized the same way in the Reggie system. When a service category did not match any category in the Reggie system the unit of service presented in the template reflects the unit of service reported by the service provider in the provider form.

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 theoretical need, more restrictive system wide eligibility criteria might be considered.

The three boxes titled "Est. PLWH/A", "Service Units 2001", and "Funding 2001-2002" are a summary based on the epidemiology, provider information form, and REGGIE system. How each is defined is shown in Figure 12-1. The estimate of 21,000 PLWH/A is used throughout these templates. It is further estimated that in San Francisco, 75% know their HIV status, leaving 15,750 PLWH/A that might seek some services.

Those in service and number of service units are based on REGGIE and self reported data, and differences in the two methods suggest further work is necessary in refining the measurements. The REGGIE data reports unduplicated clients served during the Ryan White Fiscal Year. The self report is based on the percentage of PLWH/A respondents who say they received the service in the past year times the number eligible for the service. For example, 55% reported receiving dental services. Based on an eligibility criteria of a diagnosis of HIV infection, EMA resident, income up to 300% of Federal Poverty Level (93% of all PLWH/A), the estimate is 8,056 clients using dental care. Note that in many instances the system-wide eligibility criteria is not sufficiently restrictive to establish a meaningful estimate.

While 83% of the Ryan White funded providers completed provider forms, the service specific funding information was inconsistent, incomplete and grossly under-represents the HIV/AIDS service dollars available in the EMA. Given the limited amount of information available from service providers regarding units of service funded and provided it was not possible to present a full description of the service delivery system nor calculate its capacity. Consequently no funding gap is presented for this needs assessment.[10] Consistent reporting of this information would provide an overview of each service in the care system, including the utilization and theoretical need and funded capacity. Notably,

[10] The boxes for this data is shown in this template, and it should be a goal of future needs assessments to provide service funding information.

for this needs assessments, these figures should be viewed as rough estimates because of the incomplete provider survey data and the problems providers had completing the REGGIE data.

Figure 12-1 Template Formulas

EST. PLWH/A	
TOTAL	Based on expert panel, 2001.
Know HIV	75% * Total
In Service	1. Reggie Undup Client count 2. % Self-Report Received x # elig
Est # Elig	Based on eligibility criteria

SERVICE UNITS 2001	
# of duplicated units/clients	From Reggie
Theoretical Units Needed	Protocol * number of eligible PLWH/A
Median # Units Received	3. Reggie 4. Self-Reported Median
# Units Reported Received	1. REGGIE 2. Self reported (% * number eligible * Median #)

FUNDING 2000-2001	
RW Care Title I & CBC	1, Provider Info Form 2. Contracts
RW Care Title II	1. Provider Info Form 2. Contracts
Other	Provider Information Form
Total Allocated	Added from above

The following boxes in the templates, shown in Figure 12-2, provide summary gap measures. The Eligibility gap asks, "what percentage of eligible PLWH/A are being served". The "Absolute service gap" asks, "what percentage of all those who should be served are being served?" 100% would be the maximum units a service system should, in theory, provide. The funding gap asks, "what percentage of units the system funds is being provided?"

Figure 12-2 Summary Gap Formulas

Summary Gaps					
Elig Gap:	(# Elig) – (# in service) / (# in service)	Absolute service Gap:	(Theoretical Need) – (#units provided) / (Theoretical Need)	Funding gap:	(Units Funded) – (Units Received) /(Units Funded)

In funding services, the first item is to determine if the system has the capacity to provide the services funded. If it has, then a large eligibility gap suggests needed capacity, and a large absolute service gap suggests that there is likely to be future need.

Each template also presents two graphs, as shown in Figure 12-3. 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 risk groups. The bottom graph shows them for risk groups and out-of-care and homeless populations.

The table to the right of the graph provides gap measures including a "knowledge gap", unmet perceived need gap, and need-received gap. For most services, the knowledge gap is based on the belief that 100% of PLWH/A should know about the service. The exceptions are child care (only those PLWH/A with children), substance abuse programs (only those with a history of substance use), and insurance continuation (only those with private insurance or COBRA).

The "unmet perceived need" is the difference between the percentage of PLWH/A who asked for the service and receive it. It is a useful in determining how well the system process PLWH/A who ask for services and how well PLWH/A understand the eligibility criteria.

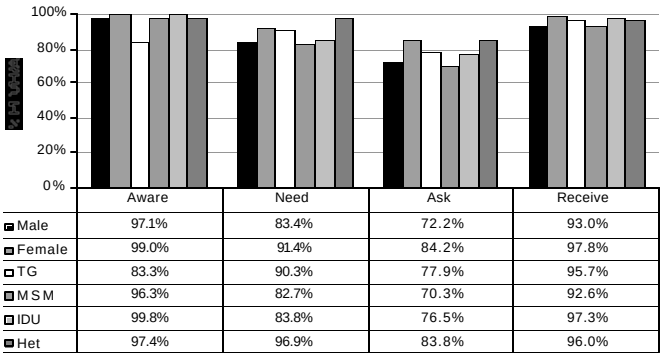
The "need-received gap" is the difference between the percentage who perceive they need the service and the percentage who received it. It speaks to how well the system meets the expectations of PLWH/A.

The box also includes figures for the recently released, stage of infection, and region which are not shown in graph format.

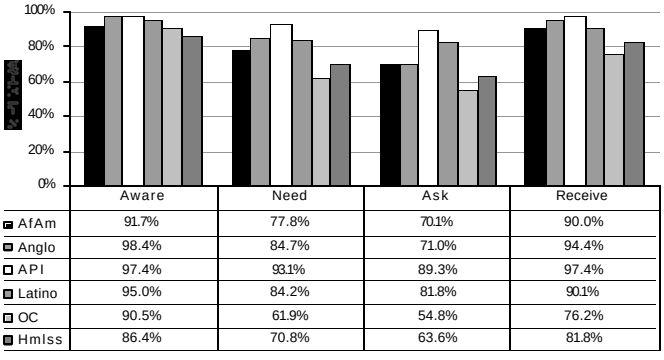
Following the graphs there is a summary of the information about what each graph and table reports.

Finally, after each of the nine major service categories, the major barriers cited by PLWH/A for the service category are listed and there are quotes about the service based on the focus groups. These give depth to the quantitative findings, or present examples of needs and barriers that may not rank high in general, but have great relevance for some PLWH/A.

Figure 12-3 Service & Barrier Template



	Aware	Need	Ask	Receive
Male	97.1%	83.4%	72.2%	93.0%
Female	99.0%	91.4%	84.2%	97.8%
TG	83.3%	90.3%	77.9%	95.7%
MSM	96.3%	82.7%	70.3%	92.6%
IDU	99.8%	83.8%	76.5%	97.3%
Het	97.4%	96.9%	83.8%	96.0%



	Aware	Need	Ask	Receive
AfAm	91.7%	77.8%	70.1%	90.0%
Anglo	98.4%	84.7%	71.0%	94.4%
API	97.4%	93.1%	89.3%	97.4%
Latino	95.0%	84.2%	81.8%	90.1%
OC	90.5%	61.9%	54.8%	76.2%
Hmlss	86.4%	70.8%	63.6%	81.8%

GAPS (a " -" indicates that more service was provided than was asked for or needed.)			
Gender	**Male**	**Female**	**TG**
Knowledge Gap	2.9%	1.0%	16.7%
Unmet perceived need	-20.8%	-13.7%	-17.8%
Need-Receive Gap	-9.6%	-6.4%	-5.4%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	8.3%	1.6%	5.0%
Unmet perceived need	-19.9%	-23.4%	-8.3%
Need-Receive Gap	-12.2%	-9.7%	-5.9%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	90.5%	86.4%	97.3%
Need	61.9%	70.8%	82.0%
Ask	54.8%	63.6%	72.1%
Receive	76.2%	81.8%	92.8%
Knowledge Gap	9.5%	13.6%	2.7%
Unmet perceived need	-21.4%	-18.2%	-20.7%
Need-Receive Gap	-14.3%	-11.0%	-10.8%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	94.2%	96.8%	96.1%
Need	77.5%	82.4%	86.9%
Ask	71.2%	72.2%	82.0%
Receive	91.4%	94.4%	92.5%
Knowledge Gap	5.8%	3.2%	3.9%
Unmet perceived need	-20.1%	-22.2%	-10.5%
Need-Receive Gap	-6.7%	-12.0%	-5.6%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	96.9%	97.2%	98.4%
Need	84.0%	97.2%	83.9%
Ask	72.9%	86.1%	76.2%
Receive	93.3%	97.2%	94.3%
Knowledge Gap	3.1%	2.8%	1.6%
Unmet perceived need	-20.4%	-11.1%	-18.1%
Need-Receive Gap	-9.4%	0.0%	-10.4%

Health Care

Primary Medical Care

Definition

General management of acute and chronic medical conditions or prevention of such conditions through initial visit and intake, complete history and physical exam, lab tests for evaluation and treatment, immunizations, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to other medical specialists, as necessary. Services are provided by a physician, practitioner, or nurse lasting a minimum of 10 minutes and occurring during a single visit at a hospital, clinic, shelter, home, or hospice.

Service Unit, Eligibility, and Funding

Unit: Encounter

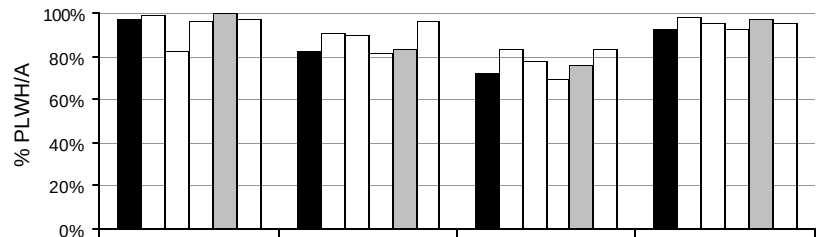
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service REGGIE	12,755
In Service Self Rpt	13,622
Estimated # Eligible	14,468

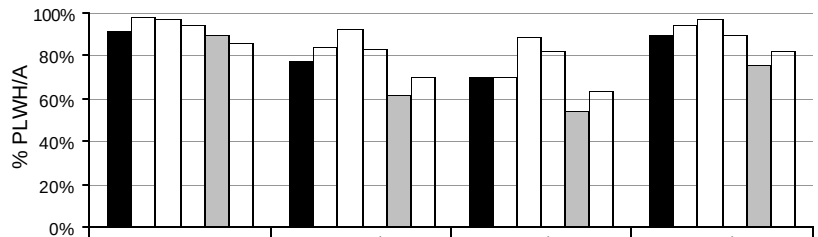
SERVICE UNITS 2001	
# of duplicated clients	36,522
Average # Units Received - REGGIE	9
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	37,780
Total # of Units Received – self rpt	68,111
Theoretical need	73,238

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	12.9%	Reported minus Theoretical Need – REGGIE	48.4%	
		Reported minus Theoretical Need: - self rpt	7.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	97.1%	83.4%	72.2%	93.0%
Female	99.0%	91.4%	84.2%	97.8%
TG	83.3%	90.3%	77.9%	95.7%
MSM	96.3%	82.7%	70.3%	92.6%
IDU	99.8%	83.8%	76.5%	97.3%
Het	97.4%	96.9%	83.8%	96.0%



	Aware	Need	Ask	Receive
AfAm	91.7%	77.8%	70.1%	90.0%
Anglo	98.4%	84.7%	71.0%	94.4%
API	97.4%	93.1%	89.3%	97.4%
Latino	95.0%	84.2%	81.8%	90.1%
OC	90.5%	61.9%	54.8%	76.2%
Hmlss	86.4%	70.8%	63.6%	81.8%

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

Gender	Male	Female	TG
Knowledge Gap	2.9%	1.0%	16.7%
Unmet perceived need	-20.8%	-13.7%	-17.8%
Need-Receive Gap	-9.6%	-6.4%	-5.4%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	8.3%	1.6%	5.0%
Unmet perceived need	-19.9%	-23.4%	-8.3%
Need-Receive Gap	-12.2%	-9.7%	-5.9%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	90.5%	86.4%	97.3%
Need	61.9%	70.8%	82.0%
Ask	54.8%	63.6%	72.1%
Receive	76.2%	81.8%	92.8%
Knowledge Gap	9.5%	13.6%	2.7%
Unmet perceived need	-21.4%	-18.2%	-20.7%
Need-Receive Gap	-14.3%	-11.0%	-10.8%

Stage of Infection	H Asymp	H Symp	AIDS
Aware	94.2%	96.8%	96.1%
Need	77.5%	82.4%	86.9%
Ask	71.2%	72.2%	82.0%
Receive	91.4%	94.4%	92.5%
Knowledge Gap	5.8%	3.2%	3.9%
Unmet perceived need	-20.1%	-22.2%	-10.5%
Need-Receive Gap	-6.7%	-12.0%	-5.6%

Region	Total	San Mateo	Tenderloin
Aware	96.9%	97.2%	98.4%
Need	84.0%	97.2%	83.9%
Ask	72.9%	86.1%	76.2%
Receive	93.3%	97.2%	94.3%
Knowledge Gap	3.1%	2.8%	1.6%
Unmet perceived need	-20.4%	-11.1%	-18.1%
Need-Receive Gap	-9.4%	0.0%	-10.4%

Summary

As might be expected in San Francisco, levels of awareness of medical care are extremely high across all groups. Only transgender persons and homeless PLWH/A have awareness levels below 90%. Native Americans and IDUs (not shown) are the most aware at 100% compared to other ethnic and risk groups.

The data also show:

- System wide there are about 14,500 persons who are eligible for care. Based on an average of five visits a year reported by the consumer in the consumer survey, there would be a theoretical demand for about 73,238 units.
- The REGGIE system shows that about 36,500 encounters of outpatient primary health care were provided through Ryan White Title I in 2001. PLWH/A reported receiving about 68,000 units. The difference is likely to be due to the non-Ryan White reimbursed providers (53%).
- An additional 13% of those who know their status and are eligible for Ryan White funded outpatient care could access this service.
- Based on REGGIE, about 50% of the PLWH/A currently access care outside the Ryan White Care funded outpatient providers or not receiving care. Based on consumer survey response, only about 7% of PLWH/A say they are not receiving services.
- Transgender persons have the highest knowledge gap at 17% compared to just 3% for men and 1% for women. In terms of stage of infection, PLWH who are asymptomatic have the largest knowledge gap at 6% compared to those who are symptomatic (3%) and those with an AIDS diagnosis (4%).
- All groups are receiving more medical services than they report asking for. This may be due to the fact that medical care, in many instances, is "automatic." Individuals have pre-established appointments across various lengths of time and therefore do not perceive themselves as having "asked" for the service. This should not be construed as too much service being delivered.
- The need-receive gap for medical care also shows that PLWH/A are receiving services even if they feel they don't need the service.
- For those out-of-care, there is high level of awareness (91%), and not surprisingly a relatively low level of asking for the service (55%). Still, 76% of those who have a history of out of care report receiving care currently, indicating a reasonable success of bringing those out-of-care into the system.

Dental Care

Definition

Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, dental students, and similar professional practitioners.

Service Unit, Eligibility, and Funding

Unit: Encounter

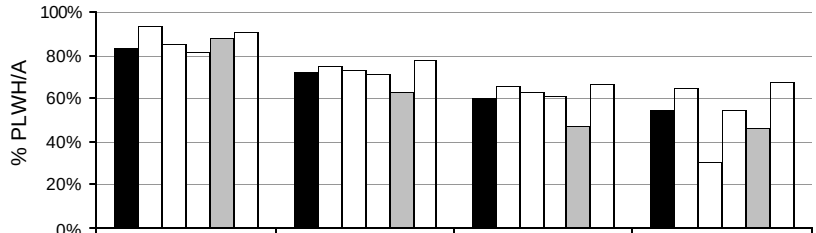
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	1,152
In Service – self rpt	8,056
Estimated # Eligible	14,648

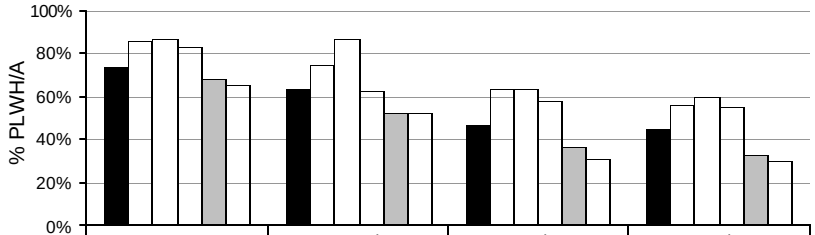
SERVICE UNITS 2001	
# of duplicated clients	3,431
Average # Units Received - REGGIE	4
Median# of Units Received – self rpt	3
Total # Units Received - REGGIE	4,417
Total # of Units Received – self rpt	24,168
Theoretical need	43,943

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	92.1%	Reported minus Theoretical Need – REGGIE	89.9%	
		Reported minus Theoretical Need: - self rpt	45.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	83.0%	71.3%	59.8%	54.5%
Female	92.5%	74.1%	65.6%	65.0%
TG	85.0%	72.9%	63.1%	31.1%
MSM	81.6%	71.2%	61.4%	55.0%
IDU	87.5%	62.5%	46.6%	45.9%
Het	89.9%	77.8%	66.3%	67.7%



	Aware	Need	Ask	Receive
AfAm	73.5%	63.7%	46.5%	44.7%
Anglo	85.6%	74.0%	63.4%	56.6%
API	86.3%	86.6%	63.7%	59.9%
Latino	83.3%	62.9%	57.8%	55.6%
OC	68.3%	52.4%	36.6%	33.3%
Hmlss	65.6%	52.3%	31.3%	30.3%

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

Gender	Male	Female	TG
Knowledge Gap	17.0%	7.5%	15.0%
Unmet perceived need	5.3%	0.6%	32.0%
Need-Receive Gap	16.7%	9.1%	41.8%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	26.5%	14.4%	16.7%
Unmet perceived need	1.9%	6.8%	2.2%
Need-Receive Gap	19.0%	17.4%	7.3%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	68.3%	65.6%	79.1%
Need	52.4%	52.3%	68.8%
Ask	36.6%	31.3%	49.5%
Receive	33.3%	30.3%	45.0%
Knowledge Gap	31.7%	34.4%	20.9%
Unmet perceiv ed need	3.3%	0.9%	4.5%
Need-Receive Gap	19.0%	22.0%	23.8%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	74.6%	80.0%	88.9%
Need	65.2%	67.5%	74.2%
Ask	47.8%	45.2%	58.2%
Receive	42.4%	41.3%	54.7%
Knowledge Gap	25.4%	20.0%	14.5%
Unmet perceived need	5.4%	4.0%	3.5%
Need-Receive Gap	22.8%	26.2%	15.4%

Region	Total	San Mateo	Tender-loin
Aware	83.6%	97.1%	81.7%
Need	71.5%	77.8%	68.9%
Ask	60.2%	69.4%	50.8%
Receive	54.7%	72.2%	46.1%
Knowledge Gap	16.4%	2.9%	18.3%
Unmet perceived need	5.5%	-2.8%	4.7%
Need-Receive Gap	16.7%	5.6%	22.8%

Summary

Over 14,500 PLWH/A are eligible for dental care, with a theoretical need of about 44,000 dental visits, 1,152 report receiving dental care from Ryan White funded providers, leaving a very large gap. More than 8,000 PLWH/A report receiving dental care – most outside of Ryan White care providers.

Generally, awareness of dental care services is high, though not as high as found in outpatient medical care. Also, need for dental care services is very high across all groups, with Asian/Pacific Islanders (87%), heterosexuals (78%), and those living in San Mateo County (78%), expressing the highest need. PLWH/A who are out-of-care and homeless PLWH/A, both at 52%, having somewhat lower expressed need for dental care.

The data also show:

- From the self reported data about 45% of those who could use dental care do not receive services.
- The unmet perceived need gap is highest among transgender persons (32%), Native Americans (18%), and youth (14%). It is lowest among women at less than 1%. Transgender appear to ask for services at the same level as other subpopulations, but they are not receiving the same level of service.
- The overall need-receive gap is high (17%) suggesting that many PLWH/A who need this service are not receiving it. It is highest among transgender persons (42%), Asian/Pacific Islanders (27%), Native Americans (24%), MSM/IDU (22%), PLWH who are symptomatic (26%), and youth (24%). PLWH/A residing in the tenderloin, those recently incarcerated and homeless PLWH/A also have a need-receive gap above 20%.
- The need-receive gap is lowest among PLWH/A who live in San Mateo (6%) and those over 55 years (4%).
- The out-of-care are much less likely to know about, ask for, or receive dental care than other populations.

Medication Reimbursement (Pharmaceuticals)

Definition

The provision of prescription medications as prescribed or ordered by a physician to prolong life, to improve health, or to prevent deterioration of health for low-income PLWH who do not have prescription drug coverage.

Service Unit, Eligibility, and Funding

Unit: Prescriptions

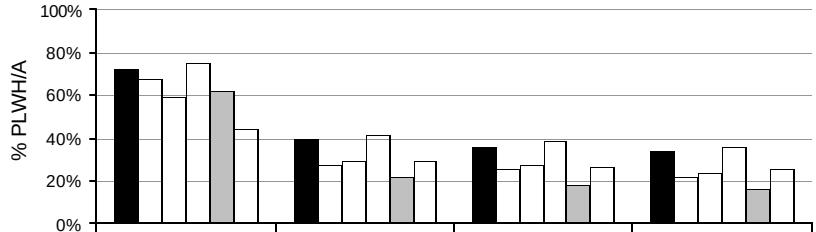
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	55
In Service – self rpt	NA
Estimated # Eligible	NA

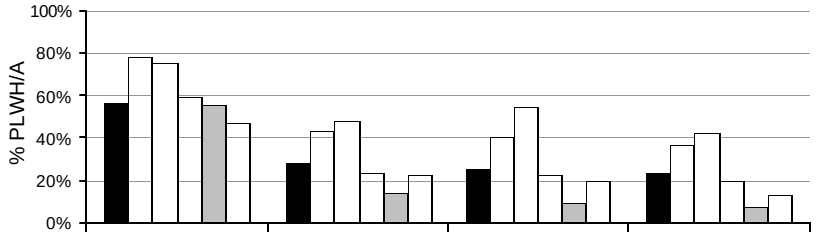
SERVICE UNITS 2001	
# of duplicated clients	115
Average # Units Received - REGGIE	1
Median# of Units Received – self rpt	9
Total # Units Received - REGGIE	34
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	72.8%	40.1%	36.5%	33.9%
Female	67.3%	27.3%	25.9%	21.9%
TG	59.6%	29.0%	27.1%	24.2%
MSM	74.8%	41.9%	38.6%	36.5%
IDU	62.3%	22.2%	18.8%	16.2%
Het	44.1%	29.1%	26.7%	25.7%



	Aware	Need	Ask	Receive
AfAm	56.6%	28.8%	24.9%	23.6%
Anglo	78.0%	43.7%	39.7%	37.0%
API	74.7%	48.4%	54.1%	41.6%
Latino	59.1%	23.6%	21.9%	19.9%
OC	55.0%	14.6%	9.8%	7.1%
Hmlss	47.6%	22.2%	19.4%	13.6%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	27.2%	32.7%	40.4%
Unmet perceived need	2.7%	4.0%	2.8%
Need-Receive Gap	6.2%	5.3%	4.8%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	43.4%	22.0%	40.9%
Unmet perceived need	1.3%	2.7%	2.0%
Need-Receive Gap	5.2%	6.7%	3.7%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	55.0%	47.6%	59.4%
Need	14.6%	22.2%	33.0%
Ask	9.8%	19.4%	30.5%
Receive	7.1%	13.6%	21.8%
Knowledge Gap	45.0%	52.4%	40.6%
Unmet perceived need	2.6%	5.7%	8.7%
Need-Receive Gap	7.5%	8.6%	11.2%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	57.4%	61.2%	69.9%
Need	25.7%	35.5%	35.9%
Ask	23.9%	28.9%	32.2%
Receive	18.2%	24.8%	28.9%
Knowledge Gap	42.6%	38.8%	30.1%
Unmet perceived need	5.6%	4.1%	3.4%
Need-Receive Gap	7.5%	10.7%	7.1%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	72.3%	58.3%	65.8%
Need	39.2%	25.0%	35.7%
Ask	35.8%	25.0%	32.8%
Receive	33.0%	27.8%	26.7%
Knowledge Gap	27.7%	41.7%	34.2%
Unmet perceived need	2.8%	-2.8%	6.1%
Need-Receive Gap	6.2%	-2.8%	9.0%

Summary

Over 25% of PLWH/A do not know about the availability of medication reimbursement. The knowledge gap is highest among women (33%) and transgender persons (40%) compared to males at 27%, though this, too, is quite high. In terms of ethnic groups, African Americans and Latinos have the highest knowledge gap. Because medication reimbursement is not funded under Ryan White Title I, there is no eligibility criteria noted for this service, and consequently, gap measures cannot be calculated.

The data also show:

- Need for medication reimbursement is highest among males (40%), Anglos (44%), Asian/Pacific Islanders (48%), Native Americans (45%), MSM (42%), and those over 55 years (41%).
- The unmet perceived need gap for PLWH/A is fairly low at only 3%, suggesting that those who do ask for the service are able to get it. However, some populations such as Asian/Pacific Islanders (13%), Native Americans (10%), youth (14%), homeless PLWH/A (6%), and recently incarcerated PLWH/A(10%) have much higher gap measures in this area than most other groups. PLWH/A who reside in San Mateo county are one of the few groups who are receiving more service than is being asked for (-3%).
- The unmet perceived need gap is highest among Native Americans (14%), MSM/IDU (11%), recently incarcerated (11%), homeless PLWH/A (9%), HIV symptomatic PLWH/A (11%). Only PLWH/A living in San Mateo and those over 55 years are receiving more service than they feel they actually need.

Home-Based and Facility-Based Home Health Care

Definition

Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/ certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals.

Service Unit, Eligibility, and Funding

Unit: Paraprofessional Patient Day-, Professional Patient Day, or Specialized Patient Day

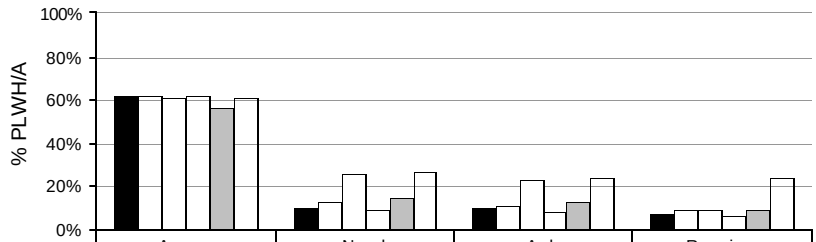
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	273
In Service – self rpt	NA
Estimated # Eligible	NA

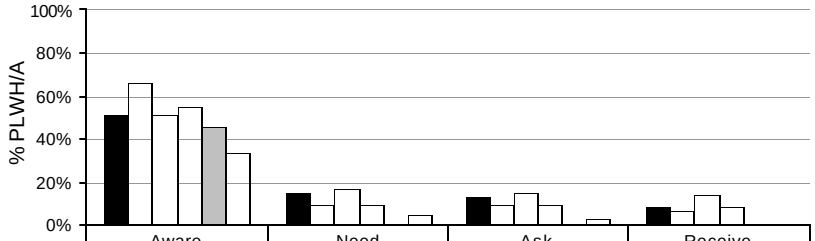
SERVICE UNITS 2001	
# of duplicated clients	1,968
Average # Units Received - REGGIE	26
Median# of Units Received – self rpt	6
Total # Units Received - REGGIE	37,734
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	61.8%	9.8%	9.4%	7.0%
Female	62.3%	12.5%	10.8%	8.5%
TG	61.4%	25.9%	23.4%	8.6%
MSM	61.8%	8.5%	8.1%	6.1%
IDU	55.7%	14.3%	12.6%	8.6%
Het	61.3%	26.2%	24.0%	23.8%



	Aware	Need	Ask	Receive
AfAm	51.1%	14.7%	12.7%	7.8%
Anglo	65.9%	9.1%	8.9%	6.4%
API	50.5%	16.8%	14.6%	13.1%
Latino	54.7%	8.9%	8.6%	8.1%
OC	45.2%	0.0%	0.0%	0.0%
Hmlss	32.8%	4.6%	3.1%	0.0%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	38.2%	37.7%	38.6%
Unmet perceived need	2.3%	2.3%	14.8%
Need-Receive Gap	2.8%	4.0%	17.3%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	48.9	34.1%	45.3%
Unmet perceived need	4.9%	2.5%	0.5%
Need-Receive Gap	6.8%	2.7%	0.9%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	45.2%	32.8%	53.2%
Need	0.0%	4.6%	16.7%
Ask	0.0%	3.1%	13.8%
Receive	0.0%	0.0%	11.7%
Knowledge Gap	54.8%	67.2%	46.8%
Unmet perceived need	0.0%	3.1%	2.0%
Need-Receive Gap	0.0%	4.6%	5.0%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	47.5%	57.7%	66.1%
Need	5.8%	18.5%	17.6%
Ask	5.8%	13.8%	15.7%
Receive	4.3%	7.1%	12.7%
Knowledge Gap	52.5%	42.3%	33.9%
Unmet perceived need	1.5%	6.7%	3.0%
Need-Receive Gap	1.4%	11.4%	4.9%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	61.8%	57.1%	59.5%
Need	10.3%	17.1%	19.5%
Ask	9.7%	17.1%	18.7%
Receive	7.2%	13.9%	14.5%
Knowledge Gap	38.2%	42.9%	40.5%
Unmet perceived need	2.5%	3.3%	4.2%
Need-Receive Gap	3.1%	3.3%	5.0%

Summary

Awareness of home health care service among PLWH/A is over 60%, though homeless PLWH/A at 33% have a significantly lower level of awareness of this service than most other groups. Transgender persons (26%), Native Americans (29%), heterosexuals (26%), and those over 55 years (22%) express the highest need for this service. While system-wide eligibility is diagnosis of HIV, more precise eligibility criteria are necessary to determine the theoretical need. This suggests a need for developing service specific criteria before service gaps can be calculated.

The data also show:

- Transgender persons have a high unmet perceived need gap at 15%, as do Native Americans (10%).
- Groups that are more likely to have received home health care include Asian/Pacific Islanders (13%), Native Americans (16%), heterosexuals (24%), those over 55 years (14%), PLWH/A living in San Mateo (14%) and the Tenderloin (15%), and those with an AIDS diagnosis (13%).

Adherence Support

Definition

Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

Service Unit, Eligibility, and Funding

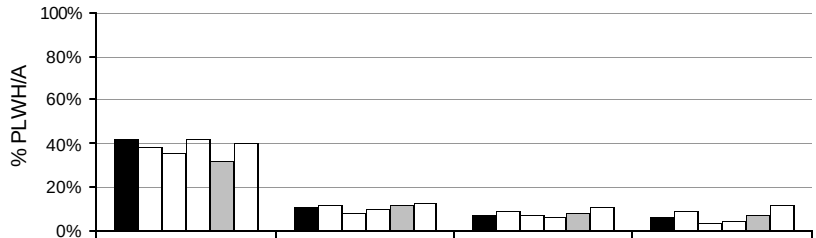
Unit: Encounters
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

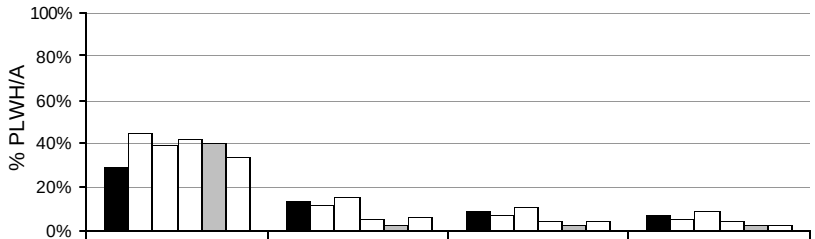
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	12
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	42.1%	11.0%	7.2%	5.8%
Female	37.7%	11.6%	8.5%	8.6%
TG	35.5%	7.7%	6.7%	3.2%
MSM	42.6%	10.0%	6.0%	4.3%
IDU	31.7%	11.2%	7.7%	6.9%
Het	40.3%	13.2%	10.4%	11.5%



	Aware	Need	Ask	Receive
AfAm	29.4%	13.0%	9.1%	7.6%
Anglo	44.3%	11.4%	7.1%	5.6%
API	39.5%	14.9%	10.5%	8.9%
Latino	42.4%	5.2%	4.4%	4.4%
OC	40.5%	2.4%	2.4%	2.4%
Hmlss	33.8%	6.2%	4.7%	3.0%

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

Gender	Male	Female	TG
Knowledge Gap	57.9%	62.3%	64.5%
Unmet perceived need	1.4%	-0.1%	3.4%
Need-Receive Gap	5.2%	3.1%	4.5%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	70.6%	55.7%	57.6%
Unmet perceived need	1.6%	1.5%	0.1%
Need-Receive Gap	5.5%	5.8%	0.9%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	40.5%	33.8%	41.5%
Need	2.4%	6.2%	10.6%
Ask	2.4%	4.9%	8.7%
Receive	2.4%	3.0%	7.2%
Knowledge Gap	59.5%	66.2%	58.5%
Unmet perceived need	0.0%	1.7%	3.4%
Need-Receive Gap	0.0%	3.1%	3.4%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	38.4%	42.7%	44.5%
Need	6.6%	11.4%	15.7%
Ask	8.1%	7.3%	10.1%
Receive	6.5%	7.9%	8.1%
Knowledge Gap	61.6%	56.8%	55.5%
Unmet perceived need	1.6%	-0.6%	2.0%
Need-Receive Gap	0.1%	3.4%	7.5%

Region	Total	San Mateo	Tender-loin
Aware	41.7%	27.8%	40.5%
Need	11.0%	5.6%	13.2%
Ask	7.2%	2.9%	7.2%
Receive	5.9%	5.6%	8.3%
Knowledge Gap	58.3%	72.2%	59.5%
Unmet perceived need	1.3%	0.0%	1.8%
Need-Receive Gap	5.1%	0.0%	4.9%

Summary

Adherence support data is not uniformly captured in REGGIE, and therefore the number receiving this service is not known. In addition there is no meaningful system-wide eligibility criteria established, such as those on medication. Consequently theoretical need and eligibility and absolute service gaps cannot be calculated.

The knowledge gap for adherence support services is nearly sixty percent for PLWH/A. It is highest among those living in San Mateo (72%), African Americans (71%), and youth (75%).

The data also show:

- Need for adherence support is lowest among Latino/a at 5% compared to other ethnic groups, which ranges from 11% to as high as 16%. MSM/IDU and those with an AIDS diagnosis also express a high need at 16% for both groups. The lowest need for adherence support is among PLWH/A out-of-care at just 2%.
- Youth have the highest unmet perceived need at 5% compared to the overall sample of 1%. The second highest is 3% for both transgender persons and recently incarcerated PLWH/A. San Mateo County residents have received more adherence support that has been asked for (-3%). This may indicate that adherence support services in San Mateo County are delivered as part of other support services without an express request by clients to receive them.
- Native Americans at 16% have asked for adherence support more than any other ethnic group and have also received adherence support (13%) more than other ethnic groups.

Complementary Care

Definition

Consultation, acupuncture treatment, herbs, and/or massage therapy provided by a licensed acupuncturist or student under supervision.

Service Unit, Eligibility, and Funding

Unit: Encounters

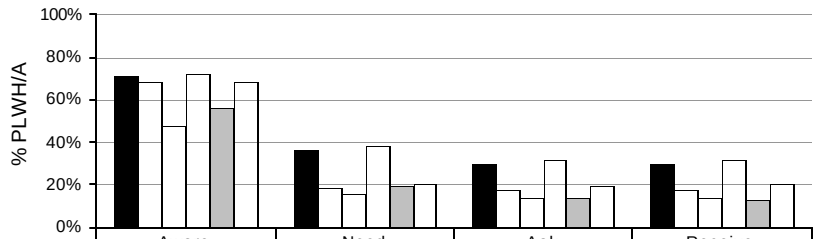
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	598
In Service – self rpt	4,248
Estimated # Eligible	14,648

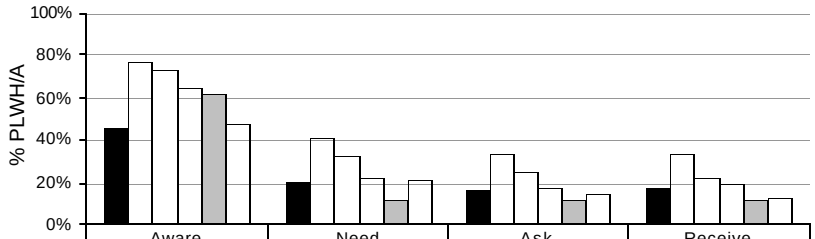
SERVICE UNITS 2001	
# of duplicated clients	8,969
Average # Units Received - REGGIE	15
Median# of Units Received – self rpt	8
Total # Units Received - REGGIE	9,118
Total # of Units Received – self rpt	33,982
Theoretical need	117,180

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	95.9%	Reported minus Theoretical Need – REGGIE	92.2%	
		Reported minus Theoretical Need: - self rpt	71.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	71.1%	36.4%	29.9%	30.1%
Female	67.8%	19.0%	17.9%	18.1%
TG	47.7%	16.3%	14.0%	14.0%
MSM	72.6%	37.8%	32.0%	32.2%
IDU	55.6%	19.2%	14.0%	13.1%
Het	68.3%	20.6%	19.4%	20.7%



	Aware	Need	Ask	Receive
AfAm	45.9%	20.4%	16.4%	16.5%
Anglo	76.6%	40.7%	33.7%	33.9%
API	73.0%	31.9%	24.6%	22.0%
Latino	64.4%	21.9%	18.2%	19.7%
OC	61.9%	11.9%	11.9%	11.9%
Hmlss	47.7%	21.5%	14.1%	12.1%

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

Gender	Male	Female	TG
Knowledge Gap	28.9%	32.2%	52.3%
Unmet perceived need	-0.2%	-0.1%	0.0%
Need-Receive Gap	6.3%	0.9%	2.3%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	54.1%	23.4%	35.6%
Unmet perceived need	-0.1%	-0.1%	-1.5%
Need-Receive Gap	3.9%	6.8%	2.3%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	61.9%	47.7%	60.2%
Need	11.9%	21.5%	21.3%
Ask	11.9%	14.1%	18.3%
Receive	11.9%	12.1%	19.8%
Knowledge Gap	38.1%	52.3%	39.8%
Unmet perceived need	0.0%	1.9%	-1.5%
Need-Receive Gap	0.0%	9.4%	1.5%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	62.6%	60.2%	69.6%
Need	24.5%	28.0%	30.5%
Ask	21.9%	18.5%	24.9%
Receive	21.6%	19.8%	25.1%
Knowledge Gap	37.4%	39.8%	30.4%
Unmet perceived need	0.3%	-1.3%	-0.2%
Need-Receive Gap	2.9%	8.2%	5.4%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	70.5%	50.0%	61.9%
Need	35.1%	16.7%	27.6%
Ask	29.0%	13.9%	22.3%
Receive	29.1%	13.9%	24.4%
Knowledge Gap	29.5%	50.0%	38.1%
Unmet perceived need	-0.2%	0.0%	-2.0%
Need-Receive Gap	6.0%	2.8%	3.3%

Summary

The REGGIE system reports that about 600 PLWH/A receive complementary care through Ryan White Funded providers. According to the survey data, over 4,200 receive complementary care. Assuming all positive persons are eligible, based on self reports, there is a large eligibility gap (over 95%).

Based on an average of eight encounters per year of complementary care, there is a theoretical need of over 117,000 units. For the most part, providers in the REGGIE system do not address this need. Based on self reported data, over 70% of PLWH/A who are eligible report not receiving services by any care provider.

Awareness of complementary care services is just over 70% among PLWH/A in the San Francisco EMA. However, there is a high knowledge gap among transgender persons (52%), African Americans (54%), homeless PLWH/A (52%), and PLWH/A in San Mateo (50%). Native Americans have the highest need for this service (43%), followed by Anglos (41%) and PLWH/A over 55 years (39%).

The data also show:

- The unmet perceived need gap, at –0.2%, suggests that slightly more of the service is being delivered than is being requested. This is particularly true for youth at –5% and PLWH/A living in the Tenderloin at –2%. Undocumented PLWH/A (7%) have the highest unmet perceived need gap than any other group.
- The need-receive gap is highest among Asian/Pacific Islanders(10%), Native Americans (11%), MSM/IDU (9%), undocumented PLWH/A (15%), and homeless PLWH/A (9%). Women, youth, and those out-of-care have the lowest need-receive gap at less than 1% for each group.
- Males (30%), Anglos (34%), Native Americans (34%), MSM (32%), and PLWH/A over 55 years (33%) have asked for this service more than other groups.
- PLWH/A over 55 years (36%) have received it the most and those out-of-care or homeless have received it the least, at 12% each.

Health Insurance Continuation

Definition

Payment of insurance premiums and related co-pays and deductibles for eligible PLWH/A to ensure continuation of insurance coverage. Not funded through Title I, but instead through Title II and available in the EMA.

Service Unit, Eligibility, and Funding

Unit: Payments

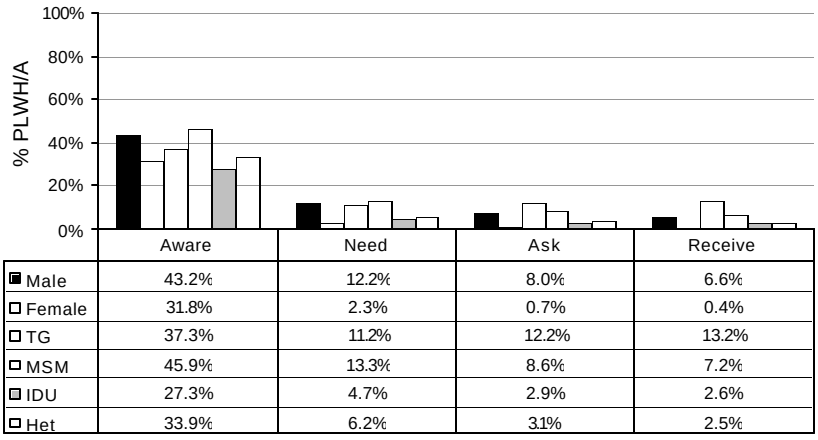
Eligibility: Diagnosis of HIV infection, EMA resident, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

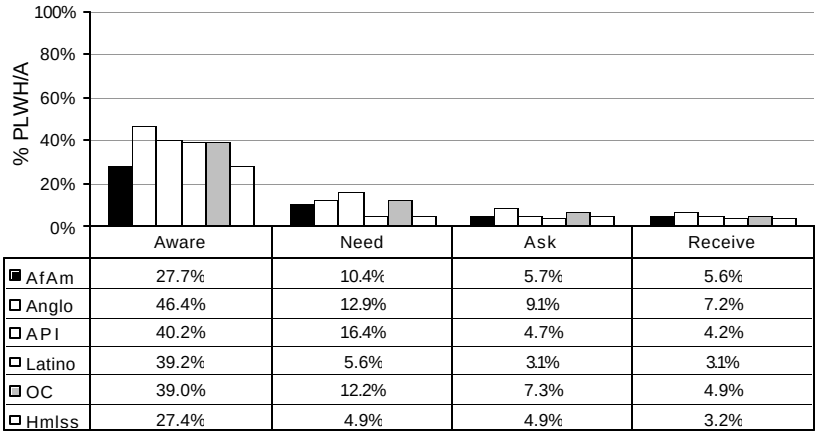
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	12
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	43.2%	12.2%	8.0%	6.6%
Female	31.8%	2.3%	0.7%	0.4%
TG	37.3%	11.2%	12.2%	13.2%
MSM	45.9%	13.3%	8.6%	7.2%
IDU	27.3%	4.7%	2.9%	2.6%
Het	33.9%	6.2%	3.1%	2.5%



	Aware	Need	Ask	Receive
AfAm	27.7%	10.4%	5.7%	5.6%
Anglo	46.4%	12.9%	9.1%	7.2%
API	40.2%	16.4%	4.7%	4.2%
Latino	39.2%	5.6%	3.1%	3.1%
OC	39.0%	12.2%	7.3%	4.9%
Hmlss	27.4%	4.9%	4.9%	3.2%

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

Gender	Male	Female	TG
Knowledge Gap	56.8%	68.2%	62.7%
Unmet perceived need	1.4%	0.4%	-1.0%
Need-Receive Gap	5.7%	1.9%	-1.9%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	72.3%	53.6%	60.8%
Unmet perceived need	0.0%	1.9%	0.0%
Need-Receive Gap	4.8%	5.7%	2.5%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	39.0%	27.4%	43.0%
Need	12.2%	4.9%	9.5%
Ask	7.3%	4.9%	8.7%
Receive	4.9%	3.2%	4.7%
Knowledge Gap	61.0%	72.6%	57.0%
Unmet perceived need	2.4%	1.7%	4.0%
Need-Receive Gap	7.3%	1.7%	4.9%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	26.8%	42.3%	39.9%
Need	11.7%	9.7%	10.4%
Ask	5.2%	7.3%	6.6%
Receive	3.7%	5.7%	5.8%
Knowledge Gap	73.2%	57.7%	60.1%
Unmet perceived need	1.5%	1.6%	0.8%
Need-Receive Gap	8.0%	4.0%	4.5%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	42.5%	25.7%	37.8%
Need	11.7%	2.9%	8.2%
Ask	7.7%	2.9%	7.2%
Receive	6.3%	2.9%	5.5%
Knowledge Gap	57.5%	74.3%	62.2%
Unmet perceived need	1.3%	0.0%	1.7%
Need-Receive Gap	5.3%	0.0%	2.7%

Summary

Because health insurance continuation is not funded under Ryan White Title I, there is no eligibility criteria noted for this service, and consequently, eligibility and service gap measures cannot be calculated.

Awareness of health care continuation is under 50% for most groups in the San Francisco EMA. Compared to other groups and San Francisco is general, it is lowest among San Mateo county residents at 26%. African Americans, Native Americans, IDUs, San Mateo residents, homeless PLWH/A, and symptomatic PLWH all have knowledge gaps of over 70%.

The data also show:

- Asian/Pacific Islanders express the highest need for this service at 16%. Other groups with high need include males, MSM, undocumented, PLWH/A out-of-care, and asymptomatic PLWH. Among these groups, need for this service is approximately 12%.
- Transgender persons at 12% have asked for the service more than other groups.
- Women and Youth have the lowest rates of receiving the service, with each at well under 1%.
- Youth at 10% and recently incarcerated at 4% have the highest unmet perceived need.
- The need-receive gap is highest among Asian/Pacific Islanders (12%), youth (10%), undocumented (9%), those who are out-of-care (7%), and asymptomatic PLWH (8%). Transgender persons at –2% and PLWH/A over 55 years (-4%) are receiving slightly more of this service than they have expressed a need for.
- Note that for most groups, there is a gap between those that express a need for this service and those that actually ask for it. The data clearly show that in general, once eligible PLWH/A ask for health insurance continuation, they are more likely to receive it than not. The question of why PLWH/A's high need does not result in their asking for the service should be addressed by the Council.

Summary Health Care

- Among health care services, PLWH/A report a greater need for outpatient medical care (84%) and dental care (72%) than other services. There are no meaningful system wide eligibility criteria for adherence support and home health care, making the calculation of eligibility and service gaps impossible to calculate.
- The highest knowledge gap among health care services is for health insurance continuation and adherence support, both at 58%. The lowest knowledge gap is for outpatient medical care at just 3%.
- Outpatient medical care has an unmet perceived need of -20%, indicating far more service is being provided than has been asked for. This may be unique to this service category in that many clients have on-going or standing appointments with their medical care provider and do not consider themselves "asking" for the service.
- Unmet perceived need is highest for dental care services at 6%. Dental care also has the highest need-receive gap of any other service in this group at 17%.

Health Care : Qualitative Comments - Services

An African American female said, *"I see my doctor every 30 days. It's the same doctor in 11 years. Before I started taking medication, at first he told me, 'This is just like cancer. If you take care of yourself and stop all of this alcohol and drinking and take care of yourself, you'll be all right. You'll live numerous years.' So we wrestled with this drug thing for a long time. At one point when I was still using real heavy he says, 'I know you're still using. I hate to tell you this, but keep taking the medication anyway as much as you can until you get over this thing.' I would say I have a good relationship with him. Very much so."*

A transgender said, *"For me my doctor is very candid. She's very understanding. She cares about my problems and tries to give me the best knowledge that I need for my health. She lets me know what's going on so I can keep my health up and I can stay where I am right now and to get better. I really like her. She talks to me. She has come to my house at 9:00 at night to make sure I had taken care of myself."* Another transgender said, *"My doctor is like that too. He's always asking me, 'Are you doing okay? You've got to let me know.' I pretty much tell him exactly what's going on and if there is anything that I need or want he just says, 'Okay if that's what you want.' I wouldn't bother with a doctor that wouldn't do like I want them to do in the first place so I pretty much get along with my doctor."*

A homeless male said, *"I've been positive since 1992 and my health is okay. In the 10 years I haven't really been sick. I've had pneumonia a couple of times and the flu. Other than that I've been fine. I have the best doctor. They have the best medical in the world. That's why I stay."* Many other participants in homeless PLWH/A focus group agreed with comments such as: *"I like San Francisco's health care;" "Yeah they have the best medical care;"* and *"They have the best medical. They have the best doctors I think."*

A San Mateo male said, *"The quality of service is outstanding. I couldn't have asked for better treatment for years at any other place. The chief of staff is also my primary care doctor. But I have another doctor that I see on each visit. If she has a question or a diagnosis that she's not sure of she goes to the chief of staff. They talk it over and a treatment is given to me. I have superior care, believe me. I have no complaints about it."* Another San Mateo male followed by saying, *"I agree with you. As far as my medications are concerned, I get outstanding care. I have no qualms at all with the services or the staff."*

An African American male said, *"There are not enough dental services available for PLWH. They only have [Agency deleted] and they are so slow. And they're not all that good either. Just to get a filling you have to go like three or four visits. So now I go to [Agency deleted]. It's not necessarily better but I don't wait long."*

An African American MSM said, *"I noticed they cut off my ADAP. At a certain stage when you get SSDI, well I've been getting that for 12 years. I don't know what happened but at one time when I first was disabled in 1990 I had to pay a premium every month for my ADAP. I was paying like $300 and some dollars a month, but I would get that back. Social Security would send that back at the end of the year or whatever, but now for the last couple of years what happened to ADAP? All of the medicines are free now with Medi-Cal and Medicare."*

A homeless male said, *"They're starting to send letters around like that now about medication and it's costing a lot of money to keep giving us medication. So now they're starting to have us sign contracts so we can only get a certain amount. Even if we go to the ER we can't get any medication."*

A homeless male said, *"They have an acupuncturist who comes in once a week and they also have a massage therapist that comes in. Then every Thursday we have these little Catholic sisters that come in and give back massages and they light an aromatherapy candle. It's nice. It is helpful. I was having some problems with nausea. They showed me a pressure point in my wrist and they also gave me some little beads to wear and it helps."*

An African American MSM explained his reason for not using complementary care. He said, *"I don't trust the process. I don't trust them. I'm off my meds right now and my T-cell count and my viral loads are dropping so without the medication I need, I don't trust alternative treatments. I just don't trust the process."*

Health Care Consumer Reported Top Barriers

- Criminal justice matters
- Communication w/ provider
- No transportation

Health Care : Qualitative Comments - Barriers

Consumers

An African American MSM said, *"One problem that I had is I see a number of specialists and the longer I live the more complicated my health condition gets, and I'm concerned that*

coordination doesn't exist. I'm a pretty good advocate for myself. I don't think that doctors are inclined to talk to one another. It's been really, really difficult to get them to do that."

A homeless male said, *"At [a Tenderloin District ASO],.I had an infection on my leg that big that was eating through my flesh. I went to the nurse. I needed to see the nurse real quick. She says, 'I can't help you. You've got to go to the hospital.' So I had to call my doctor who works at [Agency name deleted]. He met me at the hospital and he gave me an antibiotic and it cleared it. The nurse could have looked at it and said, 'Let's clean this up and then we'll send you off to the hospital,' but she didn't do that. She was very rude. I'm thinking about never going back to [that ASO], but then again what do I have left? The only thing I have left is all this information and it's from people who don't even work at these resources."*

An African American MSM said, *"One thing I'm beginning to notice, and it's probably been going on a long time, I think the health care professionals are overworked. It's beginning to be noticeable to me, because my doctor is always in a hurry."*

Another African American MSM said, *"While I'm in seeing the doctors I find that I really don't think they're taking good notes. That really pisses me off because there are things that I believe I've had previous exposure to and I can't keep up with the dates, but I'm hoping that my doctor's are keeping track of it. I've tried to research things and it's that they didn't take the notes. Sometimes I read the notes and I'm disgusted that things aren't in there that I have mentioned on previous visits."*

An African American MSM said, *"I want to say that already some of the services in terms of alternative health have been cut back. I'm really distressed, because a few years ago one of the things that helped me maintain my health was massage and acupuncture and it's a great loss to have these services cut out and now it looks like the massage therapy is going to be cut out. Not that I feel like I have no right to them, but certainly I really appreciate it."*

A homeless male said, *"I think if there were branches of these services in or around the Tenderloin or someplace where we saw it everyday then it would be helpful. But it's out in Castro or on your way to Castro, and frankly sometimes it's difficult to get out there even with the discounts."*

<u>Health Care : Qualitative Comments – Providers</u>

"The most common reason that people who apply for service do not receive them is people do not show up at the program "

"There are several elements that provide a barrier to delivering services to all in need. Funding is the most obvious element: with increased funding we would be able to hire more clinicians, support staff, and purchase necessary supplies to better serve an increased case load. However, more problematic, is the physical plant itself. The [agency site] currently lacks the necessary space to expand beyond it's current case load. Many of our buildings are in need of constant repair, and the medical clinic runs a small unit with limited capacity. This unit , located up a

steep flight of stairs, is not ADA accessible, and while the medical clinic has a downstairs unit to serve those with special needs, our location severely limits our ability to serve those with ambulatory disabilities. Other challenging barriers to accessing care for our clients are substance abuse, homelessness, and mental health issues. If a client does not know where he/she is going to sleep, eat a meal, or find enough money for that day, it is extremely difficult for that client to keep scheduled appointments, and/or keep to treatment regimens such as taking medication. Many of our clients suffer mental health conditions such as depression, bipolar and some even schizophrenia. [The agency] has found ways to respond to these problems, by making appointments more accessible to homeless clients, and those with dual or triple diagnosis, but these issues still pose a significant barrier."

"The most common reasons people who apply for services do not receive them is 1) not being a San Francisco resident, 2) not HIV positive, and 3) they must be 18+ years old."

"We have after years of being able to take all comers capped our RWCA funding to 140 clients. We can no longer take new patients unless we discharge a client. Our FTE has so significantly been reduced over the years that we are at risk of having to close the program if we don't find significant other sources of funding."

"The biggest reason for people not receiving the service they apply for is that clients do not consistently show up for appointments. Not showing up for appointments has many reasons and excuses of which the top three are: homelessness, drug abuse, and psychological issues. Many clients present with at least two of these areas of concern. These three excuses are the top three among many excuses given for missing an appointment. The [agency] is addressing the above concerns in many ways. We successfully applied for a one year grant to address the needs of high utilizers of [our] services. More importantly, the study will follow 30 randomly selected clients of the [agency] and follow them from service to service to study why services are not met."

"Spanish monolingual clients encounter barriers due to language, immigration law and cultural stigma."

"Many of our patients tend to be disorganized and often can be more concerned about drugs or housing over healthcare. The patients tend to look for help when it meets their particular concerns such as when health problems develop that they cannot ignore or when they are coerced into care by the legal system from the threat of losing monetary incentive. Nursing outreach which works with primary care providers is needed to find or see patients in the community. Our women's clinic has an RN who is critical in getting follow through care for the patient. Once the patient is done with the primary care provider, the RN helps the patient get the next appointment and assists with education and navigation through the system. The RN also establishes a rapport with the patient to make him or her more comfortable with the environment and increases the likelihood of the patient returning. More outreach like this is needed but the funding isn't available."

"Sometimes clients are not referred to our service until they meet with their case managers. We need to figure out how to let clients know that they can come to our service prior to their case management meeting. We are contacting organizations to let them know."

"Work at the dental school is very high quality but does take more time. This is for all of our clients. We are working on this very topic at our clinic and trying to improve this for all clients. We really do not have an upper limit of how many clients we will take. We never stop our intake system."

"Initial year of contract not necessary to turn patients away due to ample capacity."

"A barrier to home health care services are for those people who require a higher level of care."

"Funding levels prohibit us from providing all of the care that is needed for the client population. We compensate for this problem by allocating our limited resources among as many clients as possible. We base our decisions on medical need, but communicate to clients that services may change when other clients need services. We provide fewer hours to each client in order to spread service hours over a wide client base."

"All residents for [our home health care service] originated from the AIDS Housing Wait List - which is managed by the SFDPH. When we do have a vacancy, we receive two eligible referrals from the HWL and admit from that limited number pre-screened by the DPH."

"Patient's are referred to [our homecare services] by other providers, physicians, social workers, clinic nurses, etc. Thus patients don't apply per se. If patients are unwilling or ambivalent about receiving homecare services, they will refuse visits from our agency's multi-disciplinary team or just never be home at time of scheduled visit."

"Much work is done by staff through harm reduction, motivational interviewing and education to work with patients who could benefit from home health services. We also work closely with the patient's primary care providers."

"Another problem is that patients can't be referred to home health services strictly for venipuncture or blood draws. This is a system-wide problem that affects all patients, regardless of HIV status."

"The only requirement for entry into [our home healthcare services] is that the client be between the ages of 18-25. This would be the only barrier for clients accessing and receiving services. When a client attempts to access services who is over the age of 25, he or she is referred to the appropriate adult provider. A client under the age of 18 will access our underage programs. The underage services will work in conjunction to develop an appropriate treatment plan and placement. Clients may have individual barriers such as substance abuse and mental health issues. Case managers work with clients to create individual service plans to address both of these issues. An on-site substance abuse counselor can provide counseling, referrals, and consultations. An on-site psychiatrist is also available for evaluation and medication

management. We have implemented an agency-wide comprehensive substance abuse and mental health initiative for clients who need additional assistance."

"Because of insufficient funding, we are not always able to meet the demand for services and there has at times been a waiting list of 12 months or more. Because of income guidelines, and due to the high cost of living in San Francisco, some potential clients cannot afford to pay for regular acupuncture and herbal therapy, yet have incomes above the guidelines for CARE-funded services. And the San Francisco residency requirements is a major barrier. We receive numerous inquiries from otherwise eligible clients who live within the EMA (in either San Mateo or Marin County) or outside the EMA (e.g. Alameda County) but are ineligible for our CARE-funded services because we are contracted to serve only San Francisco residents."

"There is a lack of awareness and education about traditional Chinese medicine (TCM), and inadequate referrals from other providers and agencies. Many potential clients who would benefit from our services never even apply for them, because they are unaware of their existence or availability. Some primary care and other providers are themselves unaware of applicability and effectiveness of TCM services for HIV related health concerns. The current Standards of Care for HIV primary care providers do not include complementary therapies a recommended referral. For example, it is not unusual for us to receive calls from new clients who had been interested in acupuncture for years but who had never been informed about the availability of TCM services, even when those services were available at the site of their primary care. On a positive note, the number is growing each year of providers who are aware of - and who recommend -TCM."

"Due to funding limitations, many people who apply for our [complementary care] services must wait on a waiting list for up to six months on average. Over the last 3-5 years, the cost of living has risen so drastically that many of our clients have been forced to move out of the city. These clients then are no longer eligible for our services through Ryan White. These clients generally still live within the EMA and work in San Francisco but not longer qualify for Ryan White services. Another barrier is often lack of awareness of the potential benefits of complementary therapies in the treatment of HIV/AIDS. This impacts many clients in that they never ever apply for our services. Many times, when PLWH/A feel that they have no more options, then they find out about our services. At that point, they are forced to wait for services on the wait list. To address these barriers, [our agency] is constantly working to increase fundraising efforts to meet the demand for our services. Increased education, outreach and funding are being utilized to overcome the current barriers to care."

"Complementary therapies have been under funded for six years. There have been lists of PLWH/A clients seeking care who cannot afford treatment. There has been no increase in funding thru CARE to address this barrier. The agency seeks funding thru private donors and raises money internally to meet the needs of clients. Currently more than 700 unduplicated clients receive complimentary therapies every contract year. Over 5,000 acupuncture treatments were provided during 2001-2002 to PLWH/A."

Housing

Housing Information Services

Definition

As part of case management services and housing placement services, includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

Service Unit, Eligibility, and Funding

Unit: Hours

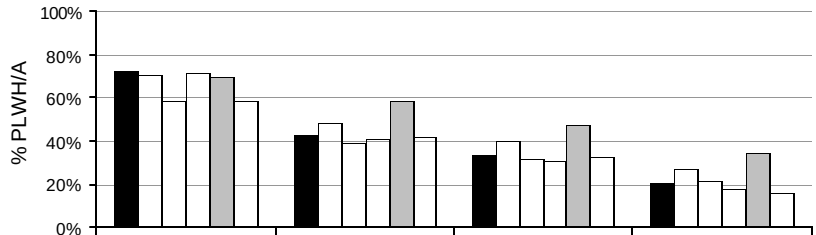
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	2,336
In Service – self rpt	NA
Estimated # Eligible	NA

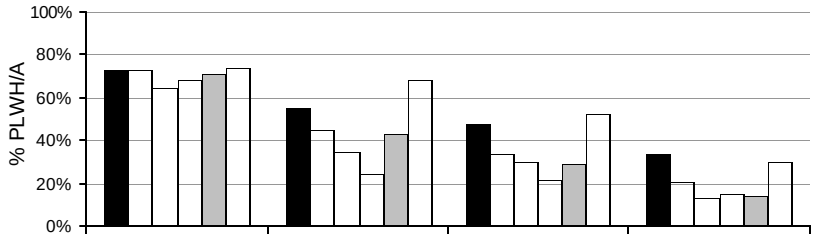
SERVICE UNITS 2001	
# of duplicated clients	15,221
Average # Units Received - REGGIE	5
Median# of Units Received – self rpt	2
Total # Units Received - REGGIE	10,258
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	72.7%	43.4%	34.0%	21.0%
Female	70.8%	49.0%	40.3%	27.4%
TG	58.6%	38.6%	32.2%	22.5%
MSM	71.6%	41.5%	30.7%	17.5%
IDU	69.7%	58.0%	47.6%	34.4%
Het	58.2%	42.2%	32.5%	15.6%



	Aware	Need	Ask	Receive
AfAm	73.3%	55.6%	47.1%	34.3%
Anglo	73.3%	45.0%	34.2%	20.3%
API	64.5%	34.5%	29.5%	13.6%
Latino	67.8%	24.5%	21.1%	14.9%
OC	71.4%	42.9%	28.6%	14.3%
Hmlss	74.2%	67.7%	52.3%	29.2%

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

Gender	Male	Female	TG
Knowledge Gap	27.3%	29.2%	41.4%
Unmet perceived need	13.0%	12.9%	9.7%
Need-Receive Gap	22.4%	21.6%	16.1%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	26.7%	26.7%	32.2%
Unmet perceived need	12.7%	14.0%	6.2%
Need-Receive Gap	21.3%	24.8%	9.7%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	71.4%	74.2%	83.6%
Need	42.9%	67.7%	62.7%
Ask	28.6%	52.3%	57.8%
Receive	14.3%	29.2%	42.2%
Knowledge Gap	28.6%	25.8%	16.4%
Unmet perceived need	13.8%	23.1%	15.6%
Need-Receive Gap	28.6%	38.5%	20.5%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	72.5%	82.5%	78.3%
Need	41.7%	55.2%	44.9%
Ask	35.8%	48.0%	39.6%
Receive	22.1%	35.2%	25.6%
Knowledge Gap	27.5%	17.5%	23.5%
Unmet perceived need	13.7%	12.8%	14.0%
Need-Receive Gap	19.7%	20.0%	19.3%

Region	Total	San Mateo	Tenderloin
Aware	72.3%	58.3%	84.8%
Need	43.6%	47.2%	50.5%
Ask	34.3%	36.1%	47.9%
Receive	21.4%	31.4%	31.6%
Knowledge Gap	27.7%	41.7%	15.2%
Unmet perceived need	12.9%	4.7%	16.3%
Need-Receive Gap	22.3%	15.8%	18.9%

Summary

Housing Information Services funded by Ryan White providers reaches over 2,300 PLWH/A. While the need for housing information services is quite high among all groups, the eligibility and service gaps are not possible to calculate because there is no meaningful measurable system wide eligibility criteria.

Housing Service needs are highest among women (49%), African Americans (56%), Native Americans (54%), IDUs (58%), and undocumented PLWH/A (51%). For homeless PLWH/A and those recently incarcerated, the need is the greatest at well over 60% for each group.

The data also show:

- Awareness of housing information services is generally high, though San Mateo county residents (58%), transgender persons (59%), and heterosexuals (58%) have lower awareness than other groups.
- Four groups have an unmet perceived need gap of over 20%. They are Native Americans (21%), youth (24%), undocumented (22%), and homeless PLWH/A (23%). The unmet perceived need gap is lowest among those living in San Mateo (5%).
- Homeless PLWH/A have the highest need-receive gap at nearly 40%, far above all other groups.

Rental Assistance or Subsidy

Definition

Monetary assistance for payment of a specific percentage of a client's rent. The payment is paid directly to the unit owner, not to the client.

Service Unit, Eligibility, and Funding

Unit: Resident Days

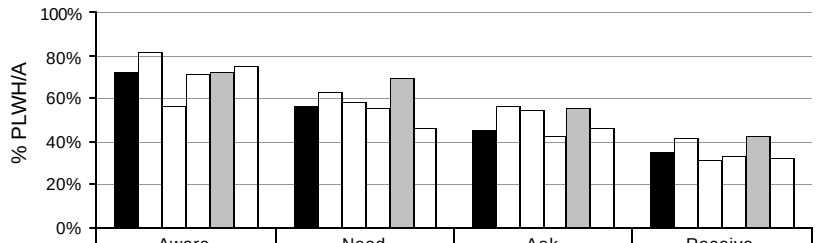
Eligibility: Disabling HIV diagnosis, resident of EMA, 30% of median income and in imminent danger of becoming homeless.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	744
In Service – self rpt	NA
Estimated # Eligible	NA

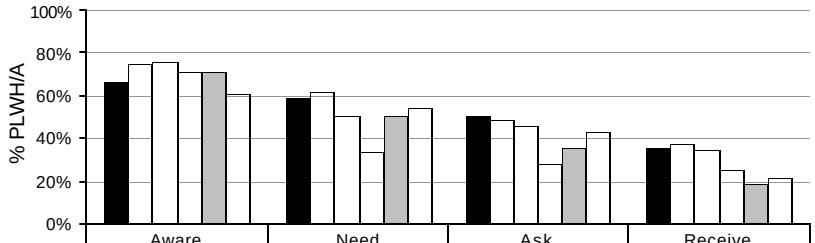
SERVICE UNITS 2001	
# of duplicated clients	6,851
Average # Units Received - REGGIE	281
Median# of Units Received – self rpt	NA
Total # Units Received - REGGIE	208,880
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	73.0%	57.0%	44.9%	35.4%
Female	81.1%	62.8%	57.0%	41.5%
TG	56.9%	58.6%	54.9%	31.1%
MSM	71.5%	55.3%	42.7%	33.9%
IDU	72.8%	70.2%	56.1%	42.2%
Het	75.2%	46.1%	46.3%	32.9%



	Aware	Need	Ask	Receive
AfAm	66.5%	58.9%	50.7%	35.9%
Anglo	74.7%	61.5%	47.9%	37.4%
API	75.9%	50.8%	45.4%	34.9%
Latino	71.3%	33.8%	27.4%	25.0%
OC	71.4%	51.2%	35.7%	19.0%
Hmlss	60.6%	54.7%	43.1%	21.2%

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

Gender	Male	Female	TG
Knowledge Gap	27.0%	18.9%	43.1%
Unmet perceived need	9.4%	15.5%	23.8%
Need-Receive Gap	21.5%	21.2%	27.5%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	33.5%	25.3%	28.7%
Unmet perceived need	14.8%	10.4%	2.4%
Need-Receive Gap	23.0%	24.0%	8.9%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	71.4%	60.6%	75.2%
Need	51.2%	54.7%	60.2%
Ask	35.7%	43.1%	58.5%
Receive	19.0%	21.2%	39.4%
Knowledge Gap	28.6%	39.4%	24.8%
Unmet perceived need	16.7%	21.9%	19.0%
Need-Receive Gap	32.2%	33.5%	20.7%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	65.0%	78.4%	79.1%
Need	47.4%	60.8%	57.9%
Ask	35.6%	50.0%	52.2%
Receive	25.9%	39.7%	40.1%
Knowledge Gap	35.0%	21.6%	20.9%
Unmet perceived need	9.6%	10.3%	12.1%
Need-Receive Gap	21.5%	21.1%	17.8%

Region	Total	San Mateo	Tenderloin
Aware	73.1%	69.4%	81.6%
Need	57.3%	52.8%	63.9%
Ask	45.7%	47.2%	53.4%
Receive	35.7%	33.3%	44.4%
Knowledge Gap	26.9%	30.6%	18.4%
Unmet perceived need	10.0%	10.9%	9.0%
Need-Receive Gap	21.6%	19.4%	19.4%

Summary

Based on the REGGIE system, about 750 PLWH/A access rental services from Ryan White providers. Based on resident days, 281 days a year are funded for persons accessing the service. Because there is no meaningful measurable system-wide eligibility criteria and the units of service are not uniformly captured, it is not possible to calculate eligibility or service gaps.

PLWH/A have high awareness of housing-related services. In the case of rental assistance or subsidies, awareness is close to or over 70% for most groups.

The data also show:

- The knowledge gap appears to be highest among transgender persons at 43%.
- The need for rental assistance is highest among women (63%), Native Americans (78%), MSM/IDU (61%), IDUs (70%), and Tenderloin residents (64%).
- Women (16%) and transgender persons (24%) have a higher unmet perceived need than do males. In terms of ethnic groups, unmet perceived need is highest among African Americans (15%) and Asian/Pacific Islanders (11%). Several other groups have unmet perceived need above 10% and include persons diagnosed with AIDS, San Mateo County residents, homeless PLWH/A and those out-of-care.
- The need-receive gap is highest among PLWH/A who are currently homeless at 34% and those out-of-care at 32%. Since most groups report a high need for this service, and the percent of PLWH/A who have received is generally low, the need-receive gap is fairly high across all groups.

Emergency Financial Assistance

Definition

Provision of short-term payments for transportation, food, essential utilities, or medication assistance, which planning councils may allocate and which must be carefully monitored to assure limited amounts, limited use, and for limited periods of time.

Service Unit, Eligibility, and Funding

Unit: Payment

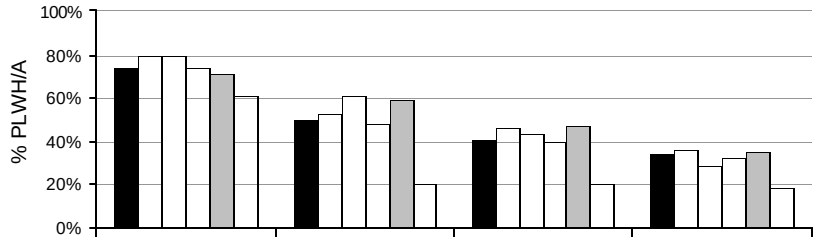
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

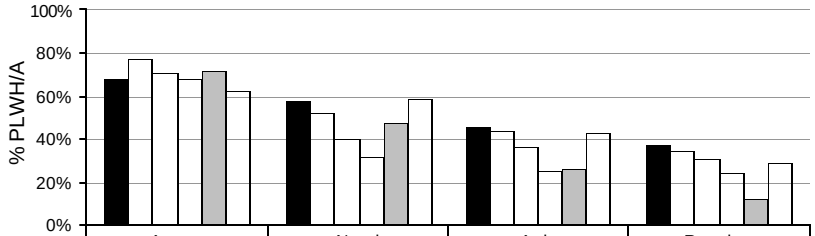
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	1
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	73.8%	49.4%	40.7%	33.2%
Female	78.7%	51.8%	46.1%	35.6%
TG	78.5%	61.4%	43.0%	27.9%
MSM	73.4%	48.1%	39.6%	31.5%
IDU	70.7%	59.6%	47.0%	34.5%
Het	61.2%	20.4%	20.1%	18.9%



	Aware	Need	Ask	Receive
AfAm	68.2%	57.2%	45.5%	36.8%
Anglo	76.7%	52.1%	43.4%	34.3%
API	70.2%	40.1%	35.7%	30.2%
Latino	68.1%	31.5%	24.6%	23.9%
OC	71.4%	47.6%	26.2%	11.9%
Hmlss	62.1%	58.5%	43.1%	28.8%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	26.2%	21.3%	21.5%
Unmet perceived need	9.4%	15.5%	23.8%
Need-Receive Gap	16.2%	16.2%	33.5%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	31.8%	23.3%	31.9%
Unmet perceived need	14.8%	10.4%	2.4%
Need-Receive Gap	20.4%	17.8%	7.5%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	71.4%	62.1%	70.6%
Need	47.6%	58.5%	59.3%
Ask	26.2%	43.1%	54.7%
Receive	11.9%	28.8%	42.2%
Knowledge Gap	28.6%	37.9%	29.4%
Unmet perceived need	14.3%	14.3%	12.5%
Need-Receive Gap	35.7%	29.7%	17.1%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	59.9%	75.4%	77.4%
Need	38.0%	56.5%	52.6%
Ask	28.9%	50.0%	45.3%
Receive	20.0%	45.2%	41.4%
Knowledge Gap	40.1%	24.6%	22.6%
Unmet perceived need	8.9%	4.8%	3.9%
Need-Receive Gap	18.0%	11.2%	11.2%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	74.2%	74.3%	76.6%
Need	49.8%	47.2%	54.7%
Ask	41.0%	36.1%	46.8%
Receive	33.2%	25.0%	41.0%
Knowledge Gap	25.8%	25.7%	23.4%
Unmet perceived need	10.0%	11.1%	5.9%
Need-Receive Gap	16.5%	22.2%	13.8%

Summary

While Emergency Financial Assistance is a funded category, the REGGIE system does not report it uniformly and there is no meaningful measurable eligibility criteria. Without the number eligible, no calculation can be made for those in service, or for eligibility and service gaps.

PLWH/A are aware of emergency financial assistance, with between 70% and 80% of all groups reporting knowledge of this service. Youth have the lowest awareness of this service of all groups at 55%.

The data also show:

- Heterosexuals (20%) report the lowest need for this service compared to over 50% for most other groups.
- Transgender persons have the highest unmet perceived need of all gender groups at 15%. Among risk groups, unmet perceived need is highest among IDUs at 13%. Among special populations, recently incarcerated (13%) and homeless PLWH/A (17%) have the highest unmet perceived need.
- The need-receive gap is high across all groups, though transgender persons (34%), homeless PLWH/A (30%), and those out-of-care (36%) have gaps well above 30%.
- PLWH/A that have received this service the most include Native Americans (41%), MSM/IDU (45%), PLWH/A over 55 years (44%), Tenderloin residents (41%), recently incarcerated PLWH/A(42%), and symptomatic PLWH (45%).

Supportive Housing

Definition

Services include individual and group counseling, community building and tenant organizing, case management, providing referrals and follow up to primary care, benefit counseling and client advocacy, substance abuse and psychiatric treatment, and meal programs. Some of these services are provided on site by collaborating agencies.

Service Unit, Eligibility, and Funding

Unit: Supportive housing day

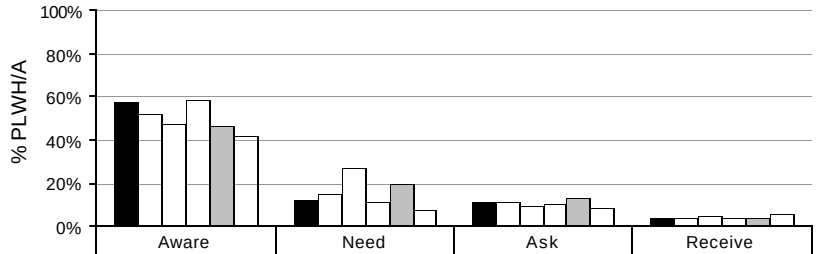
Eligibility: Diagnosis of HIV infection, homeless resident of EMA, at least 18 years of age, no income to less than 20% of median income.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	260
In Service – self rpt	NA
Estimated # Eligible	NA

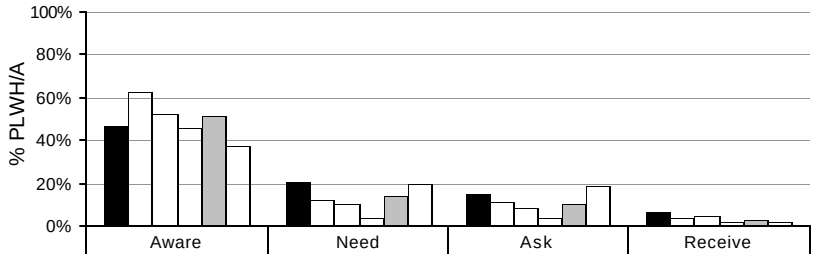
SERVICE UNITS 2001	
# of duplicated clients	1,208
Average # Units Received - REGGIE	4
Median# of Units Received – self rpt	2
Total # Units Received - REGGIE	36,788
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	58.0%	12.3%	11.1%	4.0%
Female	52.3%	15.0%	11.4%	4.3%
TG	47.7%	27.5%	9.8%	5.4%
MSM	58.4%	11.5%	11.0%	4.0%
IDU	47.2%	20.2%	13.1%	4.3%
Het	42.7%	8.3%	8.8%	6.3%



	Aware	Need	Ask	Receive
AfAm	46.4%	20.6%	15.4%	6.1%
Anglo	62.3%	12.9%	11.7%	4.0%
API	52.3%	9.5%	8.0%	4.6%
Latino	45.4%	3.5%	3.5%	2.1%
OC	51.2%	14.3%	9.5%	2.4%
Hmlss	37.9%	20.0%	18.5%	1.5%

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

Gender	Male	Female	TG
Knowledge Gap	42.0%	47.7%	52.3%
Unmet perceived need	7.1%	7.1%	4.3%
Need-Receive Gap	8.3%	10.6%	22.0%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	53.6%	37.7%	54.6%
Unmet perceived need	9.3%	7.7%	1.3%
Need-Receive Gap	14.5%	8.9%	1.3%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	51.2%	37.9%	46.8%
Need	14.3%	20.0%	22.9%
Ask	9.5%	18.5%	23.6%
Receive	2.4%	1.5%	10.2%
Knowledge Gap	48.8%	62.1%	53.2%
Unmet perceived need	7.1%	16.9%	13.4%
Need-Receive Gap	11.8%	18.5%	12.8%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	48.6%	56.8%	58.0%
Need	13.8%	18.3%	17.4%
Ask	13.3%	12.8%	14.6%
Receive	6.8%	5.6%	7.0%
Knowledge Gap	51.4%	43.2%	42.0%
Unmet perceived need	6.5%	7.2%	7.6%
Need-Receive Gap	6.9%	12.7%	10.5%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	57.4%	41.7%	59.7%
Need	12.7%	11.1%	20.7%
Ask	11.1%	5.6%	16.3%
Receive	4.1%	5.7%	8.5%
Knowledge Gap	42.6%	58.3%	40.3%
Unmet perceived need	7.0%	-0.2%	7.8%
Need-Receive Gap	8.7%	5.4%	12.2%

Summary

The REGGIE system reports that 260 PLWH/A receive supportive housing from Ryan White Title I care providers. However, there is no meaningful measurable system-wide eligibility criteria, and without the number eligible, no calculation can be made for those in service, or for eligibility and service gaps.

The knowledge gap for supportive housing services is somewhat high among most groups, ranging from just under 50% in some instances to over 60% in others.

The data also show:

- Among gender groups, transgender persons report the highest need at 27% and also have the highest need-receive gap (22%). However, the unmet perceived need gap for transgender persons is just 4%, suggesting that those who ask for the service are able to receive it. The need for supportive housing is also high among undocumented PLWH/A (24%), recently incarcerated (23%), and homeless PLWH/A (20%).
- Homeless PLWH/A have the highest unmet perceived need at 17%, followed by recently incarcerated at 13%. Other groups with an unmet perceived need above the total sample of 7% include males, females, African Americans, Anglos, Native Americans, IDUs, youth, over 55, undocumented PLWH/A, and symptomatic PLWH. The difference between those who need and ask for supportive housing is greatest among transgender persons.
- African Americans and Native Americans have asked for the service more than other ethnic groups, both at 15%, compared to a low of just 4% among Latino/as. PLWH/A over 55 years (21%), undocumented (18%), recently incarcerated (24%) and homeless PLWH/A (19%) have all asked for this service more than other groups.
- The percent of PLWH/A who have received the service is relatively low across most groups.

Summary Housing

Overall, there is high need for most housing services among PLWH/A. Supportive housing has the lowest need at 13%. Need is highest for rental assistance (57%), followed by DEFA (50%) and housing information services (44%).

- For most housing services there are no meaningful measurable eligibility criteria. Without clear eligibility criteria and uniform units of measurement, gap measures cannot be calculated and planning for unmet need is difficult.
- Housing services also have higher levels of unmet perceived need than any other service. This is not surprising since the housing needs of many PLWH/A are greater than the resources available under Title I to meet. Transgenders, women, homeless PLWH/A and recently incarcerated all have high unmet perceived need for most housing services.
- The need-receive gap for most housing services is also significantly higher than that of other services. Homeless PLWH/A have the highest need-receive gap of any group, though youth, transgender persons, heterosexuals, undocumented PLWH/A, and women also have a high need-receive gap.

Housing : Qualitative Comments - Services

An African American female said, *"I just wanted to say if someone would give me a place to stay that's what will open the door to get off of disability and that's all I need to motivate me. My hope is gone for housing and I just can't do it any longer. I can't go backwards. I have to do things in order. You know get into a place, because I talked to my doctor and he says, 'You're trying to do too much at one time and you're going to get sick.'"*

A transgender said, *"Housing is a service that's a big issue. With us it's a big, big issue. They need to have more housing for us, more accessible housing for us. People see us coming and they look at us like we are out of our freaking mind like you've got some kind of freaking disease."*

A San Mateo African American female suggested that housing is connected to medical care. She said, *"If you don't have somewhere to sleep how are you going to get yourself to go to a doctor's appointment? How can you take medication if you don't have somewhere to keep it? I mean I know from experience from living on the street and trying to hide your medication in the backpack. You lose it or you don't take it, because you're too busy."* An African American male followed by saying, *"But if a person had housing, if a person had a decent place to live they probably would take their medicine. They probably would go to the doctor. They probably would eat a decent meal. Housing is a part of prevention. Just like your medical care and all of that is part of prevention, but housing is the big picture of prevention and I think that they ought to look at that."*

An African American female said, *"But where I live at I can't understand why HIV people don't have any priorities. If we don't get any housing we're not going to take our medicine. We might*

take it, but we're not going to be able to do it the right way. As long as you are on the streets and you say you're not going to take a drink and you are on medication you will take a drink when you don't have a place to stay or you are staying with people you don't like and they don't like you."

Housing Consumer Reported Top Barriers

- Service not available or discontinued
- Not eligible
- Provider expertise
- Wait time for appointment
- Communication with provider

Housing : Consumer Qualitative Comments - Barriers

A transgender said, *"Basically being a transgender and coming from a homeless environment you go in and apply for housing and they say you've got to have this much credit, this much credit, this much credit. You have to jump through all of these hoops and then they still deny you, because you are transgender. I don't know if I feel comfortable about living around here. Do you know what I'm saying? I haven't actually had to because basically you move into an establishment that already has transgender than trying to move to a straight establishment. [In a straight establishment] they kind of prowl on you and they look at you really strange, and then that makes you feel uncomfortable with yourself."*

Another transgender said, *"I went and applied for an apartment. On the phone she said, 'Bring this and bring that and bring this,' and then when I get there and she sees that I'm transgender everything turned around. 'Well, we will call you.'"*

A homeless male said, *"The waiting list is a problem. You're supposed to call every month to find out where you are on that list. You call and you get a machine. It says, 'Leave your number. We'll call you back.' I don't care if you call them a hundred times they have never called me back. They have never returned my call. I have to go down to the [agency]. It takes like a week to find out where I am on the list and for some reason I am going backwards on the list. My number is getting higher when it should be getting lower."*

When asked their opinion of why it has been hard to get permanent housing, three women in the African American group agreed when a woman said, *"They don't like me or something."* Another woman said, *"That's not it, but that's how you think though. I have so many aspirations. One place like on Church Street said, 'You can't apply here, because you don't have a certificate.' I brought it here and they said, 'You don't have a certificate to get in.' I've got my lawyers working on a place to stay even if I have to go and put the money up myself and pay my rent. I don't want to do that but I will. I don't have a case manager working with me. It just doesn't make sense. I'm sick. I sleep on the floor. It's so small and I've been on the floor. My head is by a window where the air comes in. That's why I keep getting these colds back and forth."*

A homeless male brought up motel vouchers as a service and his concern of the location of the motel. He said, *"If you could get a motel voucher and they put you on 6th Street. I guess it depends on the individual or they think we can make it up and down 6th Street everyday without using any crack or smoking any crack or using any drugs they might advance you something else, but that's too hard for people. They don't understand."*

Another homeless male said, *"Housing wise services in San Francisco really suck. There's not enough housing for people with no income like we have no income. Trying to find something that's affordable in this city is impossible and trying to find somebody to help you pay your rent, because you get $700 a month or even more if possible so it would be [poorly rated]."*

An African American IDU female mentioned her experience in trying to get housing in San Francisco by saying, *"I moved from Mission when I got burned out. First I went to the [Agency deleted] and I got burned out in there. Then I moved over to Mission and I got burned out of there. Then I went to an SRO and stayed there a few days and then I went to another SRO. I went there on Monday morning and I said, "Look I've got to have a place to stay." I walked from one SRO to another and I told them I had to have a place to stay. It's been hard to get permanent housing because they don't like me or something – or at least that's what you start to think."*

A homeless male said, *"I lived in supportive housing, but it took me 7 years to get there."*
A currently homeless African American MSM said, *"I've been homeless on and off for years. I don't know why they moved the housing alerts to the city because now everybody is thrown together on one list. And the way they do it is they pick your name off the list and put you in a category. It's not a lottery but they give you around the city, and the list is so bad now, because I was number six when the list was at [one ASO]. I was number six for subsidy and then when they switched it to the city's housing wait list, and I'm now number 166 because all of the people they just put them together. They just threw them together and now like I call once a month and I'm going back further and further, because people are living longer."*

A San Mateo African American male said, *"Before you get the subsidy for housing the one thing I wanted to point out is that the resources here, immediate resources that most people have, all they want to do is shove you into the drug program. They don't have any resources for the housing or any plan implemented for the housing program. All they want to talk to you about is getting into a drug program and they've got a spot already open."* Another African American male followed by saying, *"Don't ever tell them about recovery, because that's what they'll do. Instead of getting you a room or place somewhere they say, 'Well this looks really nice. You'd probably do better here,' and then it's a drug program. Then I go, 'Well I'm not in recovery.'"*

A homeless male said, *"I'm living at a hotel right now. It's hard to find housing. I'm hoping that I can move into a room somewhere else because I can't afford the $800 they want for my room with a bath. So I'm hoping I can move into a room without a bath. What I really need and can't find is help with paying my rent. I need a subsidy and I can't get one, because they've put me on a waiting list. Once your name is on their housing list you can't get a subsidy from anybody else."*

A San Mateo African American male said, *"If the county, government, state, whatever is looking at prevention of people spreading HIV and AIDS they really should look at housing for people with HIV and AIDS, because all of that money they have there they can set up a thing just like Section 8 and call it Section HIV. Whatever they want to call it but they could set up a separate thing for that because they didn't always have a Section 8. That's the most important and valuable thing you can do besides asking about the doctor care and all of that. We are all getting good medical care, but what we're not all getting housing."*

A San Mateo African American female said, *"They haven't taken any new names for Section 8 in over 8 years and they're just now getting ready to do it now. You've got a 5 year waiting list. They need to split it up with HIV and AIDS, those should be priority. Why should we have to wait 5 years? We may not be here in 5 years. Nobody is guaranteed, but for us it's even worse."*

Housing: Provider Qualitative Comments

"There is not enough housing service in San Francisco. And especially with people on fixed income."

"Some of the referrals from the Housing Wait List are not appropriate for [our housing program]. This includes people who do not have six months clean and sober as well as those who are not interested in a shared living situation. We have discussed this problem with the Department of Housing and Urban Health and are trying to obtain more appropriately screened referrals off the Wait List."

"The main barrier to co-op housing, long term congregate housing and rental subsidy is lack of available housing for low income population in the city and county of San Francisco. Barriers to services provided at [our agency] include (1) diagnosis letter is not strong enough to qualify for services, (2) the client does not live or is not a resident of San Francisco, (3) the client's income surpasses the maximum income policy set by [our agency], and (4) attempted fraud. Since these are policies set by [our agency], they cannot be overcome."

"The most common reason that people who apply for services do not receive them is that they do not meet eligibility requirements for entry. Usually this means they are a danger to themselves or others (uncontrolled, mental illness, incarcerated). Mental illness and refusal to accept treatment is the number one barrier."

"Residents referred for housing [at our agency] are denied if there is behavior that has caused past evictions at other sites such as failure to pay rent, violence or threats of violence and drug dealing."

"In September of 2001, [our agency] began to coordinate the HIV Emergency Housing Program. In December we began tracking the number of individuals referred for Emergency Housing who were not housed due to lack of room availability. We have tracked at least 74 individuals who got to the referral stage, and who could not be housed in emergency housing.

This number represents only a fraction of those in need of this service during this time, as many were never referred since the referring agencies are notified when there are no rooms available. Insufficient resources (rooms) for Emergency Housing is clearly the main reason why those who apply for this service do not receive it. Insufficient resources for those agencies referring into the system is another reason why those in need do not receive this service. Insufficient access to permanent housing for those exiting emergency housing is another reason why those who need to access emergency housing cannot - the rooms are filled with those unable to locate permanent housing. It is clear that insufficient housing resources, and the resulting lack of access to stable housing is the single most potent obstacle to our client's ability to access adequate health care and support services."

"The only requirement for entry into [our home healthcare services] is that the client be between the ages of 18-25. This would be the only barrier for clients accessing and receiving services. When a client attempts to access services who is over the age of 25, he or she is referred to the appropriate adult provider. A client under the age of 18 will access our underage programs. The underage services will work in conjunction to develop an appropriate treatment plan and placement. Clients may have individual barriers such as substance abuse and mental health issues. Case managers work with clients to create individual service plans to address both of these issues. An on-site substance abuse counselor can provide counseling, referrals, and consultations. An on-site psychiatrist is also available for evaluation and medication management. We have implemented an agency-wide comprehensive substance abuse and mental health initiative for clients who need additional assistance."

Food

Food Pantry

Definition
Provision of food, meals, or nutritional supplements.

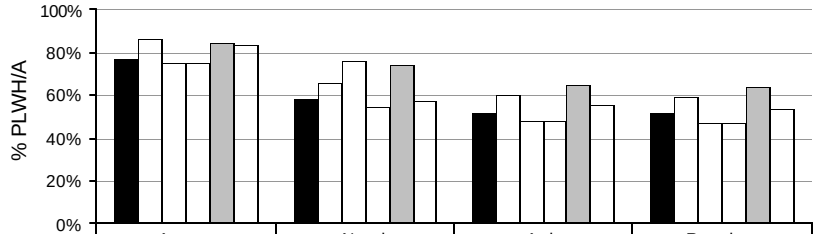
Service Unit, Eligibility, and Funding
Unit: Visit
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	7,617
Estimated # Eligible	14,648

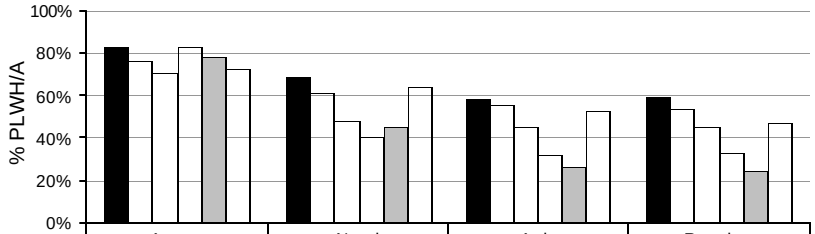
SERVICE UNITS 2001	
# of duplicated clients	
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	15
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	114,251
Theoretical need	219,713

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	48%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	77.3%	58.7%	52.3%	51.4%
Female	86.4%	65.2%	60.1%	59.7%
TG	75.2%	76.1%	47.7%	46.6%
MSM	74.8%	54.7%	48.2%	47.2%
IDU	84.1%	74.8%	64.2%	63.5%
Het	83.4%	57.3%	55.6%	54.4%



	Aware	Need	Ask	Receive
AfAm	83.0%	68.5%	57.8%	59.0%
Anglo	76.1%	61.5%	55.7%	54.0%
API	70.7%	48.4%	45.1%	45.1%
Latino	82.7%	39.9%	32.4%	33.3%
OC	78.6%	45.2%	26.2%	23.8%
Hmlss	72.7%	64.6%	52.3%	47.0%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	22.7%	13.6%	24.8%
Unmet perceived need	0.9%	0.4%	1.1%
Need-Receive Gap	7.3%	5.5%	29.5%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	17.0%	23.9%	17.3%
Unmet perceived need	-1.2%	1.7%	-0.9%
Need-Receive Gap	9.5%	7.6%	6.6%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	78.6%	72.7%	82.6%
Need	45.2%	64.6%	73.4%
Ask	26.2%	52.3%	67.0%
Receive	23.8%	47.0%	60.9%
Knowledge Gap	21.4%	27.3%	17.4%
Unmet perceived need	2.4%	5.3%	6.1%
Need-Receive Gap	21.4%	17.6%	12.5%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	78.3%	84.1%	83.1%
Need	55.1%	66.4%	62.0%
Ask	41.9%	60.8%	56.9%
Receive	39.7%	61.6%	56.7%
Knowledge Gap	21.7%	15.9%	16.9%
Unmet perceived need	2.2%	-0.8%	0.2%
Need-Receive Gap	15.4%	4.8%	5.2%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	77.7%	91.4%	85.8%
Need	59.4%	75.0%	71.4%
Ask	52.7%	66.7%	68.4%
Receive	51.8%	66.7%	66.3%
Knowledge Gap	22.3%	8.6%	14.2%
Unmet perceived need	0.9%	0.0%	2.1%
Need-Receive Gap	7.6%	8.3%	5.0%

Summary

All PLWH/A are currently eligible for food pantry services. Using this eligibility criteria, there would be a large estimated eligibility gap and a high gap (48%) between utilization and theoretical need. Common sense would suggest, however, that this overstates need, and there is a need to adopt an eligibility criteria that explicitly has basic nutritional requirements as the core of the criteria.

Awareness of food pantry services is above 70% for all groups except youth (53%). The knowledge gap is much lower in San Mateo (8%) compared to San Francisco (18%). Among ethnic groups, the knowledge gap is highest among African Americans (24%) and Asian/Pacific Islanders (29%).

The data also show:

- Based on self reports in the survey, over 7,600 PLWH/A access food pantry services, on average 15 times a year.
- Need for food pantry services are high across all groups. Several sub-populations express an extremely high need (over 70%) and they include: transgender persons, Native Americans, MSM/IDU, IDUs, San Mateo residents, Tenderloin residents, and the recently incarcerated.
- The unmet perceived need gap is very low for all groups, indicating that those who ask for the service are receiving it.
- The need-receive gap is significantly higher among transgender persons (30%), youth (16%), recently incarcerated (13%), and homeless PLWH/A (18%) than it is among other groups.

Food Vouchers

Definition

Provision of a voucher for groceries or a meal.

Service Unit, Eligibility, and Funding

Unit: Vouchers

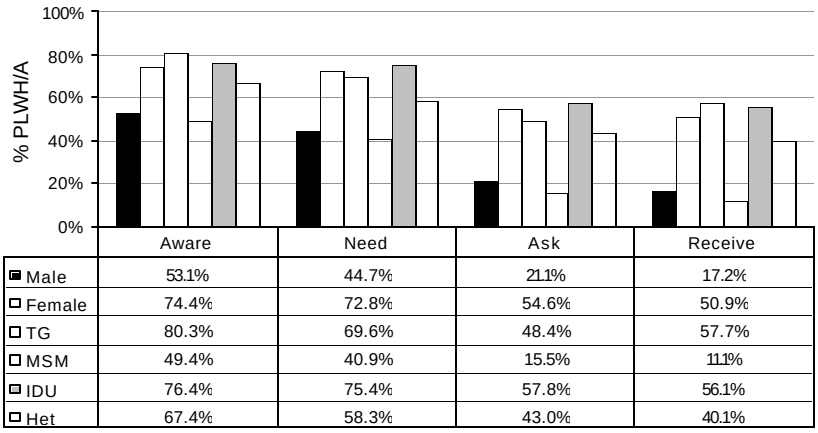
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,930
Estimated # Eligible	14,648

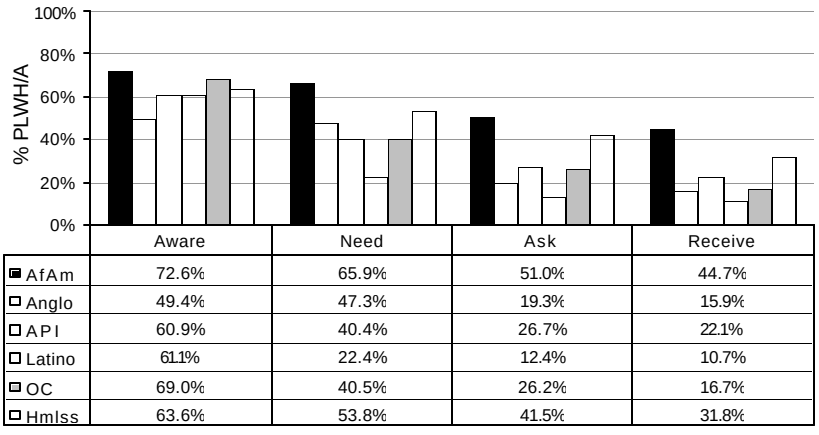
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	3
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	8,789
Theoretical need	43,943

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	80.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	53.1%	44.7%	21.1%	17.2%
Female	74.4%	72.8%	54.6%	50.9%
TG	80.3%	69.6%	48.4%	57.7%
MSM	49.4%	40.9%	15.5%	11.1%
IDU	76.4%	75.4%	57.8%	56.1%
Het	67.4%	58.3%	43.0%	40.1%



	Aware	Need	Ask	Receive
AfAm	72.6%	65.9%	51.0%	44.7%
Anglo	49.4%	47.3%	19.3%	15.9%
API	60.9%	40.4%	26.7%	22.1%
Latino	61.1%	22.4%	12.4%	10.7%
OC	69.0%	40.5%	26.2%	16.7%
Hmlss	63.6%	53.8%	41.5%	31.8%

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

Gender	Male	Female	TG
Knowledge Gap	46.9%	25.6%	19.7%
Unmet perceived need	3.9%	3.7%	-9.3%
Need-Receive Gap	27.5%	21.9%	11.9%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	27.4%	50.6%	38.9%
Unmet perceived need	6.2%	3.4%	1.8%
Need-Receive Gap	21.2%	31.4%	11.7%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	69.0%	63.6%	75.5%
Need	40.5%	53.8%	69.4%
Ask	26.2%	41.5%	59.3%
Receive	16.7%	31.8%	52.3%
Knowledge Gap	31.0%	36.4%	24.5%
Unmet perceived need	9.5%	9.7%	7.0%
Need-Receive Gap	23.8%	22.0%	17.2%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	61.6%	67.2%	65.0%
Need	42.8%	62.6%	50.3%
Ask	28.1%	49.2%	35.5%
Receive	22.6%	42.3%	31.1%
Knowledge Gap	38.4%	15.9%	16.9%
Unmet perceived need	5.5%	6.9%	4.4%
Need-Receive Gap	20.1%	20.3%	19.2%
Region	**Total**	**San Mateo**	**Tenderloin**
Aware	54.7%	91.7%	62.6%
Need	46.7%	77.8%	56.6%
Ask	23.5%	65.7%	43.5%
Receive	19.8%	66.7%	37.4%
Knowledge Gap	45.3%	8.3%	37.4%
Unmet perceived need	3.7%	-1.0%	6.1%
Need-Receive Gap	26.9%	11.1%	19.2%

Summary

Like food pantry services, all PLWH/A are currently eligible for food voucher services based on the current system-wide criteria. Using this criteria, there would be a large estimated eligibility gap and a very large gap (80%) between utilization and theoretical need. Common sense would suggest, however, that this overstates need and there is a need to adopt an eligibility criteria that explicitly has basic nutritional requirements as a criteria.

There is wide variation in the level of awareness of food vouchers among PLWH/A. For example, transgender persons have an awareness level of 80% compared to just 55% for males. Among ethnic groups, African Americans have a high awareness at 73% compared to just 49% for Anglos. San Mateo residents have the highest level of awareness at 92% compared to just 55% for all PLWH/A.

The data also show:

- The need for food vouchers is 47% among all PLWH/A, though some sub-populations have extremely high need. These include women (73%), transgender persons (70%), IDUs (75%), San Mateo residents (78%), and recently incarcerated (69%).
- In terms of unmet perceived need, transgender persons appear to be receiving more service than is being requested. Compared to all PLWH/A, several groups have a high unmet perceived need. These include Native Americans (9%), undocumented PLWH/A (9%), recently incarcerated (7%), homeless PLWH/A (10%), and those out-of-care (10%).
- The overall need-receive gap is very high at 27%, indicating that a sizeable proportion of PLWH/A have expressed a need for food vouchers but have not received them. This gap is highest among Anglos (31%) and MSM (30%). It should be noted that among all service categories, the difference between those who need and ask for a service is greatest for food vouchers. For some reason, although PLWH/A may perceive a need for this service, they are unlikely to ask for it.
- Women, transgender persons, African Americans, Native Americans, IDUs, heterosexuals, homeless PLWH/A, and PLWH/A living in San Mateo county are more likely to have asked for this service than any other group.

Prepared Meals (Home Delivered)

Definition

Home-delivered prepared meals.

Service Unit, Eligibility, and Funding

Unit: Meals

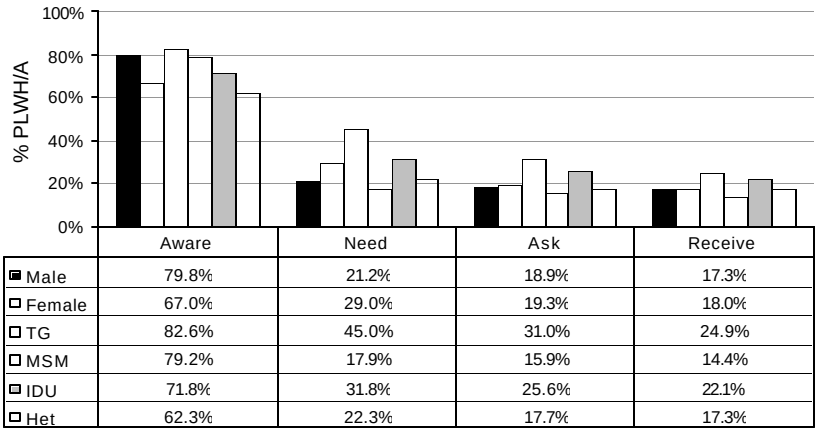
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	1,101
In Service – self rpt	2,637
Estimated # Eligible	14,648

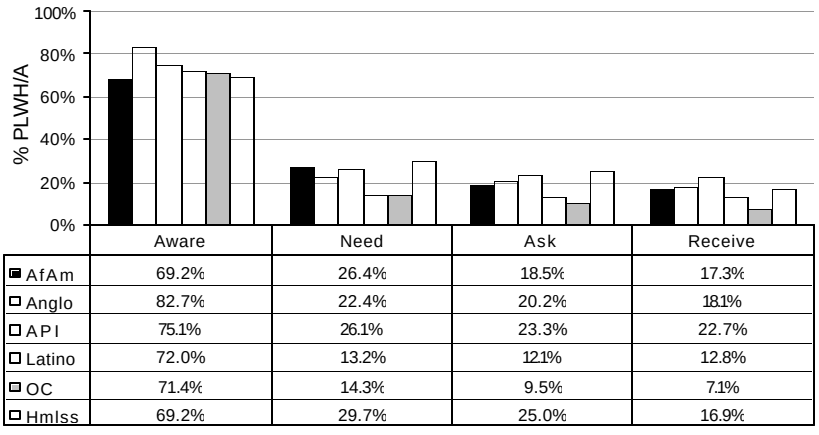
SERVICE UNITS 2001	
# of duplicated clients	6,413
Average # Units Received - REGGIE	134
Median# of Units Received – self rpt	36
Total # Units Received - REGGIE	4,417
Total # of Units Received – self rpt	94,916
Theoretical need	527,310

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	92.5%	Reported minus Theoretical Need – REGGIE	99.2%	
		Reported minus Theoretical Need: - self rpt	82.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	79.8%	21.2%	18.9%	17.3%
Female	67.0%	29.0%	19.3%	18.0%
TG	82.6%	45.0%	31.0%	24.9%
MSM	79.2%	17.9%	15.9%	14.4%
IDU	71.8%	31.8%	25.6%	22.1%
Het	62.3%	22.3%	17.7%	17.3%



	Aware	Need	Ask	Receive
AfAm	69.2%	26.4%	18.5%	17.3%
Anglo	82.7%	22.4%	20.2%	18.1%
API	75.1%	26.1%	23.3%	22.7%
Latino	72.0%	13.2%	12.1%	12.8%
OC	71.4%	14.3%	9.5%	7.1%
Hmlss	69.2%	29.7%	25.0%	16.9%

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

Gender	Male	Female	TG
Knowledge Gap	20.2%	33.0%	17.4%
Unmet perceived need	1.6%	1.3%	6.1%
Need-Receive Gap	3.9%	10.9%	20.1%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	30.8%	17.3%	28.0%
Unmet perceived need	1.2%	2.2%	-0.7%
Need-Receive Gap	9.1%	4.3%	0.4%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	71.4%	69.2%	73.6%
Need	14.3%	29.7%	38.9%
Ask	9.5%	25.0%	31.8%
Receive	7.1%	16.9%	27.8%
Knowledge Gap	28.6%	30.8%	26.4%
Unmet perceived need	2.4%	8.1%	4.0%
Need-Receive Gap	7.1%	12.8%	11.1%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	71.7%	79.2%	81.9%
Need	17.5%	37.6%	31.4%
Ask	14.2%	33.1%	27.5%
Receive	13.2%	31.1%	24.8%
Knowledge Gap	28.3%	20.8%	18.1%
Unmet perceived need	0.9%	1.9%	2.7%
Need-Receive Gap	4.3%	6.5%	6.6%

Region	Total	San Mateo	Tenderloin
Aware	79.1%	61.1%	79.5%
Need	22.1%	16.7%	34.6%
Ask	19.2%	8.6%	31.2%
Receive	17.5%	5.6%	31.0%
Knowledge Gap	20.9%	38.9%	20.5%
Unmet perceived need	1.6%	3.0%	0.2%
Need-Receive Gap	4.6%	11.1%	3.6%

Summary

Like other food services, the current system-wide eligibility criteria for home delivered meals is very broad. The REGGIE system reports about 1,100 PLWH/A receive meals from Ryan White Care providers, and the survey data suggest that about 2,600 receive meals. REGGIE reports that the average number of meals received is 134 a year, while consumers say that they receive about 36 meals a year. Even with the lower estimate, this leaves a large gap between reported use and theoretical need. In large part this suggests a more restrictive eligibility criteria might be useful in creating realistic expectations for persons in care.

The need for home delivered meals among all PLWH/A is 22%, much lower than found for other food services (60% for food pantry and 47% for food vouchers). Those populations that have a higher need for this service include transgender persons (45%), Native Americans (43%), MSM/IDU (39%), Tenderloin residents (35%), and symptomatic PLWH/A (38%).

The data also show:

- Awareness of the service is generally quite high, though youth (50%) have a substantially lower level of awareness than the overall sample (79%).
- The unmet perceived need gap is highest among Native Americans (9%) and homeless PLWH/A (8%) compared to all PLWH/A (2%). Latinos and undocumented PLWH/A are the only two groups who appear to be receiving more service than has been asked for.
- The need-receive gap is extremely high among women, San Mateo County residents, and recently incarcerated PLWH/A all at 11%. Homeless PLWH/A at 13% also have a high need-receive gap, suggesting that for many groups the level of service delivery is below what clients feel they need.

Nutrition Education and Counseling

Definition

Provision of nutrition education and/or counseling provided by a licensed/registered dietitian outside of a primary care visit.

Service Unit, Eligibility, and Funding

Unit: Hours

Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

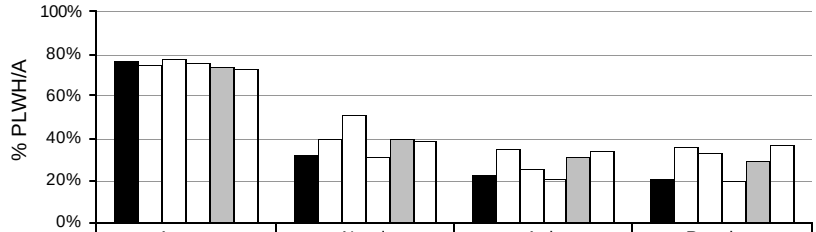
ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	263
In Service – self rpt	3,369
Estimated # Eligible	14,648

SERVICE UNITS 2001	
# of duplicated clients	673
Average # Units Received - REGGIE	2
Median# of Units Received – self rpt	2
Total # Units Received - REGGIE	508
Total # of Units Received – self rpt	6,738
Theoretical need	29,295

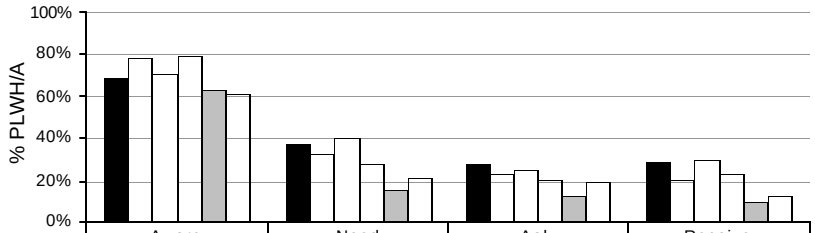
FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps			
Eligibility Gap:	98.2%	Reported minus Theoretical Need – REGGIE	98.3%
		Reported minus Theoretical Need: - self rpt	77.0%

Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	76.8%	31.6%	22.9%	21.5%
Female	74.3%	40.1%	35.4%	36.3%
TG	78.3%	51.2%	26.0%	33.2%
MSM	76.4%	30.6%	21.2%	20.2%
IDU	73.5%	39.7%	30.6%	29.5%
Het	72.5%	38.8%	34.8%	37.0%



	Aware	Need	Ask	Receive
AfAm	68.8%	37.4%	28.0%	28.7%
Anglo	78.2%	32.0%	23.4%	20.8%
API	70.9%	40.3%	25.0%	29.5%
Latino	79.1%	27.2%	20.8%	23.4%
OC	63.4%	15.4%	12.5%	10.0%
Hmlss	60.6%	21.5%	18.5%	12.3%

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

Gender	Male	Female	TG
Knowledge Gap	23.2%	25.7%	21.7%
Unmet perceived need	1.5%	-0.9%	-7.2%
Need-Receive Gap	10.1%	3.8%	18.0%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	31.2%	21.8%	20.9%
Unmet perceived need	-0.7%	2.6%	-4.5%
Need-Receive Gap	8.7%	11.2%	3.9%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	63.4%	60.6%	67.3%
Need	15.4%	21.5%	30.8%
Ask	12.5%	18.5%	26.2%
Receive	10.0%	12.3%	25.9%
Knowledge Gap	36.6%	39.4%	32.7%
Unmet perceived need	2.5%	6.2%	0.2%
Need-Receive Gap	5.4%	9.2%	4.9%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	72.5%	73.6%	77.0%
Need	25.2%	29.6%	35.1%
Ask	15.7%	22.8%	28.3%
Receive	17.0%	22.6%	28.3%
Knowledge Gap	27.5%	26.4%	23.0%
Unmet perceived need	-1.4%	0.2%	0.0%
Need-Receive Gap	8.1%	7.0%	6.8%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	76.7%	77.8%	72.4%
Need	32.4%	58.3%	25.8%
Ask	23.7%	45.7%	21.2%
Receive	22.5%	47.2%	21.6%
Knowledge Gap	23.3%	22.2%	27.6%
Unmet perceived need	1.2%	-1.5%	-0.4%
Need-Receive Gap	9.9%	11.1%	4.2%

Summary

Like the food services noted above, the lack of a more restricted eligibility criteria make the estimates of the eligibility and service gaps unrealistically large. REGGIE reports that under 300 persons received nutritional education and counseling. The low number is more likely to reflect misreporting by providers, or that nutritional education and counseling was combined with other services reported. About 3,400 PLWH/A report receiving nutritional education and counseling based on the survey. However, with over 14,0000 PLWH/A who know their status eligible, this still leaves a large eligibility gap and service gap. Both REGGIE and PLWH/A report receiving, on average, two hours of nutritional counseling and education and year.

Most PLWH/A are aware of nutrition education services, with a total of 77% indicating that they know about this service. The knowledge gap is highest among youth (55%), PLWH/A out-of-care (37%), recently incarcerated (39%), and homeless PLWH/A (33%).

The data also show:

- Approximately one-third of all PLWH/A have expressed a need for this service, with transgender persons and those living in San Mateo county expressing the highest need (over 50% for each group).
- The unmet perceived need gap is extremely low across most groups. In fact, many PLWH/A indicate that more service is being delivered than is being asked for. This may be due to the fact that nutrition education services are typically part of a larger food delivery service system and are not necessarily independent. Only undocumented PLWH/A (9%) and homeless PLWH/A (6%) have a substantially higher unmet perceived need than others.
- The need-receive gap is lowest among heterosexuals (2%). Several groups have a need-receive gap of 10% or greater, and include males, transgender persons, Anglos, Asian/Pacific Islanders, Native Americans, MSM, IDUs, San Mateo County residents, and undocumented PLWH/A.

Summary Food

Food services are among several high priority services for PLWH/A. Food pantry services and food vouchers are needed more than other food services. The system-wide eligibility criteria places a very low threshold for PLWH/A to access food services, but the number of units of service available appears to be far lower than demand, creating large eligibility gaps, service gaps, and need-receive gaps. Many PLWH/A feel they need food vouchers but do not receive them. Focus group comments related to food vouchers suggest that this high need-receive gap may be related to the perception among PLWH/A that food vouchers are not available to them in spite of their expressed need.

- Women and transgender persons have extremely high need for food services in general, with Native Americans, recently incarcerated PLWH/A and Tenderloin residents also expressing high need.
- The majority of PLWH/A who have asked for food pantry services are receiving services, resulting in a very low unmet perceived need gap.
- While most PLWH/A have a higher need for food vouchers than are being provided, transgender persons is the only population that appears to be receiving more food vouchers than is being asked for or needed.
- As in other areas of food services, women, transgender persons, homeless PLWH/A, and recently incarcerated PLWH/A indicate their need for home delivered meals is greater than the amount of service being provided.

The system sends mixed messages to the PLWH/A regarding food. On one hand they say virtually everyone is eligible, thereby establishing an expectation. On the other, there appears to be no capacity to meet the expected service.

Food Services : Qualitative Comments - Services

A homeless male said, *"Everybody knows we are getting less food now from the food bank. To make it easier all you have to do is go to [another agency] over here, take your letter of diagnosis and you get food from them six times a year."* Other agency options were brought up in the conversation.

Food Services Consumer Reported Top Barriers

- Service not available/ discontinued
- No transportation
- Fear of being reported to
- Not knowing location

Food Services – Qualitative Comments – Barriers

Consumers

A transgender said, *"You need to be like 200 T-cell before you can go to the food bank. I was turned down, because they said my doctor needs to sign a paper. He said, 'You're well. You are over 500 T-cells so you can work. Your health is good, you're doing good'. But they are cutting down on services--do you know what I'm saying? What's the use of taking medication if they turn all of the services down?"*

A homeless male said, *"The food voucher service is a problem. At [the ASO] they say it's not available because other people have ruined it for the rest of us. They're not giving out any. They say no, because other people have ruined it."*

A homeless male said, *"Food vouchers have been taken away from us. You can't get food vouchers anymore. You have to go through somebody else and they send you to somebody else. By the time you go through all of these people you are starved. That's where I'm at. I'm just hoping that my health gets better."*

Providers

"We have no waiting list, so we never turn away qualified clients. Those we cannot serve are: 1) can't be certified symptomatic by their MD, 2) don't live in San Francisco. Our main barrier to serving the same number or more clients is less funding from government and fundraising to support these services. We worked with [another organization] to get the Board of Supervisors to backfill 1/3 of the CARE cuts with local funding. [Our agency] is always trying to come up with new and more effective fundraising activities, like expanding direct mail appeals."

Mental Health

Residential Mental Health Services

Definition

Mental health and other support services that are provided within a residential setting. Residential treatment includes housing, food, mental health treatment, and may include HIV and substance abuse counseling, supervision of compliance to prescribed medications, case specific nutritional planning, health and fitness training, transportation services, alternative healing techniques, psychiatric evaluations and treatment services, adult educational classes, case management of primary medical care, and/or other support services.

Service Unit, Eligibility, and Funding

Unit: Bed Days

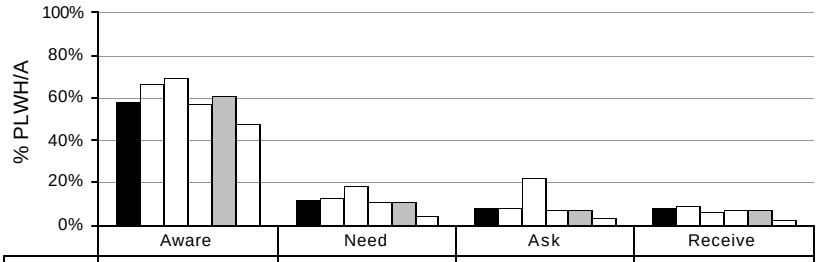
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	26
In Service – self rpt	NA
Estimated # Eligible	NA

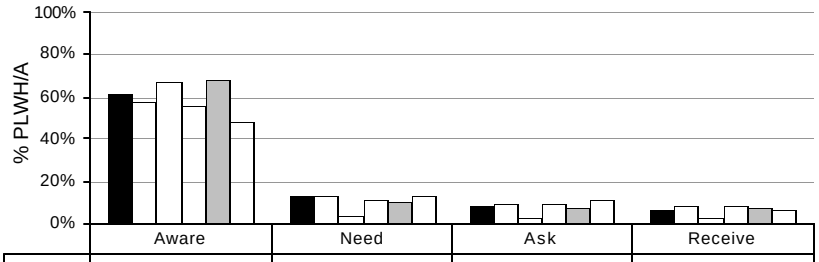
SERVICE UNITS 2001	
# of duplicated clients	111
Average # Units Received - REGGIE	120
Median# of Units Received – self rpt	10
Total # Units Received - REGGIE	3,116
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	57.2%	11.8%	8.3%	7.6%
Female	66.6%	12.8%	8.0%	8.7%
TG	68.9%	18.9%	22.1%	6.4%
MSM	56.5%	10.8%	7.5%	7.5%
IDU	61.0%	10.2%	6.8%	7.5%
Het	47.9%	4.6%	3.9%	2.5%



	Aware	Need	Ask	Receive
AfAm	61.8%	13.1%	8.1%	6.2%
Anglo	57.1%	12.3%	8.5%	7.9%
API	67.0%	3.4%	2.9%	2.9%
Latino	55.6%	11.1%	9.3%	8.4%
OC	68.3%	9.5%	7.1%	7.5%
Hmlss	48.5%	13.6%	10.6%	6.2%

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

Gender	Male	Female	TG
Knowledge Gap	42.8%	33.4%	31.1%
Unmet perceived need	0.6%	-0.7%	15.7%
Need-Receive Gap	4.2%	4.1%	12.4%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	38.2%	42.9%	44.4%
Unmet perceived need	1.9%	0.6%	0.9%
Need-Receive Gap	6.8%	4.4%	2.7%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	68.3%	48.5%	55.9%
Need	9.5%	13.6%	18.2%
Ask	7.1%	10.6%	17.3%
Receive	7.7%	6.2%	13.6%
Knowledge Gap	31.7%	51.5%	44.1%
Unmet perceived need	-0.4%	4.5%	3.6%
Need-Receive Gap	2.0%	7.5%	4.5%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	50.4%	66.4%	61.6%
Need	10.1%	17.1%	14.0%
Ask	8.1%	16.4%	10.5%
Receive	6.6%	11.7%	9.8%
Knowledge Gap	49.6%	33.6%	38.4%
Unmet perceived need	1.5%	4.7%	0.7%
Need-Receive Gap	3.5%	5.4%	4.2%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	58.0%	66.7%	64.6%
Need	12.0%	11.4%	16.1%
Ask	8.5%	8.3%	14.7%
Receive	7.7%	5.6%	12.8%
Knowledge Gap	42.0%	33.3%	35.4%
Unmet perceived need	0.8%	2.8%	2.0%
Need-Receive Gap	4.3%	5.9%	3.4%

Summary

The unavailability of meaningful system-wide eligibility criteria for residential mental health services makes estimating eligibility gaps and gaps based on theoretical need impossible. According to REGGIE, the are 26 persons in the system who access Ryan White supported residential mental health. Yet, based on survey data, twelve percent of PLWH/A have expressed a need for residential mental health services. The need is highest among transgender persons (19%), Native Americans (24%), MSM/IDU (22%), youth (25%), undocumented PLWH/A (20%), and recently incarcerated (18%). These groups are also more likely to have asked for this service compared to others. Transgender persons, at 16%, and undocumented PLWH/A, at 9%, have the highest unmet perceived need.

Psychiatric Consultation and Evaluation, Medication Monitoring, Psychiatric Liaison

Definition

Provided by a Psychiatrist (M.D.) and includes comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans and disposition.

Service Unit, Eligibility, and Funding

Unit: Hours

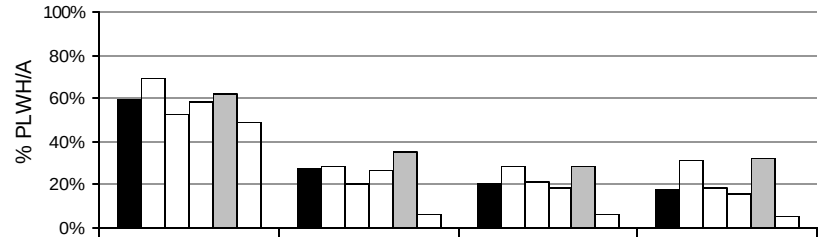
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

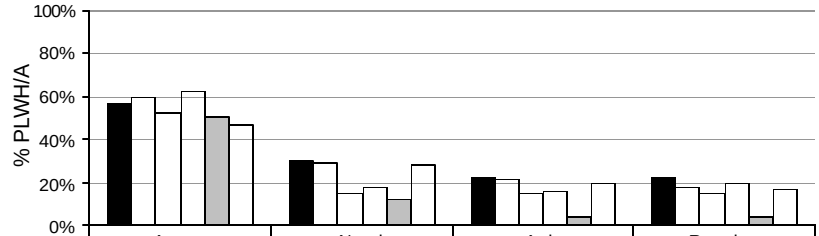
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	3
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	58.9%	27.8%	20.3%	18.0%
Female	68.9%	28.4%	28.5%	30.9%
TG	52.6%	20.4%	21.5%	18.2%
MSM	58.3%	26.8%	18.7%	16.0%
IDU	62.4%	35.3%	28.7%	31.5%
Het	48.9%	6.6%	6.4%	5.6%



	Aware	Need	Ask	Receive
AfAm	57.0%	30.2%	22.2%	21.9%
Anglo	59.5%	29.6%	21.5%	18.1%
API	52.7%	15.5%	15.6%	15.6%
Latino	62.3%	18.1%	16.4%	19.4%
OC	51.2%	12.2%	4.9%	4.9%
Hmlss	47.0%	28.8%	19.7%	16.7%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	41.1%	31.1%	47.4%
Unmet perceived need	2.3%	-2.4%	3.2%
Need-Receive Gap	9.7%	-2.5%	2.1%

Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	43.0%	40.5%	37.7%
Unmet perceived need	0.3%	3.4%	-3.1%
Need-Receive Gap	8.3%	11.5%	-1.4%

Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	51.2%	47.0%	59.5%
Need	12.2%	28.8%	32.1%
Ask	4.9%	19.7%	31.2%
Receive	4.9%	16.7%	29.4%
Knowledge Gap	48.8%	53.0%	40.5%
Unmet perceived need	0.0%	3.0%	1.8%
Need-Receive Gap	7.3%	12.1%	2.8%

Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	54.3%	70.4%	63.4%
Need	25.4%	34.7%	23.1%
Ask	19.1%	36.1%	19.8%
Receive	18.4%	33.3%	18.4%
Knowledge Gap	45.7%	29.6%	36.6%
Unmet perceived need	0.7%	2.7%	1.4%
Need-Receive Gap	7.0%	1.3%	4.7%

Region	**Total**	**San Mateo**	**Tenderloin**
Aware	59.3%	61.1%	69.3%
Need	27.7%	30.6%	28.4%
Ask	20.8%	25.0%	27.0%
Receive	18.8%	27.8%	26.5%
Knowledge Gap	40.7%	38.9%	30.7%
Unmet perceived need	2.0%	-2.8%	0.5%
Need-Receive Gap	8.9%	2.8%	2.0%

Summary

The unavailability of meaningful system-wide eligibility criteria for psychiatric consultation and evaluation services makes estimating eligibility gaps and gaps based on theoretical need impossible. Nearly 60% of PLWH/A are aware of psychiatric assessments, though less than half that (28%) have expressed a need for this service. The need is highest among MSM/IDU (31%), IDUs (35%), PLWH/A over 55 years (43%), and undocumented PLWH/A (31%).

The data also show:

- Among gender groups, women are more likely to ask for this service (29%) than are males (20%) or transgender persons (21%). Among risk groups, MSM/IDU and IDUs at 29% each are more likely to ask for this service than are MSM or heterosexuals.
- The unmet perceived need for all PLWH/A is just 2%, indicating that most people who ask for the service have received it. Unmet perceived need is highest among Native Americans and undocumented PLWH/A at 5% each.
- The need-receive gap, which is 9% for all PLWH/A, is highest among Anglos (12%), MSM (11%), PLWH/A over 55 years (11%), undocumented PLWH/A (11%), and homeless PLWH/A (12%).
- Females (31%), IDUs (31%), PLWH/A over 55 years (32%), and symptomatic PLWH (33%) are more likely to have received psychiatric assessments than other groups.

Crisis Mental Health Intervention

Definition

Rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral.

Service Unit, Eligibility, and Funding

Unit: Hours

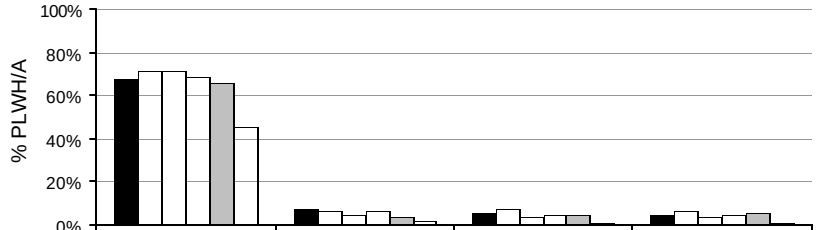
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

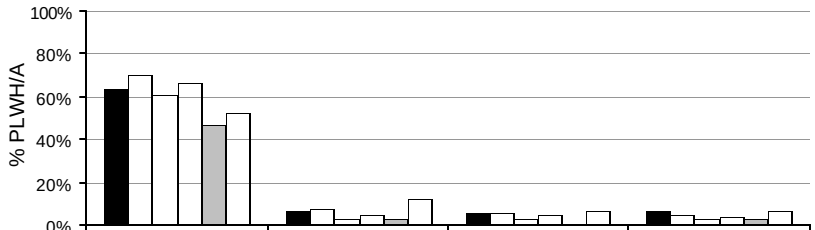
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	2
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	68.4%	7.7%	6.1%	4.9%
Female	71.9%	6.9%	7.6%	7.2%
TG	71.8%	5.4%	3.3%	3.3%
MSM	68.7%	7.2%	5.7%	4.2%
IDU	66.2%	3.6%	4.1%	6.0%
Het	46.3%	1.8%	0.7%	1.0%



	Aware	Need	Ask	Receive
AfAm	63.2%	7.4%	6.5%	6.9%
Anglo	70.6%	8.4%	6.4%	5.0%
API	60.6%	2.6%	2.9%	2.9%
Latino	66.7%	4.9%	4.8%	3.4%
OC	47.5%	2.4%	0.0%	2.4%
Hmlss	53.0%	12.1%	7.6%	7.6%

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

Gender	Male	Female	TG
Knowledge Gap	31.6%	28.1%	28.2%
Unmet perceived need	1.2%	0.3%	0.0%
Need-Receive Gap	2.7%	-0.3%	2.2%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	36.8%	29.4%	33.3%
Unmet perceived need	-0.4%	1.5%	1.4%
Need-Receive Gap	0.4%	3.4%	1.5%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	47.5%	53.0%	60.4%
Need	2.4%	12.1%	12.6%
Ask	0.0%	7.6%	11.8%
Receive	2.4%	7.6%	11.8%
Knowledge Gap	52.5%	47.0%	39.6%
Unmet perceived need	-2.4%	0.0%	0.0%
Need-Receive Gap	0.0%	4.5%	0.8%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	63.0%	71.8%	64.4%
Need	6.5%	11.2%	7.2%
Ask	5.1%	9.8%	5.6%
Receive	4.4%	8.9%	5.6%
Knowledge Gap	37.0%	28.2%	35.6%
Unmet perceived need	0.7%	0.8%	0.0%
Need-Receive Gap	2.1%	2.3%	1.6%

Region	Total	San Mateo	Tenderloin
Aware	68.7%	69.4%	67.0%
Need	7.6%	5.6%	8.9%
Ask	6.1%	5.6%	7.4%
Receive	5.0%	8.3%	6.3%
Knowledge Gap	31.3%	30.6%	33.0%
Unmet perceived need	1.1%	-2.8%	1.1%
Need-Receive Gap	2.6%	-2.8%	2.6%

Summary

The unavailability of meaningful system-wide eligibility criteria for psychiatric consultation and evaluation services makes estimating eligibility gaps and gaps based on theoretical need impossible. Close to 70% of PLWH/A are aware of crisis intervention services. The knowledge gap is highest among those who are out-of-care (53%), heterosexuals (54%), and homeless PLWH/A (47%).

The data also show:

- Homeless PLWH/A (12%), recently incarcerated PLWH/A (13%), MSM/IDU (14%), and undocumented PLWH/A (13%) have expressed a higher need for crisis intervention services than other groups.
- The unmet perceived need for PLWH/A is just 1%, indicating effective delivery of services to those who request them. For San Mateo county residents, more crisis intervention services have been delivered than have been requested (-3%).
- The need-receive gap is fairly low for all groups, and in some instances, service has been provided to PLWH/A who have not expressed a need for it. These include IDUs (-2%), PLWH/A over 55 years (-4%), and San Mateo county residents (-3%).
- MSM/IDU (11%), PLWH/A over 55 years (11%), undocumented PLWH/A (9%), recently incarcerated (12%) and symptomatic PLWH (10%) are more likely to have asked for this compared to all PLWH/A (6%).

Peer Counseling, Support, or Drop-In Groups

Definition

Support groups for PLWH/A who are in need of support with issues secondary to recent developments in HIV-related treatment.

Service Unit, Eligibility, and Funding

Unit: Session

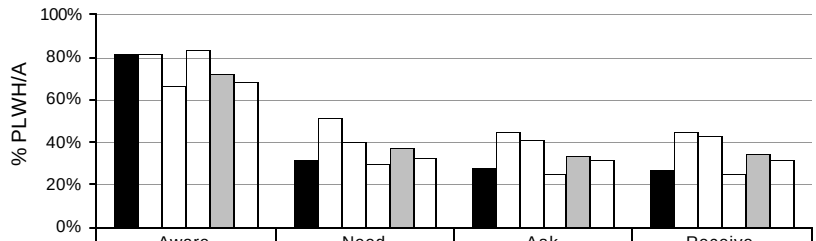
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

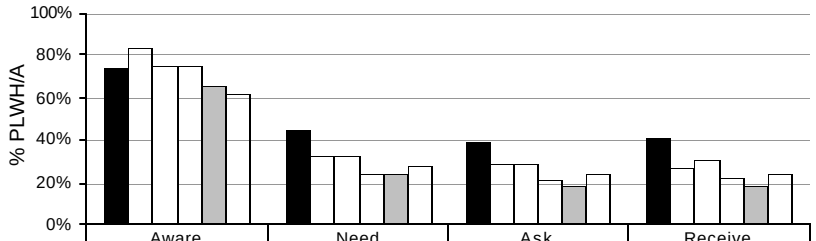
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	12
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	81.1%	31.9%	28.3%	27.5%
Female	81.7%	51.6%	45.3%	45.3%
TG	66.4%	40.8%	41.9%	43.0%
MSM	83.5%	29.8%	26.0%	25.2%
IDU	72.9%	37.3%	34.0%	34.3%
Het	68.0%	32.6%	32.3%	32.3%



	Aware	Need	Ask	Receive
AfAm	74.5%	44.3%	39.7%	41.5%
Anglo	83.7%	32.4%	28.8%	27.1%
API	74.7%	32.5%	28.8%	29.9%
Latino	74.9%	24.2%	21.6%	22.5%
OC	65.9%	23.8%	19.0%	19.0%
Hmlss	61.5%	27.3%	24.2%	24.2%

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

Gender	Male	Female	TG
Knowledge Gap	18.9%	18.3%	33.6%
Unmet perceived need	0.8%	0.0%	-1.1%
Need-Receive Gap	4.4%	6.3%	-2.2%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	25.5%	16.3%	25.1%
Unmet perceived need	-1.8%	1.7%	-1.0%
Need-Receive Gap	2.8%	5.3%	1.6%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	65.9%	61.5%	70.0%
Need	23.8%	27.3%	40.0%
Ask	19.0%	24.2%	36.9%
Receive	19.0%	24.2%	41.4%
Knowledge Gap	34.1%	38.5%	30.0%
Unmet perceived need	0.0%	0.0%	-4.5%
Need-Receive Gap	4.8%	3.0%	-1.4%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	75.5%	80.6%	76.3%
Need	32.6%	46.8%	35.6%
Ask	28.7%	43.7%	33.2%
Receive	30.1%	43.7%	33.9%
Knowledge Gap	24.5%	19.4%	23.7%
Unmet perceived need	-1.5%	0.0%	-0.7%
Need-Receive Gap	2.5%	3.1%	1.8%
Region	**Total**	**San Mateo**	**Tenderloin**
Aware	80.9%	77.1%	74.7%
Need	33.1%	41.7%	37.8%
Ask	29.5%	38.9%	37.0%
Receive	28.8%	41.7%	37.0%
Knowledge Gap	19.1%	22.9%	25.3%
Unmet perceived need	0.7%	-2.8%	0.0%
Need-Receive Gap	4.3%	0.0%	0.7%

Summary

The unavailability of meaningful system-wide eligibility criteria for psychiatric consultation and evaluation services makes estimating eligibility gaps and gaps based on theoretical need impossible. Although awareness of peer counseling service is relatively high at 81%, some groups are much less familiar with this service. Compared to an overall knowledge gap of 19%, several groups have a knowledge gap of over 30%. These include transgender persons, youth, homeless PLWH/A, and those out-of-care.

The data also show:

- The unmet perceive-need for peer counseling is extremely low across all groups, and in fact, some groups report receiving somewhat more service than has been requested. These include transgender persons, African Americans, Asian/Pacific Islanders, and Latinos all at –1%. Youth, at –5%, shows the largest difference between asking for and receiving services.
- The need for peer counseling services is highest among women (52%), transgender persons (41%), African Americans (44%), Native Americans (45%), MSM/IDU (49%), PLWH/A over 55 years (61%), undocumented PLWH/A (49%), and symptomatic PLWH (47%). Many of these groups are more likely to have asked for the service compared to other groups.
- The need-receive gap is low among all groups, indicating that the service is available for those who express a need.

Summary Mental Health

Most PLWH/A are aware of the various mental health services available to them. Peer counseling and psychiatric assessment services have higher needs than do crisis intervention or residential mental health counseling services.

- Slightly more PLWH/A indicate a need for psychiatric assessments than are being received.
- Of all mental health services available, only peer counseling service delivery exceeds actual demand among most PLWH/A.
- Need for mental health services is greatest among recently incarcerated PLWH/A, homeless PLWH/A, undocumented PLWH/A, women, transgender persons and both MSM and non-MSM IDUs.
- Among ethnic populations, Native Americans and African Americans express higher need for mental health services.

Mental Health : Qualitative Comments – Services

A recently incarcerated San Mateo African American male suggested homeless PLWH/A would need mental health services. He said, *"I want to point out that being infected with this disease you go through enough stress and depression without having additional stress and depression of being out there on the street, because if you're out there on the streets your emotions are going to feel worthless. That's what I felt when I was on the street. I felt worthless. I wasn't shit, and I might as well go on and do these drugs and if that doesn't kill me my liver situation and just laying up under this cardboard and all this kind of stuff. They should address this by facilitating some type of program to where people infected with HIV, Hep C or what not have an adequate chance to get a life."*

A San Mateo Latino male said, *"I need one-on-one because of my physical ailments and what not sometimes I get a little depressed. There are so many things that I want to do and I can't stand up for long periods of time. I can't keep my mind focused on something, because I'm in so much pain sometimes. So maybe I need somebody to talk to. Maybe that's wrong. I don't know."*

After a Latino MSM brought up his past history of letting his depression get the better of him, another focus group participant said, *"There are agencies that provide psychiatric help for depression and the psychiatrist can prescribe pills for depression. The important thing is not to close yourself up, but to speak with a professional."*

A transgender said, *"We don't have support groups for transgender. Not that I know of."* But the others participants in the group gave details of three different locations for peer counseling in San Francisco.

A Latino MSM told another participant the following, *"When one is under these types of conditions, one needs to attach to everything that is positive. Of course there will be times you will feel depression, anguish, and fear. But never let these feelings drag you down because if*

you're in a negative space your cell count will become lower. You have to keep focusing ahead. You're not the first one. You have a lifetime ahead of you, but you have to take care of yourself and maybe change your habits. For example you can sleep and eat well and avoid alcohol and drugs so that they don't cause any stress or depression. Try to distract yourself and work on your self esteem. There are groups that may be good for you. They have not worked for me, but they may for you."

Mental Health Consumer Reported Top Barriers

- Communication with provider
- Fear of being reported to
- Wait time for appointment
- State of mind

Mental Health Services – Qualitative Comments – Barriers

Providers

"This sub-segment of the programs is under funded and does not provide adequate resources necessary to meet needs of children on the waiting list."

"Very few clients who apply for CARE- funded HIV Mental Health services at [our agency] do not receive them. Summarized below are the factors that would prevent getting the service: (1) client changes mind and does not wish to receive services; (2) client relapses on substances and needs residential treatment; (3) client is more appropriate for primary outpatient substance abuse services, and is referred;. (4) client is not eligible for services because of income or insurance status; and (5) staff caseloads are at capacity."

"Substance abuse, marginal housing, and multiple medical problems seem to most impact client follow through. This program tries to identify particularly vulnerable cuts at intake and encourage increased retention efforts from providers and help/assistance from case managers in getting to and keeping appointments."

"People are calling from different counties outside of SF who want to access mental health service but there is a dearth or paucity of such services outside of SF that is HIV+ / API specific. We do have to turn them away or refer to the most feasible available services, often times this would not be HIV-targeted nor API sensitive. Because our mental health therapist is only paid .25 FTE under Care Title I funding, she can only accept limited number of clients. And therefore she can only provide services in English and Japanese. Clients who are limited English speakers or monolingual in other languages other than Japanese can't be served. In response to this, we are doing: 1) occasionally some interpretation during mental health therapy services is possible but it is not satisfying and often times there are clinical concerns because the staff who can provide interpretation are the case managers or peer advocates who are actively providing services to the client, this creates a conflict of roles for them. 2) We are trying to look into accessing language bank programs but it is based in another country. 3) We would like to be

able to have bilingual mental health therapy interns work in the program pro bono but we don't have the clinical supervision resources required to set it up."

"Residency is a barrier. Clients are referred to their county of origin by providing referrals and contacts. No other barriers that prevent our agency from delivering therapy and psychiatric services."

"We find it is difficult for clients to keep appointments in several different locations on one day which is why we go to the other locations to provide therapy services."

"The most common reasons people who apply for services do not receive them is 1) not being a San Francisco resident, 2) not HIV positive, and 3) they must be 18+ years old."

"Barriers include the client relocated to an other sector of bay area or out of state and they received a multiple diagnosis, substance abuse being a primary concern. The consumer not following through with our program to offer collaborative services is a problem."

"Any clients requesting these services receive them. The only barriers are funding cuts which result in reduced hours available for client services. We are looking for non-government funding to provide access to services."

"Significant substance abuse/dependence issues as well as health issues can interfere with clients receiving services. Additionally, the demand for services exceeds our capacity so clients have to sometimes be on a wait list for services. Increased staffing would serve to eliminate the wait which some clients have difficulty tolerating."

"The primary barriers to providing psychiatric treatment to this multiple diagnosed population are, in order, 1) the high salary expectation of psychiatrists and psychiatric nurse practitioners, and 2) the high cost of mental health pharmaceuticals which we prefer to purchase and dispense ourselves on-site during and concurrently with the treatment services."

"Insufficient number of funded treatment slots for uninsured/underinsured clients."

"Clients do not want to commit to a long term program. We build trust and rapport to support clients in committing to a long term program."

Substance Use

Outpatient Substance Abuse Treatment or Counseling

Definition

Provision of individual and/or group treatment and counseling to address substance use issues (including alcohol, legal and illegal drugs) as well as service coordination, provided in an outpatient health service setting.

Service Unit, Eligibility, and Funding

Unit: Hours

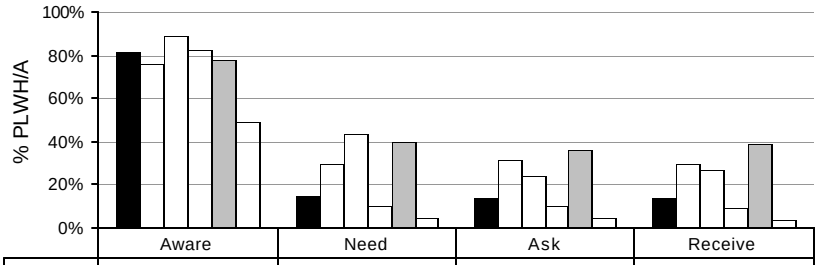
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	1,389
In Service – self rpt	NA
Estimated # Eligible	NA

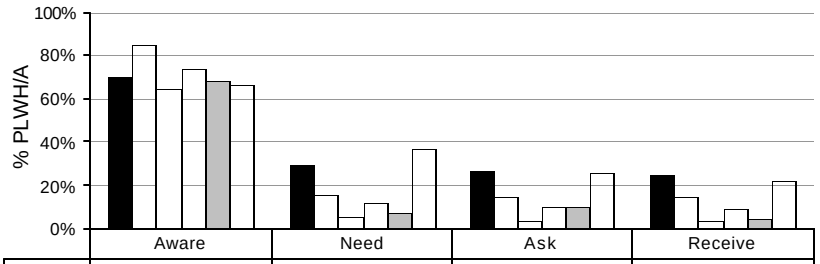
SERVICE UNITS 2001	
# of duplicated clients	14,794
Average # Units Received - REGGIE	10
Median# of Units Received – self rpt	4
Total # Units Received - REGGIE	14,134
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	81.0%	15.5%	14.2%	14.1%
Female	74.8%	29.4%	31.0%	29.3%
TG	88.2%	43.1%	24.2%	26.4%
MSM	82.2%	9.7%	9.3%	9.1%
IDU	76.7%	39.5%	36.2%	38.8%
Het	48.3%	4.5%	4.7%	3.5%



	Aware	Need	Ask	Receive
AfAm	70.4%	29.3%	27.0%	25.2%
Anglo	85.1%	15.6%	14.4%	14.7%
API	64.2%	5.5%	3.2%	3.2%
Latino	73.9%	11.6%	9.5%	9.2%
OC	69.0%	7.1%	9.5%	4.8%
Hmlss	66.2%	36.4%	25.8%	22.7%

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

Gender	Male	Female	TG
Knowledge Gap	25.2%	25.2%	11.8%
Unmet perceived need	0.1%	1.7%	-2.1%
Need-Receive Gap	1.4%	0.1%	16.7%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	29.6%	14.9%	26.1%
Unmet perceived need	1.8%	-0.3%	0.3%
Need-Receive Gap	4.2%	0.9%	2.4%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	69.0%	66.2%	74.5%
Need	7.1%	36.4%	40.0%
Ask	9.5%	25.8%	37.6%
Receive	4.8%	22.7%	35.5%
Knowledge Gap	31.0%	33.8%	25.5%
Unmet perceived need	4.8%	3.0%	2.2%
Need-Receive Gap	2.4%	13.6%	4.5%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	71.2%	81.7%	78.4%
Need	20.3%	31.7%	22.2%
Ask	16.8%	27.6%	19.6%
Receive	16.2%	26.6%	18.6%
Knowledge Gap	28.8%	18.3%	21.6%
Unmet perceived need	0.6%	1.0%	1.0%
Need-Receive Gap	4.1%	5.1%	3.6%

Region	Total	San Mateo	Tenderloin
Aware	80.8%	69.4%	77.6%
Need	16.7%	27.8%	22.5%
Ask	15.3%	27.8%	21.5%
Receive	15.2%	28.6%	18.8%
Knowledge Gap	19.2%	30.6%	22.4%
Unmet perceived need	0.2%	-0.8%	2.6%
Need-Receive Gap	1.6%	-0.8%	3.7%

Summary

REGGIE reports over 1,300 PLWH/A receiving more than 14,000 hours of substance abuse treatment services. REGGIE reports that on average PLWH/A receive about 10 hours of outpatient substance abuse treatment annually compared to an average of four hours of service reported by consumers. However, there is no meaningful system-wide eligibility criteria established for substance abuse treatment, such as those with a history of substance use. Consequently theoretical need, eligibility, and absolute service gaps cannot be calculated.

Just over 80% of PLWH/A are aware of outpatient substance abuse counseling services. Only heterosexuals at 48% and youth at 57% have awareness levels that are strikingly lower than the overall sample. Compared to an overall need of 17%, need for this service is greatest among transgender persons (43%), MSM/IDU (42%), IDUs (40%), recently incarcerated (40%), and homeless PLWH/A (36%).

The data also show:

- Native Americans at 4% and PLWH/A out-of-care at 5% have the highest unmet perceived need. Transgender persons (-2%) and IDUs (-3%) have received more service than was requested. This may be due to eligibility requirements that require active substance users to enter treatment in order to receive some HIV services. In general, however, the low level of unmet perceived need for most populations indicates that those seeking outpatient substance abuse services are receiving them.
- The high need-receive gap found among transgender persons (17%) and homeless PLWH/A (14%) suggests that although they recognize a need for the service, these groups are not asking for it at the same level. As a result, less service is being delivered than is needed. However, as can be seen in the low unmet perceived need figures for these same groups, those who do ask for the service are getting it.

Residential Substance Abuse Treatment or Counseling

Definition

Provision of treatment and/or counseling to address substance use issues provided in a residential health service setting. Includes housing, food, substance use counseling, and may include HIV and mental health counseling, supervision of compliance to prescribed medications, case specific nutritional planning, health and fitness training, transportation services, alternative healing techniques, psychiatric evaluations and treatment services, adult educational classes, case management of primary medical care, and/or other support services.

Service Unit, Eligibility, and Funding

Unit: Bed Days

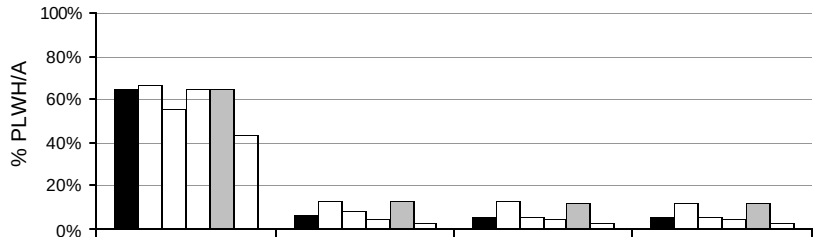
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	324
In Service – self rpt	NA
Estimated # Eligible	NA

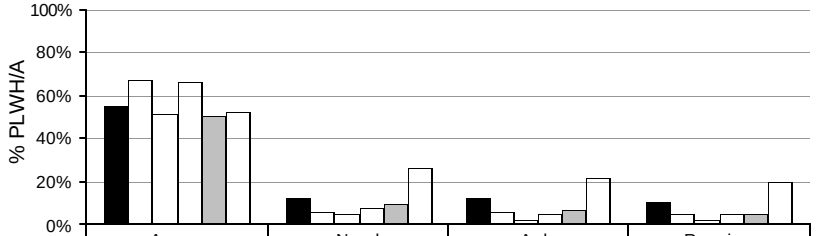
SERVICE UNITS 2001	
# of duplicated clients	1,571
Average # Units Received - REGGIE	61
Median# of Units Received – self rpt	86
Total # Units Received - REGGIE	19,771
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	64.9%	6.8%	6.5%	5.9%
Female	66.1%	13.0%	13.1%	12.6%
TG	55.8%	8.6%	6.4%	6.4%
MSM	65.0%	4.4%	4.3%	4.3%
IDU	64.3%	13.3%	12.6%	12.6%
Het	42.9%	2.7%	2.7%	2.7%



	Aware	Need	Ask	Receive
AfAm	55.3%	12.3%	12.9%	10.8%
Anglo	67.3%	5.9%	6.1%	5.6%
API	50.9%	5.6%	1.7%	1.7%
Latino	65.7%	8.3%	5.0%	5.7%
OC	50.0%	9.5%	7.3%	4.8%
Hmlss	53.0%	25.8%	21.5%	20.0%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	35.1%	33.9%	44.2%
Unmet perceived need	0.6%	0.5%	0.0%
Need-Receive Gap	1.0%	0.4%	2.1%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	44.7%	32.7%	34.3%
Unmet perceived need	2.1%	0.6%	-0.7%
Need-Receive Gap	1.5%	0.3%	2.6%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	50.0%	53.0%	61.3%
Need	9.5%	25.8%	26.1%
Ask	7.3%	21.5%	23.6%
Receive	4.8%	20.0%	22.7%
Knowledge Gap	50.0%	47.0%	38.7%
Unmet perceived need	2.6%	1.5%	0.9%
Need-Receive Gap	4.8%	5.8%	3.4%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	61.2%	72.2%	63.8%
Need	8.6%	18.3%	11.8%
Ask	8.8%	16.1%	9.9%
Receive	7.4%	12.9%	8.9%
Knowledge Gap	38.8%	27.8%	36.2%
Unmet perceived need	1.4%	3.2%	1.0%
Need-Receive Gap	1.3%	5.4%	2.9%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	64.9%	61.1%	63.7%
Need	7.2%	5.6%	12.0%
Ask	6.9%	5.6%	11.6%
Receive	6.2%	5.7%	8.4%
Knowledge Gap	35.1%	38.9%	36.3%
Unmet perceived need	0.6%	-0.2%	3.2%
Need-Receive Gap	0.9%	-0.2%	3.6%

Summary

According to the REGGIE system about 320 people are accessing residential substance abuse counseling and with an average stay of about 61 days are using over 19,700 units of residential substance abuse services. Consumers report receiving on average close to three months of residential treatment. With the lack of a system-wide eligibility criteria specific to the needs of PLWH/A with a history of substance use the theoretical need, eligibility and absolute service gaps cannot be calculated.

Overall awareness of residential substance abuse counseling among PLWH/A is 65%. In spite of this high level of awareness, some groups are less familiar with this service. Knowledge gaps are highest among transgender persons (44%), African Americans (45%), Asian/Pacific Islanders (49%), heterosexuals (57%), PLWH/A over 55 years (50%), homeless PLWH/A (47%) and those out-of-care (50%).

The data also show:

- The need for residential substance abuse counseling is 7%. Several groups, however, have much higher levels of need. They include homeless PLWH/A and recently incarcerated PLWH/A (26%), undocumented PLWH/A (20%), Native Americans (19%), MSM/IDU (19%), and women and IDUs at 13% each.
- Overall, unmet perceived need is quite low for this service (<1%), indicating successful provision of service to those who request it. On the other hand, several groups do show a much higher unmet perceived need than all other groups. They include MSM/IDU and undocumented PLWH/A at just over 4% each and PLWH/A out-of-care at 3%.
- Compared to just under 1% for the overall sample, the need-receive gap is quite high among Native Americans (8%), MSM/IDU (6%), undocumented and homeless PLWH/A (6%), and those out-of-care (5%).

Detox and/or Methadone Maintenance

Definition

Detox may include both residential and outpatient. Services include housing, food, HIV and substance abuse counseling, alternative healing techniques, discharge planning and complete referral assistance for on-going health and social services. Methadone Maintenance includes individual and group counseling with attendant medication monitoring and services coordination activities.

Service Unit, Eligibility, and Funding

Unit: Bed Days for "Detox" and Hours for "Methadone Maintenance"

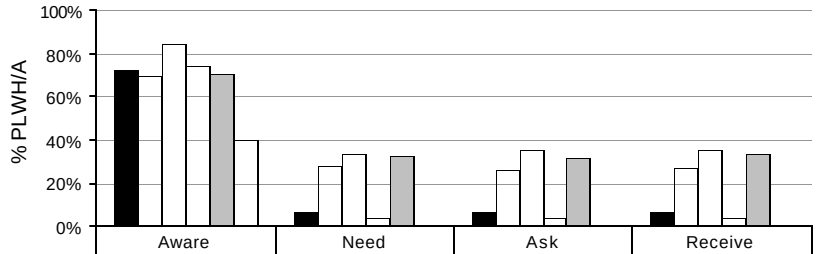
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

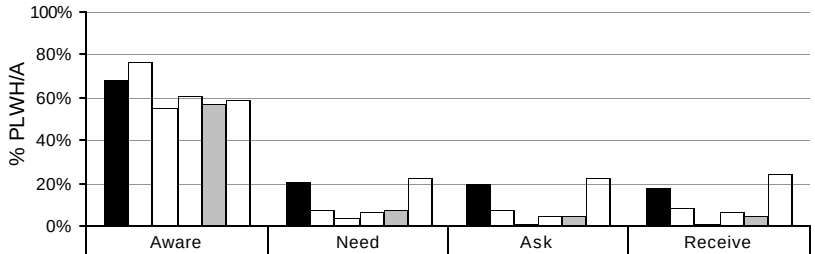
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	72.7%	7.5%	7.0%	7.4%
Female	70.0%	28.0%	26.6%	27.2%
TG	85.0%	33.5%	35.6%	35.6%
MSM	74.1%	4.4%	4.1%	4.2%
IDU	70.4%	32.4%	31.7%	33.3%
Het	39.8%	0.7%	0.7%	0.7%



	Aware	Need	Ask	Receive
AfAm	67.5%	20.4%	19.4%	18.1%
Anglo	77.0%	7.5%	7.5%	8.0%
API	55.3%	3.4%	0.9%	0.9%
Latino	60.9%	6.2%	4.1%	6.2%
OC	57.1%	7.1%	4.9%	4.8%
Hmlss	59.1%	22.7%	22.7%	24.2%

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

Gender	Male	Female	TG
Knowledge Gap	27.3%	30.0%	15.0%
Unmet perceived need	-0.4%	-0.6%	0.0%
Need-Receive Gap	0.1%	0.8%	-2.1%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	32.5%	23.0%	39.1%
Unmet perceived need	1.4%	-0.5%	-2.1%
Need-Receive Gap	2.4%	-0.5%	0.0%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	57.1%	59.1%	64.9%
Need	7.1%	22.7%	22.5%
Ask	4.9%	22.7%	22.7%
Receive	4.8%	24.2%	21.8%
Knowledge Gap	50.0%	47.0%	38.7%
Unmet perceived need	0.1%	-1.5%	0.9%
Need-Receive Gap	2.4%	-1.5%	0.7%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	64.7%	72.0%	71.3%
Need	9.4%	17.5%	16.3%
Ask	10.9%	16.1%	13.8%
Receive	9.5%	16.9%	14.7%
Knowledge Gap	38.8%	28.0%	28.7%
Unmet perceived need	1.5%	-0.8%	-0.9%
Need-Receive Gap	-0.1%	0.5%	1.6%
Region	**Total**	**San Mateo**	**Tenderloin**
Aware	72.8%	58.3%	69.8%
Need	9.1%	25.0%	14.6%
Ask	8.6%	25.0%	14.1%
Receive	9.0%	25.0%	13.6%
Knowledge Gap	27.2%	41.7%	30.2%
Unmet perceived need	-0.4%	0.0%	0.5%
Need-Receive Gap	0.1%	0.0%	1.0%

Summary

Detox and methadone maintenance service providers do not uniformly report to REGGIE the units provided or clients served, and without a meaningful system-wide eligibility criteria articulated for this service theoretical need, eligibility and absolute service gaps cannot be calculated.

There is generally a high level of awareness among PLWH/A about detox/methadone maintenance programs. In most cases, 50% or more of PLWH/A are aware of this service. Only heterosexuals at 39% have a very low level of awareness compared to other groups.

The data also show:

- Need for the overall sample is 9%. Several groups have expressed a much higher need for this service. They include women (28%), transgender persons (34%), African Americans (20%), MSM/IDU (19%), IDUs (32%), San Mateo residents (25%), recently incarcerated PLWH/A (23%), and homeless PLWH/A (23%).
- Unmet perceived need and the need-receive gap is low across all groups, averaging near 1%. In some instances, service provision exceeds demand and perceived need.

Summary Substance Abuse

The lack of system-wide meaningful and measurable eligibility criteria does not permit the measurement of eligibility or absolute service gaps. The perceived need for substance abuse treatment is close to 10% for most PLWH/A, though outpatient substance abuse has a higher need than other types of substance abuse services.

- Populations that expressed the greatest need for substance abuse services include MSM and non-MSM/IDU, homeless PLWH/A, recently incarcerated PLWH/A, and women.
- Among ethnic populations, Native Americans have the highest need for substance abuse services.
- Very few PLWH/A who ask for substance abuse services are unable to receive them, however some populations have expressed a need for services but have not asked for them resulting in a somewhat high need-receive gap.

Substance Abuse : Qualitative Comments – Services

A transgender said, *"There are plenty of substance abuse services. There's no problem getting that service. If somebody really wants to get the treatment they can. It's not impossible."*

An African American MSM currently in recovery said, *"None of the services in San Francisco are based upon substance free as a requirement to getting services. As long as I've been here in the city and been a substance user, none of the services that I go to have that criteria. They ask that you don't come there high or intoxicated. I don't think they can do that. I don't think they can dangle the services over your head and say, 'You have to be clean and sober.' They can't do that. I don't think they can do that."*

Some insight into why some use illegal drugs was given in the transgender focus group. When asked why they did drugs from one time to another, responses included:

- "I'm not going to lie. I'm a man. You know? I'm a man."
- "I was a sex worker and I needed drugs to keep me going. At first crystal meth was my drug of choice, but I couldn't find it when I got out here. It was easier to find crack."
- "I don't think I need it now, because I'm going to a psychiatrist and a therapist."
- "I worked in a bar for so many years and it was just right there and I just went from the bars to partying. It just went from there."
- "At one time it was a sexual thing for me and it kind of helped, or I felt it made my female hormones more active."

An African American female said, *"I came out here in 1999 and I've been out here ever since. My drug addictions picked up. I was using and prostituting. I was shooting dope. I was shooting crack cocaine for six to eight years. I found out in 1994 when I went to prison. Well I went to city jail when I found out I was HIV positive. So when I found out I was HIV positive I went in denial and kept using. When I was released, I quit shooting dope and started smoking*

crack cocaine for like four years. I went a year without doing anything and then I went into the program. Then I went to [a residential substance abuse program] where I started my clean and sober. I stayed clean and sober for a year and a half. And I've been clean and sober now for almost 5 years. My life has been pretty good. I'm back with my daughter. I have contact with my daughter and my grandkids, something that I had lost in my addiction. I've got housing now and have my own place."

A homeless male said, *"I've been on the streets for a while. I'm now in a co-op which is a drug and alcohol rehab organization in San Francisco. I did the 90 day primary program, which is basically stabilization and learning various things and getting yourself started with meetings and groups. And then you go into a co-op which is for six guys. Like in the house I'm at we each have our own room and the rent is only like $130 a month so you can't beat that."*

A recently incarcerated San Mateo African American male said, *"I went in and I detoxed for 21 days before I even started any medication period because I didn't want to play myself by saying, 'Oh yeah I need medication' and then I'm still over here drinking and shit while taking medication and just throwing my life away that way. So I just went into the program for 21 days. After I did the 21 days my SSI came through. A week later my housing came through."*

Substance Abuse Consumer Reported Top Barriers

- Criminal justice matter
- No transportation
- Do not get along with provider
- Not eligible
- Service not available/discontinued

Substance Abuse : Qualitative Comments – Barriers

Consumers

A homeless male discussed his experience in staying at a residential substance abuse service agency. He said, *"I had the great thing of sleeping in the chair at [the ASO]. I slept in a chair just like this and I had the worst back ache the next day. They wake you up early in the morning and you're walking like this. My legs were sore and everybody else was sleeping and having a good time on a cot and I'm up there in a chair, and it's unfair. It's really unfair."*

A homeless male said, *"I think a lot more should be available for HIV people who have a drug and alcohol problem and want to get help. There's only one shelter right now to house, because a lot of these programs have a long waiting list, and there's only one shelter to house these folks if they do get on the list and get into a primary program. There's only one shelter that will house them so they can get in. It's really not that good of a place, not the quality of the building or anything like that, but the staff. The staff are very confrontational, very humiliating. They just totally treat you like shit. I was at one for a couple of days and I went back out on the street. I went camping underneath one of those off ramps for probably a week and a half. I told them,*

'You have to excuse me. I look like shit, and I'm filthy dirty, but I've been on the street,' and I told them about the quality of the service of this place."

Providers

"The most common reason clients who apply for services and do not receive them is because the clients leave before they are admitted to [residential center]. They were not ready for treatment as evidenced by seeing them on the streets or they come back at a later time to re-access services. The case managers, as much as possible, attempt to intake clients upon entering into the program to begin building a relationship and building trust. Having immediate contact with the clients and building rapport seems to help the clients to stabilize so if they do leave, they are more apt to return. With our other facility, the center may be full when a client is seeking services. The client may stay at [our other facility] until there is room in the program for them."

"Client changes mind and does not want services. Active substance abuse interferes with clients' ability to follow through with services. Client is assessed as needing detox or residential treatment prior to outpatient. Unstable housing interferes with clients' ability to follow through with services."

"Insufficient number of funded treatment slots for uninsured/underinsured clients."

"The most common reasons people who apply for residential detox treatment services do not receive them are: 1) lack of follow through on initial interview appointment or 2) [the potential client has] mental health issues which are incompatible with residential detox setting. To overcome these barriers we are integrating our mental health providers into our residential detox methodologies and we are working more strongly with referral sources, such as the DPH Treatment Access Program, to ensure initial appointments are followed up on."

"The main barrier to [our] program is lack of available bed days. Programs only have a set number of beds."

Client Advocacy

Benefits Counseling

Definition

Assessment of individual need, provision of advice and assistance in obtaining medical and financial benefits, and representation in appeal and court actions to obtain benefits.

Service Unit, Eligibility, and Funding

Unit: Hours

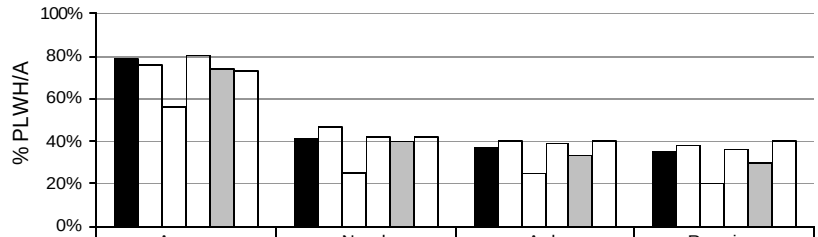
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	5,127
Estimated # Eligible	14,648

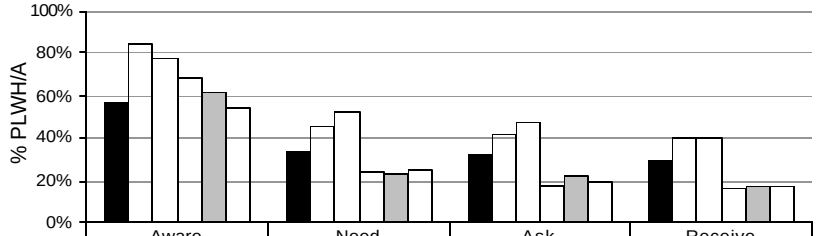
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	2
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	10,253
Theoretical need	29,595

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	65%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	65.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	78.9%	41.5%	37.5%	35.3%
Female	76.1%	47.3%	40.9%	38.3%
TG	56.9%	26.0%	24.7%	20.4%
MSM	80.2%	42.6%	38.7%	36.6%
IDU	74.7%	39.5%	33.3%	30.0%
Het	73.2%	42.6%	41.0%	40.4%



	Aware	Need	Ask	Receive
AfAm	57.0%	34.3%	32.1%	29.6%
Anglo	84.6%	45.8%	42.0%	39.8%
API	77.5%	52.6%	47.0%	40.2%
Latino	68.9%	24.3%	17.7%	16.0%
OC	61.9%	23.1%	22.0%	17.1%
Hmlss	54.5%	25.0%	20.0%	16.9%

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

Gender	Male	Female	TG
Knowledge Gap	21.1%	23.9%	43.1%
Unmet perceived need	2.2%	2.6%	4.3%
Need-Receive Gap	6.2%	8.9%	5.6%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	43.0%	15.4%	31.1%
Unmet perceived need	2.6%	2.1%	1.7%
Need-Receive Gap	4.8%	6.0%	8.3%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	61.9%	54.5%	60.4%
Need	23.1%	25.0%	32.1%
Ask	22.0%	20.0%	27.3%
Receive	17.1%	16.9%	23.6%
Knowledge Gap	38.1%	45.5%	39.6%
Unmet perceived need	4.9%	3.1%	3.6%
Need-Receive Gap	6.0%	8.1%	8.5%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	61.6%	69.8%	74.8%
Need	24.8%	41.9%	35.1%
Ask	21.6%	34.7%	28.9%
Receive	19.1%	31.7%	26.5%
Knowledge Gap	38.4%	30.2%	25.2%
Unmet perceived need	2.5%	3.0%	2.4%
Need-Receive Gap	5.7%	10.2%	8.6%

Region	Total	San Mateo	Tender-loin
Aware	78.3%	80.6%	70.5%
Need	41.5%	52.8%	33.0%
Ask	37.4%	51.4%	28.6%
Receive	35.2%	52.8%	25.9%
Knowledge Gap	21.7%	19.4%	29.5%
Unmet perceived need	2.3%	-1.3%	2.6%
Need-Receive Gap	6.4%	0.0%	7.1%

Summary

In the REGGIE system benefits counseling has multiple codes under "minor service category" under the "major service" of client advocacy and it is constantly reported by service providers. According to self-reports, PLWH/A receive about two hours of benefits counseling per year for a total of over 10,000 hours of service. With about 5,000 PLWH/A reporting receiving the service, there remains about a 65% eligibility gap and about 65% of the eligible PLWH/A are not receiving the service.

Awareness of client advocacy services varies widely across groups. Transgender persons, African Americans, youth, and homeless PLWH/A have the lowest awareness levels, while Anglos, MSM, and San Mateo county residents have the highest.

The data also show:

- The need for benefits counseling services ranges between 40% and 50% for most groups, with Asian/Pacific Islanders (53%) and San Mateo county residents (53%) expressing the highest need.
- Asian/Pacific Islanders (7%), transgender persons (4%), and PLWH/A out-of-care (5%) have the highest unmet perceived need compared to 2% for the overall sample.
- The need-receive gap is highest among Asian/Pacific Islanders (13%), Native Americans (12%), IDUs (10%), undocumented PLWH/A (11%), and symptomatic PLWH and PLWA (10%).

Money Management

Definition

Representative payee, where an agency is authorized to make payments on behalf of a client, and money management services (budget planning, establishing bank account, authorizing disbursements, and cutting checks).

Service Unit, Eligibility, and Funding

Unit: Hours

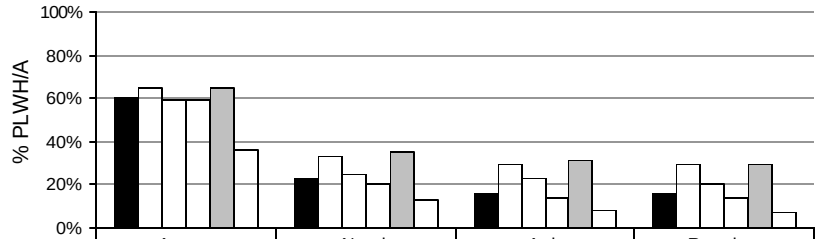
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,490
Estimated # Eligible	14,648

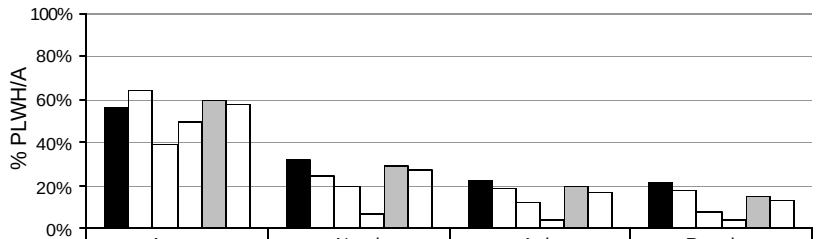
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	12,450
Theoretical need	73,238

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	83%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	83.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	60.4%	22.8%	16.3%	15.9%
Female	64.3%	32.8%	29.1%	29.6%
TG	59.0%	24.9%	22.8%	20.6%
MSM	59.0%	20.3%	14.1%	14.1%
IDU	64.6%	35.4%	30.5%	29.5%
Het	35.9%	12.9%	8.2%	7.4%



	Aware	Need	Ask	Receive
AfAm	56.7%	31.8%	22.1%	21.8%
Anglo	64.3%	24.6%	18.5%	18.2%
API	39.4%	19.4%	12.1%	8.1%
Latino	50.2%	7.4%	4.4%	4.7%
OC	60.0%	29.3%	19.5%	15.0%
Hmlss	58.5%	27.3%	16.7%	13.6%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	39.6%	35.7%	41.0%
Unmet perceived need	0.4%	-0.4%	2.2%
Need-Receive Gap	6.9%	3.3%	4.3%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	43.3%	35.7%	49.8%
Unmet perceived need	0.3%	0.4%	-0.3%
Need-Receive Gap	10.0%	3.3%	4.3%
Special Pops	**Out-of-care**	**Homeless**	**Rec Inc**
Aware	60.0%	58.5%	63.3%
Need	29.3%	27.3%	38.5%
Ask	19.5%	16.7%	32.4%
Receive	15.0%	13.6%	29.6%
Knowledge Gap	40.0%	41.5%	36.7%
Unmet perceived need	4.5%	3.0%	2.8%
Need-Receive Gap	14.3%	13.6%	8.9%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	51.1%	68.8%	67.8%
Need	19.9%	36.0%	27.3%
Ask	14.9%	27.3%	22.1%
Receive	14.9%	25.8%	20.4%
Knowledge Gap	48.9%	31.2%	32.2%
Unmet perceived need	0.0%	1.4%	1.7%
Need-Receive Gap	4.9%	10.2%	6.9%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	60.6%	50.0%	75.0%
Need	23.4%	20.0%	36.8%
Ask	17.1%	17.1%	30.3%
Receive	16.8%	17.1%	29.0%
Knowledge Gap	39.4%	50.0%	25.0%
Unmet perceived need	0.4%	0.0%	1.2%
Need-Receive Gap	6.6%	2.9%	7.8%

Summary

REGGIE service providers do not systematically report hours spent providing money management services. Assuming that all PLWH/A with low incomes are eligible for money management services, self-report data indicates that there is an 83% eligibility gap and with an average of five hours of service per year, and there remains 83% of the PLWH/A who are not receiving this service.

PLWH/A who live in the Tenderloin neighborhood have the highest level of awareness of money management services at 75%, while heterosexuals have the lowest level of awareness at 36%. Generally, 50% or more of most groups are aware of this service.

The data also show:

- Nearly one-quarter of PLWH/A have expressed a need for money management services. The need is highest among women (33%), African Americans (32%), Native Americans (31%), MSM/IDU (34%), IDUs (35%), PLWH/A over 55 years (31%), Tenderloin residents (37%), PLWH/A recently incarcerated (39%), symptomatic PLWH (36%), and symptomatic PLWA (31%).
- PLWH/A who have requested money management services have been fairly successful in receiving them, with less than a 1% unmet perceived need gap for the overall sample. Those with a higher unmet perceived need include Asian/Pacific Islanders (4%) and PLWH/A out-of-care (5%).

Legal Services

Definition

Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under CARE, disposition planning for dependent children (adoption and foster care) as well as consultation, referral, and representation on immigration issues.

Service Unit, Eligibility, and Funding

Unit: Hours

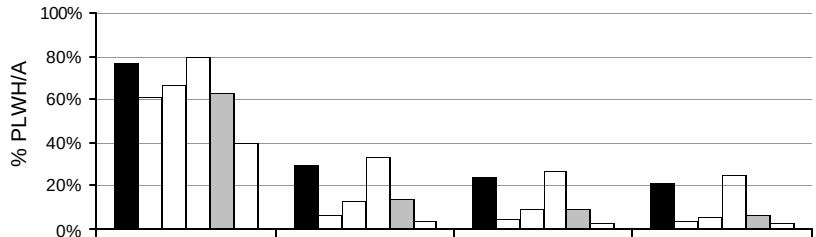
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,930
Estimated # Eligible	14,648

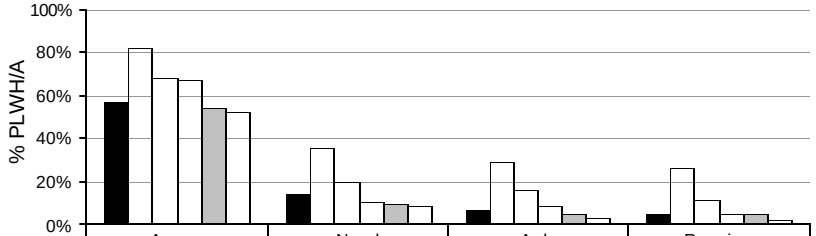
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	1
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	2,930
Theoretical need	14,648

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	80%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	80.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	76.9%	30.4%	23.9%	21.0%
Female	61.2%	7.4%	4.6%	3.7%
TG	66.1%	12.9%	9.7%	6.4%
MSM	79.4%	33.4%	26.7%	24.4%
IDU	62.5%	14.1%	9.9%	7.2%
Het	39.8%	3.8%	2.3%	2.3%



	Aware	Need	Ask	Receive
AfAm	57.3%	14.4%	7.4%	4.5%
Anglo	81.8%	35.7%	28.6%	26.0%
API	67.8%	19.4%	15.9%	11.7%
Latino	66.9%	10.3%	9.1%	5.7%
OC	54.8%	9.5%	4.8%	4.8%
Hmlss	53.0%	9.1%	3.0%	1.5%

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

Gender	Male	Female	TG
Knowledge Gap	23.1%	38.8%	33.9%
Unmet perceived need	2.9%	0.9%	3.2%
Need-Receive Gap	9.3%	3.8%	6.4%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	42.7%	18.2%	33.1%
Unmet perceived need	2.9%	2.6%	3.5%
Need-Receive Gap	9.9%	9.7%	4.6%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	54.8%	53.0%	58.6%
Need	9.5%	9.1%	17.1%
Ask	4.8%	3.0%	10.8%
Receive	4.8%	1.5%	9.0%
Knowledge Gap	45.2%	47.0%	41.4%
Unmet perceived need	0.0%	1.5%	1.8%
Need-Receive Gap	4.8%	7.6%	8.1%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	60.1%	68.0%	73.1%
Need	13.0%	19.2%	20.7%
Ask	7.4%	8.9%	16.8%
Receive	5.9%	5.7%	11.9%
Knowledge Gap	39.9%	32.0%	26.9%
Unmet perceived need	1.5%	3.3%	5.0%
Need-Receive Gap	7.2%	13.5%	8.8%

Region	Total	San Mateo	Tenderloin
Aware	75.8%	58.3%	69.9%
Need	28.8%	11.1%	21.4%
Ask	22.6%	11.1%	15.3%
Receive	19.8%	8.3%	11.6%
Knowledge Gap	24.2%	41.7%	30.1%
Unmet perceived need	2.8%	2.8%	3.6%
Need-Receive Gap	9.0%	2.8%	9.7%

Summary

Within the REGGIE system, service providers do not systematically report hours spent providing legal services and therefore it is difficult to quantify units of service and clients served. However, through self-reports. It is calculated that about 3,000 PLWH/A receive on average one hour of legal services per year. With over 14,600 hours of legal services needed to address the needs of PLWH/A, about 80% of clients remain unserved.

Awareness of legal services is at or above 50% for all groups. It is highest among Anglos (82%) and lowest among heterosexuals (40%).

The data also show:

- The most requests for legal services have been made by males (24%), Anglos (29%), MSM (27%), and symptomatic PLWA (20%). These groups have also expressed a higher need for legal services than others.
- Approximately 3% of PLWH/A who have asked for legal services have not received them. The unmet perceived need gap is highest among Asian/Pacific Islanders (4%), MSM/IDU (6%), youth and PLWH/A over 55 years (4%), undocumented PLWH/A (4%), and PLWA (5%).
- Native Americans, MSM/IDU and undocumented PLWH/A have the highest need-receive gap of between 12% and 13%, compared to 9% for all PLWH/A.

Consumer Advocate

Definition

Gathering information about clients and their complaints, mediation to resolve complaints, assisting clients to file grievances, and providing grievance procedure and other information to clients.

Service Unit, Eligibility, and Funding

Unit: Hours

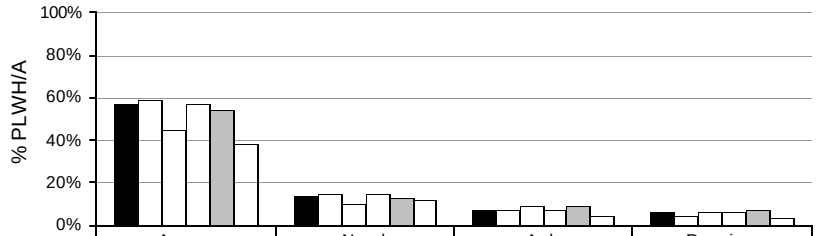
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	1,025
Estimated # Eligible	14,648

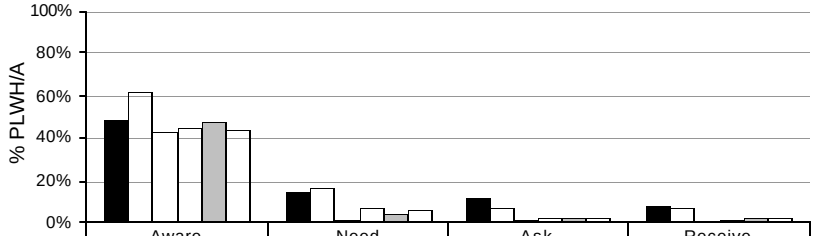
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	4
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	4,101
Theoretical need	58,590

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	93%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	93.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	57.4%	14.3%	7.1%	6.6%
Female	59.5%	15.3%	7.3%	4.8%
TG	45.1%	10.7%	8.6%	6.4%
MSM	57.5%	14.8%	6.7%	6.6%
IDU	54.1%	13.7%	9.7%	6.8%
Het	38.2%	12.8%	4.5%	3.8%



	Aware	Need	Ask	Receive
AfAm	49.5%	14.3%	11.4%	8.0%
Anglo	62.0%	16.3%	7.4%	7.3%
API	43.0%	2.2%	0.6%	0.0%
Latino	44.5%	6.8%	2.4%	1.9%
OC	47.6%	4.8%	2.4%	2.4%
Hmlss	43.9%	6.1%	3.0%	3.0%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	42.6%	40.5%	54.9%
Unmet perceived need	0.5%	2.5%	2.1%
Need-Receive Gap	7.7%	10.5%	4.3%
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	50.5%	38.0%	55.5%
Unmet perceived need	3.4%	0.1%	0.4%
Need-Receive Gap	6.3%	9.0%	4.9%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	47.6%	43.9%	46.8%
Need	4.8%	6.1%	11.7%
Ask	2.4%	3.0%	9.1%
Receive	2.4%	3.0%	9.1%
Knowledge Gap	52.4%	56.1%	53.2%
Unmet perceived need	0.0%	0.0%	0.0%
Need-Receive Gap	2.4%	3.0%	2.6%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	48.2%	56.3%	56.2%
Need	5.8%	12.7%	13.2%
Ask	4.4%	8.1%	8.2%
Receive	2.2%	5.8%	6.6%
Knowledge Gap	51.8%	43.7%	43.8%
Unmet perceived need	2.2%	2.3%	1.6%
Need-Receive Gap	3.5%	6.9%	6.6%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	57.3%	55.6%	56.5%
Need	14.3%	16.7%	14.5%
Ask	7.1%	11.1%	7.3%
Receive	6.5%	13.9%	6.8%
Knowledge Gap	42.7%	44.4%	43.5%
Unmet perceived need	0.6%	-2.8%	0.5%
Need-Receive Gap	7.8%	2.8%	7.7%

Summary

Consumer advocate services are not a category captured in the REGGIE system. According to self-report data, about 1,000 PLWH/A receive, on average, four hours of this service per year. With a theoretical need of over 58,000 hours of service, 93% of consumers are not being served by consumer advocate services.

The knowledge gap for consumer advocate services is above 50% for nearly all groups, indicating a somewhat low level of awareness of this service compared to other services offered in the San Francisco EMA.

The data also show:

- Need for consumer advocate services is highest among women (15%), Anglos (16%), MSM (15%), PLWH/A over 55 years (18%), symptomatic PLWA (15%), and San Mateo county residents (17%).
- Unmet perceived need is generally low for all groups. African Americans (3%) and PLWH/A over 55 years (4%) have the highest unmet perceived need compared to 2% or lower for most other groups. The data indicate that San Mateo county residents have received more consumer advocacy services than have been requested (-3%).
- Consumer advocacy services have been received most often by African Americans (8%), Anglos (7%), PLWH/A over 55 years (7%), San Mateo county residents (14%), PLWH/A recently incarcerated (9%), and symptomatic PLWA (7%).
- The need-receive gap is highest among women (11%), Native Americans (12%) and PLWH/A over 55 years (11%).

Summary Client Advocacy

Benefits counseling is used by more PLWH/A than other services in this category, including money management, legal services, or consumer advocate services. The need for benefits counseling services is higher than for other services in this category, as well, with consumer advocate services having the lowest need.

- In almost every service in this category, the greatest need is among people of color. Their need-receive gap and unmet perceived need gap is also generally higher than that of other populations.
- Undocumented PLWH/A have a high need-receive gap for both benefits counseling services and legal services.
- Use of consumer advocate services is below 10% for all populations except San Mateo county residents, recently incarcerated PLWH/A, and PLWH/A over 55 years.

Client Advocacy : Qualitative Comments – Services

A San Mateo Latino male the agency that provides money management services *"has to be updated. They are using too much funding for something else. Every time we go to MHA we have to provide so much information."* An African American male responded by saying, *"That's good, because then the money will go for the real thing. Don't you understand that? Instead of going there and getting money and spending it on nothing. I hope they keep on with receipts. I like that. I like they have to cover for every dime. I've been sitting in there when people come in there bullshitting and try to get money. I hope they make people give receipts. Every time they get something I hope they get a receipt so the won't give any more free money to somebody that doesn't need it."*

A San Mateo Anglo IDU female said brought up her problem with her "payee" or money manager. She said, *"I had a payee. I'm my own payee now. I'm just more inspired finally, but they say they only have one payee at [the agency] for people who are HIV positive so you can't change if you are not happy. The person that they have there is ridiculous. Right now I'm my private person. It's having somebody that you trust. That's the problem. I don't really have anybody around here that I trust that would be able to be my payee, because if you've got a felony or anything like that you can't do it."* An African American male followed by saying, *"You can't manage your own money if you are on drugs or what not. They're not going to send it to you. You're going to have to have a payee. When they put you on there they pretty much know you need a payee. Like if I interviewed you for SSI you are going to have a really tough interview. I know if you are an addict or what not I'll tell you at the end of the interview, 'Well you're going to have to find a payee. We can't send it to you, because you aren't responsible. You won't pay your rent. You won't do anything but go use it for dope.' So that person pays your rent. He gives you so much a week."*

Client Advocacy Consumer Reported Top Barriers

- Communication with provider

Client Advocacy – Qualitative Comments – Barriers

Consumers

A homeless male said he doesn't know where to go for, *"Legal services because I had to call [one ASO] a couple of times to get a power of attorney and I can't find it. I called [another ASO] and they said they couldn't help me."*

Providers

"The only requirement for entry into [our home healthcare services] is that the client be between the ages of 18-25. This would be the only barrier for clients accessing and receiving services. When a client attempts to access services who is over the age of 25, he or she is referred to the appropriate adult provider. A client under the age of 18 will access our underage programs. The underage services will work in conjunction to develop an appropriate treatment plan and placement. Clients may have individual barriers such as substance abuse and mental health issues. Case managers work with clients to create individual service plans to address both of these issues. An on-site substance abuse counselor can provide counseling, referrals, and consultations. An on-site psychiatrist is also available for evaluation and medication management. We have implemented an agency-wide comprehensive substance abuse and mental health initiative for clients who need additional assistance."

"Some clients prefer appointments and find the wait time (max. 2 weeks) to be untenable."

"The most common reason that people who apply for services do not receive them is that they do not show for their intake appointment, or do not follow-through with a referral appointment or with the provider to whom they are referred for other services. The most common reasons for this include:

1) *Most of those accessing HIV services at [our agency] do not have a place to live, making it difficult for them to organize their daily lives sufficiently to allow them to access services in an organized fashion. To address this barrier, we offer services on a drop-in basis, and bring services to clients via the mobile team.*
2) *Many of those accessing HIV services at [our agency] are struggling with mental health and/or substance use/abuse problems. These problems also interfere with their ability to organize themselves to access services, and we address these barriers through a program design that operates under harm reduction principles and practices. Our agency embraces harm reduction fully, and those who are actively using are welcomed to access services here. Since substance abuse and mental illness are often concurrent in this population, these principles are also used with those suffering from mental illness. Practical support needed to successfully access services is also available to those for whom it is indicated. This often takes the form of physically escorting the client to an appointment, or providing transportation.*

3) *Many of those we serve have developed mistrust of traditional systems of care, and we address this barrier to their accessing services by providing services in a way, and in a setting that is more comfortable and accessible to them. Our long-standing store-front location helps to make this possible. Many are aware of and recognize our presence for what it is - a safe place to come to talk about and get help with HIV and AIDS. The co-location of our HIV Prevention Program helps to remove the stigma often associated with neighborhood AIDS service organizations, since this program is open to all neighborhood denizens, regardless of HIV status."*

"No funding / not enough funding for street case management and funding for additional advocacy for housing and advocacy for ancillary systems for HIV+ prisoners, particularly for transgender and monolingual Spanish speakers."

"[Our facility] is considerably short staffed when it comes to client advocacy. There is 1.0 FTE client advocate for 1800 patients."

"Clients not meeting minimum criteria for placement with volunteers are not referred. To qualify clients must: 1) reside primarily in San Francisco, 2) must be HIV+, 3) meet income guidelines, 4) and have an immigration problem that our volunteers are trained to handle. Other barriers to providing our services: 1) client moves or we lose contract and client does not update us with new information. Many immigrants do not have permanent housing and sometimes we lose contact before client is placed with an attorney. 2) Client is in deportation proceedings, in jail or other detainment / legal proceedings. Volunteers are not trained to step in, and it is too late to provide advocacy. Ineligible clients are given referrals to immigration service agencies and lawyer referrals service/bar association in client's area. Referrals are also provided to social service and HIV+ support agencies if clients are not connected to a support group."

"We have a relatively small program and have rarely if ever turned an intake away. We have the ability to do the intakes that are asked of us if the client can return for a scheduled intake (usually within 2-3 days). Clients often face barriers regarding access to services, particularly housing, that does not necessarily have anything to do with [our organization], but rather San Francisco in general."

"All clients requesting services receive them. Barriers to providing services are lack of resources and lack of staff to do increased outreach. Our client advocates consistently provide more services than our contracts require and [our organization] has been absorbing those costs. Constant reductions in funding will compromise our ability to continue providing services at these non-funded levels."

"Anyone applying for services receive them. Challenges are limited hours and staff to provide a more quality based service. Often staff other than client advocates must assist in meeting the demand."

"The most common reasons people who apply for services do not receive them is 1) not being a San Francisco resident, 2) not HIV positive, and 3) they must be 18+ years old."

"[We have a need for] additional funding to increase staff. [Our] Benefits Counseling program provides comprehensive benefits counseling services which are in high demand. Additionally, CARE funding does covers less than 50% of the Benefits Counseling program budget. Due to the funding limitations increasing our staff is prevented and thus we cannot meet the need for our services. We often must close down to taking new clients if there is more than a 50-day wait. Benefits counseling issues have become more complex and more time consuming as PWLH/A continue to live longer. Our agency is continually seeking additional funding sources both in unrestricted funds from individual donations and more targeted funds through foundation support and contracts w/ government agencies in all levels of the government."

"We provide services primarily by referring clients to a panel of attorneys. We are sometimes limited in our ability to serve clients because we do not always have enough attorneys in a specific area of law. We especially do not have enough attorneys to take insurance cases. I must note here that housing is huge issue for our clients. The large increase in the demand for housing advocacy is now about one-third of our case load. I do not know what you have heard from clients but these numbers speak volumes about the need for this service."

Case Management

Definition

A service that links and coordinates assistance from multiple agencies and caregivers who provide psycho-social, medical, and practical support. The purpose is to enable clients to obtain the highest level of independence and quality of life consistent wit their functional capacity and preferences for care. It is comprised of seven core activities: initial interview and intake; comprehensive assessment; individual care planning; implementation of the care plan, follow-up and monitoring; reassessment, and transfer and discharge.

Service Unit, Eligibility, and Funding

Unit: Hours

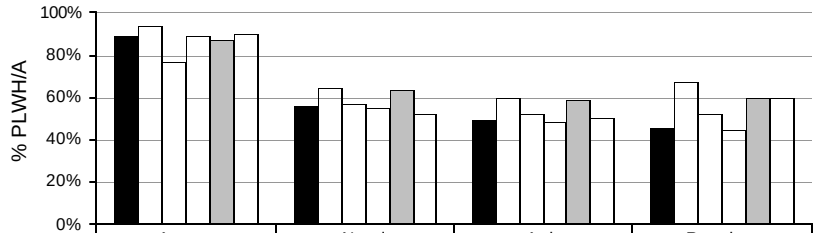
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	3,392
In Service – self rpt	6,884
Estimated # Eligible	14,648

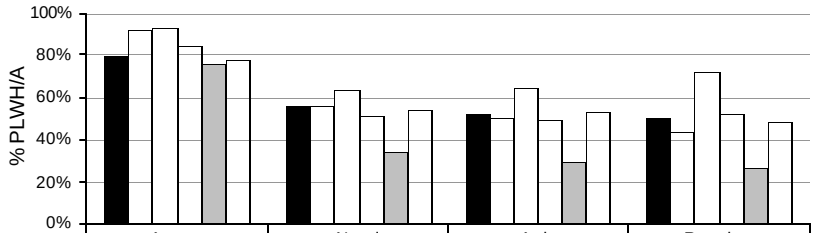
SERVICE UNITS 2001	
# of duplicated clients	46,628
Average # Units Received - REGGIE	12
Median# of Units Received – self rpt	4
Total # Units Received - REGGIE	41,385
Total # of Units Received – self rpt	27,537
Theoretical need	58,590

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	76.8%	Reported minus Theoretical Need – REGGIE	29.4%	
		Reported minus Theoretical Need: - self rpt	53.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	89.1%	55.6%	49.8%	45.5%
Female	94.2%	65.0%	60.2%	67.4%
TG	76.8%	56.4%	52.1%	52.1%
MSM	89.4%	55.1%	48.7%	44.0%
IDU	86.9%	64.1%	58.2%	59.6%
Het	89.9%	52.0%	50.7%	60.3%



	Aware	Need	Ask	Receive
AfAm	79.8%	56.4%	51.5%	50.0%
Anglo	91.8%	56.5%	49.7%	44.0%
API	92.7%	63.4%	64.0%	72.4%
Latino	85.1%	51.1%	48.8%	51.4%
OC	75.6%	34.1%	29.3%	26.8%
Hmlss	77.3%	54.5%	53.0%	48.5%

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

Gender	Male	Female	TG
Knowledge Gap	10.9%	5.8%	23.2%
Unmet perceived need	4.3%	-7.2%	0.0%
Need-Receive Gap	10.0%	-2.4%	4.3%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	20.2%	8.2%	14.9%
Unmet perceived need	1.5%	5.7%	-2.6%
Need-Receive Gap	6.4%	12.5%	-0.3%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	75.6%	77.3%	87.4%
Need	34.1%	54.5%	65.8%
Ask	29.3%	53.0%	64.0%
Receive	26.8%	48.5%	63.1%
Knowledge Gap	24.4%	22.7%	12.6%
Unmet perceived need	2.4%	4.5%	0.9%
Need-Receive Gap	7.3%	6.1%	2.7%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	80.4%	88.1%	87.9%
Need	52.2%	56.8%	59.0%
Ask	47.4%	52.8%	55.4%
Receive	46.7%	49.2%	55.7%
Knowledge Gap	19.6%	11.9%	12.1%
Unmet perceived need	0.7%	3.6%	-0.3%
Need-Receive Gap	5.5%	7.6%	3.3%

Region	Total	San Mateo	Tender-loin
Aware	89.2%	91.7%	89.1%
Need	56.1%	72.2%	58.5%
Ask	50.5%	69.4%	53.9%
Receive	46.9%	75.0%	53.4%
Knowledge Gap	10.8%	8.3%	10.9%
Unmet perceived need	3.6%	-5.6%	0.5%
Need-Receive Gap	9.2%	-2.8%	5.2%

Summary

According to the REGGIE system about 3,400 clients are receiving case management services by Ryan White funded providers. Self-report indicate that closer to 7,000 clients are being served by the system. A range of 4 to 12 hours of case management services is provided annually. Although service providers may have an acuity scale for access to case management, the lack of a system-wide acuity criteria for eligibility results in an eligibility gap of over 75% and up to 53% of consumers report not receiving case management services.

The substantial majority of PLWH/A are aware of case management services, with 75% or more in every group indicating knowledge of the service. Those who are not accessing this service, such as PLWH/A out-of-care (24%) and asymptomatic PLWH (20%) have the highest knowledge gaps.

The data also show:

- Approximately 56% of PLWH/A have expressed a need for case management services. Those with the greatest need include women (65%), Asian/Pacific Islanders (63%), Native Americans (72%), IDUs (64%), PLWH/A over 55 years (63%), San Mateo county residents (72%), undocumented PLWH/A (65%), recently incarcerated PLWH/A (66%), and symptomatic PLWA (64%).
- Several groups, such as women (-7%), Asian/Pacific Islanders (-8%), Latinos (-3%), IDUs (-2%), heterosexuals (-10%), and San Mateo county residents (-6%) have all received a higher level of service than has been requested.
- Unmet perceived need among PLWH/A is approximately 4%. Those with a higher level of unmet perceived need include MSM and homeless PLWH/A, both at 5%.
- Those most likely to request case management services compared to other groups include women (60%), Asian/Pacific Islanders (64%), Native Americans (69%), PLWH/A over 55 years (63%), San Mateo county residents (69%), undocumented PLWH/A (61%), recently incarcerated PLWH/A (64%), and symptomatic PLWA (61%).

Treatment Advocate

Definition

Assessment, counseling, and referral in individual and/or group format aimed at facilitating access to HIV treatments, clinical trials, expanded access, and parallel track programs and ensuring adherence to HIV treatments; provision of treatment, adherence, and clinical trails education to clients.

Service Unit, Eligibility, and Funding

Unit: Hours

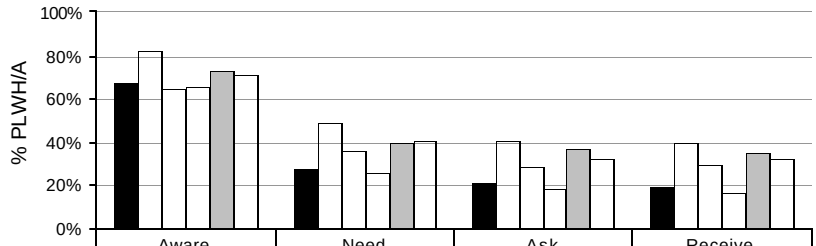
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

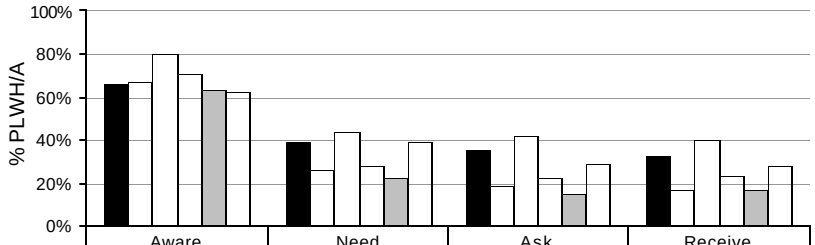
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	67.1%	27.6%	21.1%	19.7%
Female	82.1%	48.3%	40.6%	39.7%
TG	65.0%	35.0%	28.5%	29.6%
MSM	65.9%	26.0%	18.8%	17.2%
IDU	72.3%	39.9%	36.2%	34.7%
Het	70.8%	41.0%	32.1%	32.2%



	Aware	Need	Ask	Receive
AfAm	66.1%	39.6%	34.6%	31.8%
Anglo	66.9%	25.9%	18.7%	17.3%
API	80.4%	43.8%	41.7%	40.1%
Latino	70.9%	27.9%	22.1%	23.3%
OC	63.4%	22.0%	14.6%	17.1%
Hmlss	62.1%	39.4%	28.8%	27.3%

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

Gender	Male	Female	TG
Knowledge Gap	32.9%	17.9%	35.0%
Unmet perceived need	1.3%	1.0%	-1.1%
Need-Receive Gap	7.8%	8.7%	5.4%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	33.9%	33.1%	29.1%
Unmet perceived need	2.8%	1.4%	-1.3%
Need-Receive Gap	7.8%	8.6%	4.6%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	75.6%	62.1%	66.7%
Need	22.0%	39.4%	38.7%
Ask	14.6%	28.8%	31.8%
Receive	17.1%	27.3%	28.8%
Knowledge Gap	36.6%	37.9%	33.3%
Unmet perceived need	-2.4%	1.5%	3.0%
Need-Receive Gap	4.9%	12.1%	9.9%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	80.4%	88.1%	73.6%
Need	30.4%	33.6%	34.5%
Ask	25.9%	24.0%	28.8%
Receive	25.0%	21.8%	29.4%
Knowledge Gap	33.3%	32.5%	26.4%
Unmet perceived need	0.9%	2.2%	-0.7%
Need-Receive Gap	5.4%	11.8%	5.1%

Region	Total	San Mateo	Tenderloin
Aware	67.9%	80.6%	69.4%
Need	28.9%	55.6%	29.5%
Ask	22.3%	52.8%	23.2%
Receive	21.1%	52.8%	23.0%
Knowledge Gap	32.1%	19.4%	30.6%
Unmet perceived need	1.3%	0.0%	0.1%
Need-Receive Gap	7.8%	2.8%	6.5%

Summary

Treatment advocate is not a minor service category under case management, instead it is more often reported as a minor service under client advocacy. Overall, there is not a uniform method of calculating units of service provided and clients served through REGGIE. Without a meaningful measurable eligibility criteria for determining who receives treatment advocate services eligibility, theoretical need and absolute service need gap measures cannot be calculated.

Seventy-percent of PLWH/A are aware of treatment advocate services. Women (82%) have a higher level of awareness than either males (67%) or transgender persons (65%). Among ethnic groups, both Native Americans and Asian/Pacific Islanders at over 80% each have higher levels of awareness than other ethnic groups. MSM/IDU have the highest level of awareness (75%) among risk groups.

The data also show:

- Overall, 30% of PLWH/A have expressed a need for treatment advocate services. However, women, African Americans, Asian/Pacific Islanders, Native Americans, IDUs, and heterosexuals report levels of need above 40%. The highest level of need is among San Mateo county residents at 56%.
- Women at 43%, Asian/Pacific Islanders at 42%, and San Mateo county residents at 53% have requested this service more than any other group.
- Unmet perceived need is low across all groups, ranging from 2% to 3%. Some groups, such as transgender persons and Latinos, at –1%, received slightly more service than requested.
- Undocumented PLWH/A (13%), those recently incarcerated (10%), and homeless PLWH/A (12%), have higher need-receive gaps than all other groups. For the overall sample, the need-receive gap is 8%.

Peer Advocate

Definition

Serve as street-based "patient navigators," outreaching to clients to engage and maintain them in service, accompanying clients to appointments, assisting clients to access services and to adhere to medication regimes, and provide practical support.

Service Unit, Eligibility, and Funding

Unit: Encounter

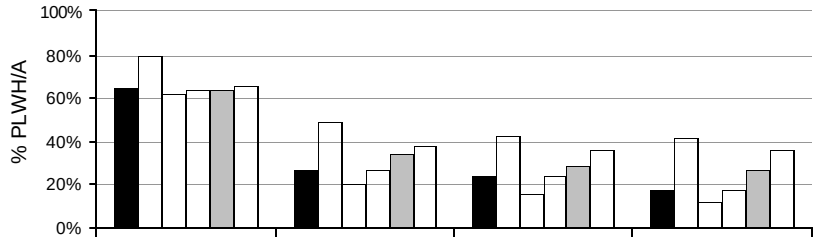
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,783
Estimated # Eligible	14,648

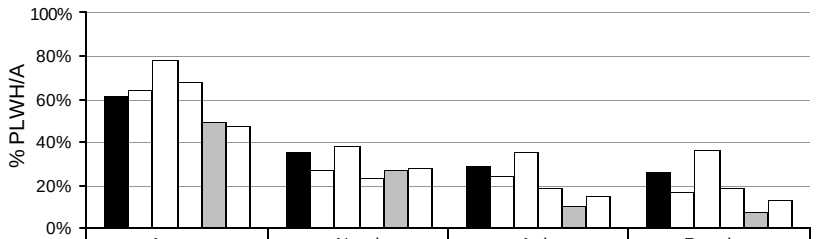
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	13,915
Theoretical need	73,238

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	81%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	81%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	64.2%	26.6%	23.6%	18.0%
Female	78.9%	48.8%	42.8%	41.4%
TG	61.8%	20.4%	16.1%	11.8%
MSM	64.2%	26.5%	23.8%	17.3%
IDU	64.0%	33.2%	28.2%	26.7%
Het	65.1%	38.0%	35.6%	35.6%



	Aware	Need	Ask	Receive
AfAm	61.7%	34.6%	28.5%	25.7%
Anglo	64.3%	26.4%	24.1%	17.0%
API	77.8%	38.1%	34.7%	35.7%
Latino	68.0%	23.2%	19.0%	19.0%
OC	48.8%	26.8%	9.8%	7.3%
Hmlss	47.0%	27.7%	13.8%	12.3%

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

Gender	Male	Female	TG
Knowledge Gap	35.8%	21.1%	38.2%
Unmet perceived need	5.6%	1.4%	4.3%
Need-Receive Gap	8.6%	7.4%	8.6%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	38.3%	35.7%	32.0%
Unmet perceived need	2.8%	7.1%	0.0%
Need-Receive Gap	8.9%	9.4%	4.2%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	48.8%	47.0%	56.8%
Need	26.8%	27.7%	36.4%
Ask	9.8%	13.8%	28.4%
Receive	7.3%	12.3%	26.4%
Knowledge Gap	51.2%	53.0%	43.2%
Unmet perceived need	2.4%	1.5%	2.1%
Need-Receive Gap	19.5%	15.4%	10.0%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	66.7%	69.0%	66.4%
Need	29.9%	34.4%	28.1%
Ask	26.3%	27.2%	21.6%
Receive	23.7%	24.2%	20.3%
Knowledge Gap	33.3%	31.0%	33.6%
Unmet perceived need	2.6%	3.0%	1.3%
Need-Receive Gap	6.2%	10.2%	7.8%

Region	Total	San Mateo	Tender-loin
Aware	65.0%	75.0%	65.8%
Need	27.7%	44.4%	31.6%
Ask	24.5%	44.4%	26.7%
Receive	19.3%	41.7%	25.5%
Knowledge Gap	35.0%	25.0%	34.2%
Unmet perceived need	5.3%	2.8%	1.2%
Need-Receive Gap	8.5%	2.8%	6.1%

Summary

While REGGIE does not capture peer advocacy, on average over 2,700 PLWH/A report having five "encounters" of peer advocate services and with about 2,800 PLWH/A reporting using it. The system-wide eligibility criteria for peer advocacy is very broad and results in a gap of about 81% of PLWH/A who report they are in need of peer advocate services.

Close to two-thirds of PLWH/A are aware of peer advocacy services. Those least familiar with this service include PLWH/A out-of-care (49%) and homeless PLWH/A (47%).

The data also show:

- Compared to the overall level of need of 28%, women (49%), African Americans (35%), Asian/Pacific Islanders (38%), Native Americans (48%), PLWH/A over 55 years (50%), San Mateo county residents (44%), undocumented PLWH/A (37%), recently incarcerated PLWH/A (36%), and symptomatic PLWH (34%) report the highest levels of need.
- Unmet perceived need for peer advocate services is approximately 5% for the sample overall. Three groups have unmet perceived need levels that are higher, including Anglos (7%), MSM (6%), and PLWH/A over 55 years (10%).
- Women (43%), San Mateo county residents (44%), and PLWH/A over 55 years (46%) have requested peer advocate services more than any other group.

Health Education / Risk Reduction (HERR)

Definition

The provision of information about medical and psychosocial support services and counseling. The services also includes the provision of information about medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.

Service Unit, Eligibility, and Funding

Unit: Encounter

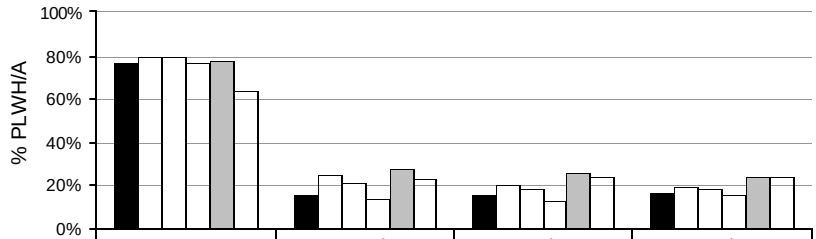
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level. The service is part of the continuum of care available to people living with HIV/AIDS in San Francisco, however, receives no RW Title I funding.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,490
Estimated # Eligible	14,648

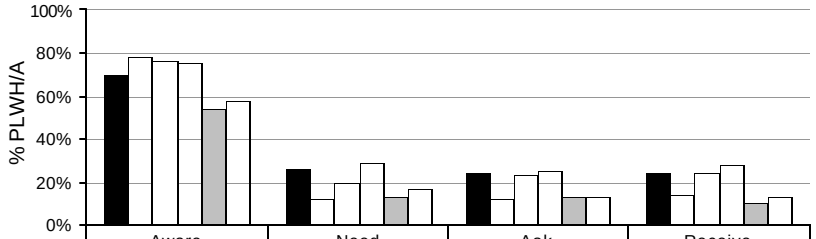
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	12,450
Theoretical need	73,238

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	83%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	83%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	75.7%	15.4%	14.9%	16.8%
Female	79.5%	25.0%	20.3%	19.2%
TG	79.6%	21.5%	18.2%	18.2%
MSM	76.1%	13.2%	12.7%	14.8%
IDU	77.1%	27.6%	25.4%	23.9%
Het	63.4%	23.4%	24.0%	24.0%



	Aware	Need	Ask	Receive
AfAm	69.9%	25.6%	24.1%	23.9%
Anglo	77.3%	11.5%	11.2%	13.1%
API	76.2%	19.8%	23.3%	24.0%
Latino	75.3%	28.5%	24.6%	27.7%
OC	53.7%	12.2%	12.2%	9.8%
Hmlss	57.6%	16.7%	12.1%	12.1%

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

Gender	**Male**	**Female**	**TG**
Knowledge Gap	24.3%	20.5%	20.4%
Unmet perceived need	-1.9%	1.2%	0.0%
Need-Receive Gap	-1.4%	5.8%	3.2%

Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	30.1%	22.7%	24.7%
Unmet perceived need	0.3%	-1.8%	-3.1%
Need-Receive Gap	5.4%	8.2%	12.6%

Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	53.7%	57.6%	66.4%
Need	12.2%	16.7%	24.5%
Ask	12.2%	12.1%	21.8%
Receive	9.8%	12.1%	21.8%
Knowledge Gap	46.3%	42.4%	33.6%
Unmet perceived need	2.4%	0.0%	0.0%
Need-Receive Gap	2.4%	4.5%	2.7%

Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	69.3%	70.6%	74.8%
Need	19.7%	18.4%	22.2%
Ask	19.3%	17.1%	19.4%
Receive	20.7%	17.1%	20.0%
Knowledge Gap	30.7%	29.4%	25.2%
Unmet perceived need	-1.5%	-5.6%	-0.6%
Need-Receive Gap	-1.0%	1.3%	2.2%

Region	**Total**	**San Mateo**	**Tender-loin**
Aware	76.0%	91.7%	70.5%
Need	16.1%	44.4%	19.7%
Ask	15.2%	41.7%	18.4%
Receive	16.9%	44.4%	17.3%
Knowledge Gap	24.0%	8.3%	29.5%
Unmet perceived need	-1.7%	-2.8%	1.1%
Need-Receive Gap	-0.9%	0.0%	2.4%

Summary

HERR services are not uniformly reported in the REGGIE system. However, according to self-reports, about 2,500 PLWH/A receive HERR services about five times a year, on average. Based on a very broad system-wide eligibility criteria, with a theoretical estimate of over 73,238 encounters needed, about 83% of PLWH/A report not receiving HERR services. At the same time, as noted below, the services provided exceed stated demand.

Knowledge of HERR services is high across groups, with 76% of the sample indicating awareness of this service. PLWH/A who are out-of-care (54%) and homeless PLWH/A (58%) have lower awareness levels than the rest of the sample.

The data also show:

- The overall level of need for HERR is 16%. However several groups have levels of need at or above 25%, including women, African Americans, Latinos, Native Americans, IDUs, PLWH/A over 55 years, recently incarcerated PLWH/A, and symptomatic PLWA. At 44%, San Mateo county residents have the highest level of need for this service.
- Nearly all groups are receiving more service than has been requested.

Employment Assistance

Definition

Service Unit, Eligibility, and Funding

Unit: Encounter

Eligibility:

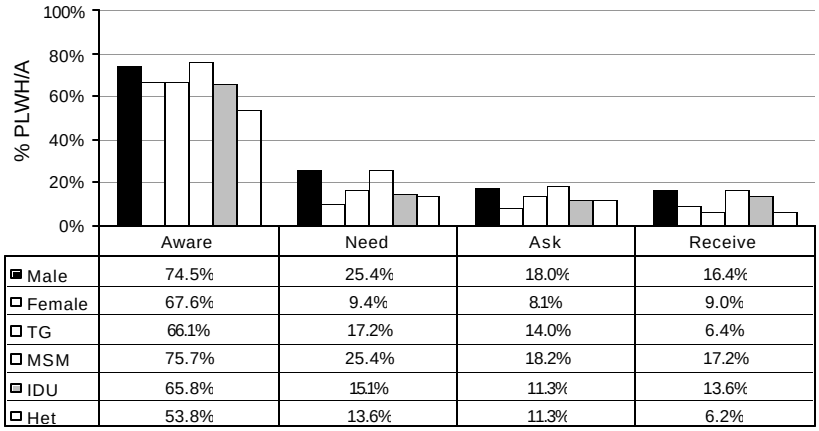
The service is part of the continuum of care available to people living with HIV/AIDS in San Francisco, however, receives no RW Title I funding.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	NA
Estimated # Eligible	NA

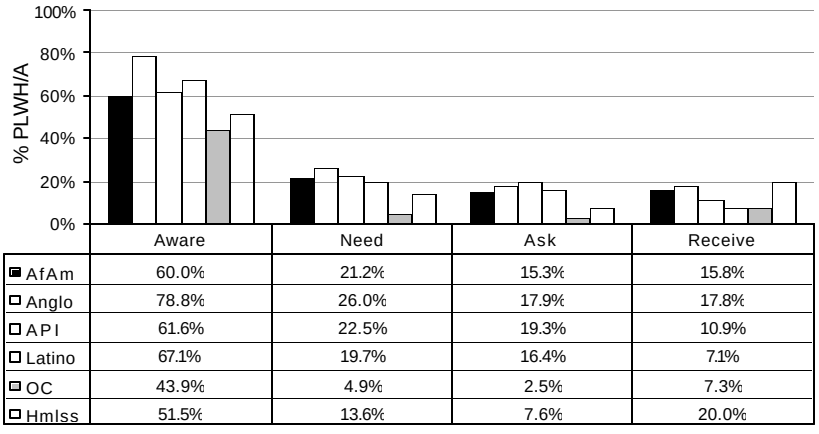
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	5
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	74.5%	25.4%	18.0%	16.4%
Female	67.6%	9.4%	8.1%	9.0%
TG	66.1%	17.2%	14.0%	6.4%
MSM	75.7%	25.4%	18.2%	17.2%
IDU	65.8%	15.1%	11.3%	13.6%
Het	53.8%	13.6%	11.3%	6.2%



	Aware	Need	Ask	Receive
AfAm	60.0%	21.2%	15.3%	15.8%
Anglo	78.8%	26.0%	17.9%	17.8%
API	61.6%	22.5%	19.3%	10.9%
Latino	67.1%	19.7%	16.4%	7.1%
OC	43.9%	4.9%	2.5%	7.3%
Hmlss	51.5%	13.6%	7.6%	20.0%

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

Gender	Male	Female	TG
Knowledge Gap	25.5%	32.4%	33.9%
Unmet perceived need	1.6%	-0.9%	7.5%
Need-Receive Gap	9.0%	0.4%	10.7%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	40.0%	21.2%	32.9%
Unmet perceived need	-0.5%	0.1%	9.2%
Need-Receive Gap	5.4%	8.2%	12.6%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	43.9%	51.5%	56.4%
Need	4.9%	13.6%	18.2%
Ask	2.5%	7.6%	10.9%
Receive	7.3%	20.0%	17.3%
Knowledge Gap	56.1%	48.5%	43.6%
Unmet perceived need	-4.8%	-12.4%	-6.4%
Need-Receive Gap	-2.4%	-6.4%	0.9%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	65.0%	70.4%	69.8%
Need	25.5%	23.2%	18.6%
Ask	18.5%	18.7%	13.8%
Receive	10.1%	20.0%	13.0%
Knowledge Gap	35.0%	29.6%	30.2%
Unmet perceived need	8.4%	-1.3%	0.8%
Need-Receive Gap	15.5%	3.2%	5.6%

Region	Total	San Mateo	Tenderloin
Aware	74.0%	75.0%	66.1%
Need	24.4%	20.0%	20.2%
Ask	17.4%	16.7%	15.9%
Receive	15.8%	0.0%	13.0%
Knowledge Gap	26.0%	25.0%	33.9%
Unmet perceived need	1.5%	16.7%	2.9%
Need-Receive Gap	8.5%	20.0%	7.2%

Summary

Employment assistance services are not funded through Ryan White Title and are therefore not captured through the REGGIE system nor is an eligibility criteria available to quantify gaps in services.

Awareness of employment assistance services ranges from a low of 44% among those out-of-care to a high of 81% among Native Americans. The knowledge gap is highest among African Americans (40%), heterosexuals (46%), recently incarcerated PLWH/A (44%), homeless PLWH/A (49%), and those out-of-care (56%).

The data also show:

- Women (9%) and those out-of-care (5%) have levels of need far below most other groups, which generally ranges from 20% to 25%.
- Unmet perceived need is quite high for several groups, including transgender persons (8%), Asian/Pacific Islanders (8%), Latinos (9%), Native Americans (11%), and MSM/IDU (7%). The need-receive gap is similarly high for many of these same groups.

Summary Case Management

Case management services are used by nearly half of all PLWH/A. Those less likely to receive the level of service being requested include MSM and homeless PLWH/A. Need for HERR is lower than for all other services in this category which include case management, peer and treatment advocacy, and employment assistance.

- More case management service has been provided to women, Asian/Pacific Islanders, Latinos, IDUs, heterosexuals, and San Mateo County residents than has been asked for.
- Among the services in this category, there is greater demand for peer advocacy services than is being provided.
- People of color have a higher need and demand for employment assistance services than is being provided.
- Women have a high need, unmet perceived need and need-receive gap for case management and peer and treatment advocacy services.

Case Management : Qualitative Comments – Services

A transgender said, *"My case manager is basic. She's positive about everything and she helps with housing. She lets me know about things, but it's up to me to change my life and stay focused. It's a very positive agency."* Another transgender said, *"You know I try to do it myself. I have a case manager on occasions like when I really need a case manager to sign paperwork and stuff like that. That's what I would use case management for. I had a case manager for five years and she's no longer here, and I don't even know who is going to keep the service for assistance with medical care. I don't know. There's no help and too much information out there for me."*

A San Mateo African American male said, *"The case manager I had was there two or three times. The one we're talking about has been there, gone and come back and now gone again. It's usually the same people down there. They've got a group down there that sticks together. They don't want to replace anybody. That's what I'm saying, they have a cool group down there. If they think you don't need a service, you don't get it. Used to be you could go in there and say, 'I lost my check and I don't have any rent money,' and they would write a check for your rent. The next month you could say, 'I got hit by a car and they robbed me,' or something. It used to be so simple like that and now they do nothing for you now except housing. It used to be you could just have your landlord write a little letter saying you had poor business and you had to spend your money on something. It's changed all the way now."*

The topic of returning to work was brought up in the transgender focus group. One participant said, *"The problem with the transgender community is it's too hard for us to get a job. There are very few transgender persons who apply for work, but there's always a lot of competition. It's hard for us, too hard."* Another participant brought up the discrimination experienced when looking for work. She said, *"Even if you go out and apply for a job at McDonald's they look at you like you are out of your mind. They won't call you. They look at you like you are out of your*

mind and you are just applying for minimum wage. And you are not getting any assistance and they don't care, so you have to turn and do sex work or something to pay the rent."

When asked about services that should have a reduction of funding, an African American MSM replied, *"The way I feel is though no one should catch HIV. No one should be catching HIV now, because everything is out there. You know about condoms. You know about safe sex. I was at a meeting the other day and this 18 year old guy came in with HIV. He wanted everybody to feel sorry for him. I said, 'Honey I don't feel sorry for you, because you were stupid. You got HIV.' That's the way I feel. You're stupid if you get it nowadays, because everything is out there to tell you how not to get it. I feel as though some of these services for harm reduction for people to not get HIV is a total waste of time because more people are getting it. More people are doing more promiscuous things, more people are having unsafe sex, and more people are sharing needles so I think that's a waste of time really. They should cut some of that money, because anybody that gets HIV now in this time with AIDS wants to get it. I feel they want to get it. They're out there doing what you're not supposed to do to get it. That's the way I feel. I don't apologize to nobody. If you get it I'm going to tell you like it is. You're stupid to get it if you're catching it in the year 2000."*

Case Management Consumer Reported Top Barriers

- No transportation
- Criminal justice matter
- Communication w/ provider
- Provider expertise

Case Management : Qualitative Comments – Barriers

Consumers

A transgender, when asked if case managers do what they should do said, *"Some do, some don't. It's almost like a hit or miss."* Another transgender said, *"I go look for something once and if I don't find the case manager to be helpful, I go to the next. So whatever I don't find there I try to look at other agencies. You almost have to be self-directed if you are wanting to start living the way you know how you need to do. I do whatever I have to do to get what I need done."*

A homeless male said, *"I could do a better job than my case manager. When you go to him for a problem he doesn't want to deal with the problem. He wants to give you something to cover up the problem. It's like a doctor that doesn't want to deal with the problem. I say, 'I don't want you to cover that up.' He says, 'I'll give you a voucher for this or this.' 'I don't want a voucher for that. I want you to help me find better housing.' He'll then say, 'I can't put you before anybody else.'"*

An African American MSM said, *"Services are accessible. I mean I think it's hard for any one case manager or one agency to be thoroughly knowledgeable of all services available because you actually have to do the networking yourself. There is a process you have to do yourself in*

order to be connected to them. I've never met any one person or case manager that could just say they had all the answers. That's probably impossible too."

An African American female said, *"I had one at [a female oriented ASO], but do you know what those folks told me? I'm not even eligible anymore. They don't feel like I need them. They don't feel like I need their service. I say, 'But I still have HIV.' They look at you and your appearance. That's what it is."*

Regarding going back to work, a transgender said, *"Losing our benefits is our concern. I mean what if we start working and get sick later. That's our concern. We would go back to work and lose the benefits we get so far, what if we get sick later can we go back and do it again? I think it would be harder."*

A homeless male said, *"Vocational rehab assistance is needed for people to go back to work other than [the current ASO]. Although [that agency] is good they just don't have the space for vocational training. A lot of us can go back to work. Even though my legs hurt and I take morphine for my legs I wouldn't mind going back to work and sitting down and doing a part-time job even. I think that would make me feel a lot better about myself, being able to work and say, 'Damn I worked hard today.'"*

Providers

"If a client does not know where he/she is going to sleep, eat a meal, or find enough money for that day, it is extremely difficult for that client to keep scheduled appointments, and/or keep to treatment regimens such as taking medication. Many of our clients suffer mental health conditions such as depression, bipolar and some even schizophrenia. If someone is in a depression, and experiencing feelings of hopelessness and lack of motivation, it may be too difficult to get out of bed, much less make an appointment."

"If someone is experiencing psychosis or paranoia, it can also be challenging to receiving regular care. We work very hard to meet every client where they are at, squeeze them in for urgent care medical appointments, and provide case management drop-in hours. The most important thing is to establish a good relationship with clients so that they feel comfortable coming to the clinic when they need us; and to try to be as accessible as possible, while still providing some structure so that the clinic can operate smoothly."

"Clients have problems receiving services due to substance abuse issues, homelessness issues, and severe health issues."

"Barriers include: 1) client does not follow through; 2) the wait list for services is too long; 3) what is most clinically appropriate for clients is not offered at our agency (i.e. long term therapy, day treatment); 4) scheduling issues (i.e. client needs a weekend or evening appointment); 5) Reggie/CIS - some people don't want the level of disclosure required before they know the agency or they don't want to be in the collaboration; 6) funding limitations and staffing limitations impact how many clients we can see at any one time; 7) space limitations

impact how many clients we can see at any one time. 8) clients do not meet eligibility criteria (i.e. live in San Francisco, high income); and 9) clients have trouble getting services through their insurance because coverage is not good enough but have too many resources to qualify for our services. In regard to the barriers, we continue to stay informed about other providers who may have shorter waiting lists, access to services (i.e. long term therapy) that we do not, and always advocate with insurance companies if clients need our help to receive benefits. We have a crisis team to help in situations where the acuity of the client makes a wait list an inappropriate choice and we prioritize clients in regard to acuity on therapy wait list. We dedicate more staff time to therapy when the wait list is long and have hired a per diem staff to help see more clients."

"The most common barrier seems to be clients not following through once a referral has been made. Our staff works hard at connecting with clients who do not show including telephone calls and eventually letters inquiring about the clients' continued interest in services. We keep the door open to clients who do not make it into therapy, giving them information about who to contact if they are interested in services in the future."

"[Our facility] is considerably short staffed when it comes to social work. There is 3.5 FTE social workers for 1800 patients."

"The only reason why people would not receive services is SF residency. What we do for people not living in SF or not able to provide SF residency is to still provide services pro bono and not charge it to SF Care Title I contract. We would just consider this as donated services if there are no existing private money to cover our staff and program costs in serving non-SF residents. Other barriers: 1) lack of staff time to follow up with clients residing out of SF area; 2) lack of language capacity (e.g. we have case managers who are bi-lingual in five Asian languages: Japanese, Mandarin, Cantonese, Vietnamese, and Tagalog, but not Thai, Lao, Burmese, Samoan, or other ethnic languages that have a sizeable population of HIV+ people); 3) lack of staff support to do outreach to clients who are lost to follow-up; 4) our model of care for case management is very involved. We assist clients in all aspects of medical, psycho-social, emotional, financial, legal and housing needs. Because clients are living longer, caseloads for each individual case manager is growing bigger therefore decreasing the total amount of time case managers can allot per client; quality of care is thus adversely impacted in some cases. In response to this, we are doing: 1) developing consumer peer leaders who can assist in practical assistance to clients: grocery shopping, bringing clients to do blood work and picking up prescriptions; some are able to assist in interpretation. 2) There is no other API-specific case management or any HIV services in all the Bay Area or Northern California for that matter - we have to step into that role albeit the limitations of funding and resources."

"The most common reason that people who apply for services do not receive them is that they do not show for their intake appointment, or do not follow-through with a referral appointment or with the provider to whom they are referred for other services. The most common reasons for this include:

1) *Most of those accessing HIV services at [our agency] do not have a place to live, making it difficult for them to organize their daily lives sufficiently to allow them to access services in*

an organized fashion. To address this barrier, we offer services on a drop-in basis, and bring services to clients via the mobile team.

2) *Many of those accessing HIV services at [our agency] are struggling with mental health and/or substance use/abuse problems. These problems also interfere with their ability to organize themselves to access services, and we address these barriers through a program design that operates under harm reduction principles and practices. Our agency embraces harm reduction fully, and those who are actively using are welcomed to access services here. Since substance abuse and mental illness are often concurrent in this population, these principles are also used with those suffering from mental illness. Practical support needed to successfully access services is also available to those for whom it is indicated. This often takes the form of physically escorting the client to an appointment, or providing transportation.*
3) *Many of those we serve have developed mistrust of traditional systems of care, and we address this barrier to their accessing services by providing services in a way, and in a setting that is more comfortable and accessible to them. Our long-standing store-front location helps to make this possible. Many are aware of and recognize our presence for what it is - a safe place to come to talk about and get help with HIV and AIDS. The co-location of our HIV Prevention Program helps to remove the stigma often associated with neighborhood AIDS service organizations, since this program is open to all neighborhood denizens, regardless of HIV status."*

"Capacity issues affect ability to participate. Additional issues include children and pediatric HIV who move out of county and are technically not eligible for services despite lack of specialized services."

"We have a relatively small program and have rarely if ever turned an intake away. We have the ability to do the intakes that are asked of us, if, the client can return for a scheduled intake (usually within 2-3 days). Clients often face barriers regarding access to services, particularly housing, that does not necessarily have anything to do with [our organization], but rather SF in general."

"Many of our clients are extremely successful at making appointments, informing us of cancellations and following through with the outpatient care plans that we provide. However some clients face many challenges to receiving regular care. Three of the most challenging barriers to accessing care for our clients are substance use, homelessness, and mental health. All of these factors cam contribute to a chaotic lifestyle, which therefore leads to difficulty with follow through. This does not mean that all clients who are actively using substances do not make their appointments; but rather that some clients who are using have trouble planning ahead and making follow-up appointments if they are not feeling sick at that moment."

"Clients receiving case management services elsewhere are ineligible for services (per eligibility requirements)."

"All clients requesting services receive them. However, due to limited staffing and resources, there is only one case manager per agency funded under this contract. This means that other staff not funded for case management often have to provide limited case management services."

"The most common reasons people who apply for services do not receive them is 1) not being a San Francisco resident, 2) not HIV positive, and 3) they must be 18+ years old."

"The social worker's time has just been cut from 90% to 70%. We are just now trying to determine how this cut will affect services."

"Everyone who applies for services receives them unless they arrive at the office too inebriated or too high to appropriately access services. The only barrier to services is the continued lack of support from the AIDS office and the lack of commitment of San Francisco to provide adequate on-going funding. Every year since 1997, when the task force on AIDS mismanaged [our organization's] CARE funding which got cut, [our organization] has had to plead for SF general funds despite assurances from the city that the funds will be annualized. Every year we are first to be cut from the AIDS office budget. This on-going funding crisis contributes to the program's difficulty in providing consistent programming."

"Spanish monolingual clients suffer a range of issues from language to immigration. Assistance is limited given language barriers, lack of translation, and materials written in Spanish."

"We only have two peer advocates who work part-time in order to allow them to support their own health. We're funded for 1.4 FTE, but our client need far exceeds our staffing capacity. We could easily fill the time for 2 FTE peer advocates; this would increase the chances of clients making it to their medical/other appointments and also lost to-follow up clients being found thru outreach efforts."

Day/Respite Care

Adult Day Care

Definition

Home- or community-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child.

Service Unit, Eligibility, and Funding

Unit: Hours

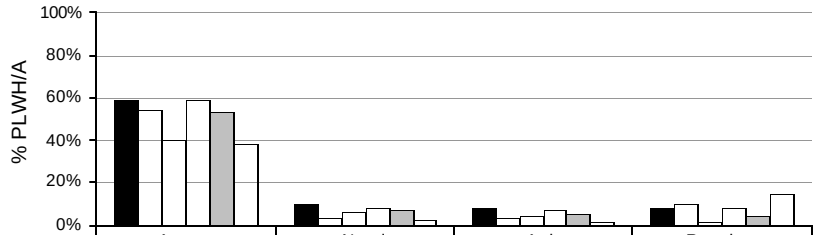
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	124
In Service – self rpt	NA
Estimated # Eligible	NA

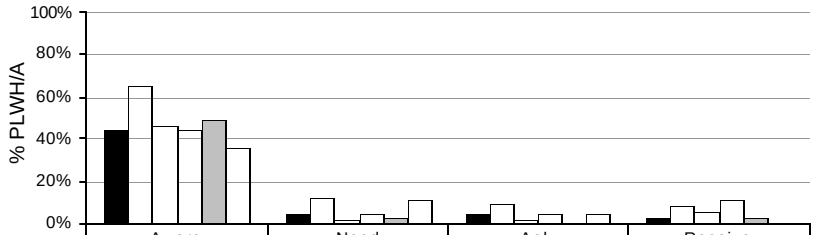
SERVICE UNITS 2001	
# of duplicated clients	767
Average # Units Received - REGGIE	49
Median# of Units Received – self rpt	10
Total # Units Received - REGGIE	6,033
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	59.3%	9.9%	8.0%	7.6%
Female	53.6%	3.8%	3.5%	9.8%
TG	40.1%	6.6%	4.4%	2.2%
MSM	59.5%	8.3%	6.7%	8.1%
IDU	53.0%	7.1%	5.6%	4.6%
Het	38.0%	2.9%	2.2%	15.4%



	Aware	Need	Ask	Receive
AfAm	45.0%	4.8%	4.5%	2.2%
Anglo	64.8%	11.8%	9.2%	8.4%
API	46.8%	1.3%	1.5%	5.3%
Latino	44.4%	4.8%	4.6%	10.4%
OC	48.8%	2.4%	0.0%	2.4%
Hmlss	35.4%	10.8%	4.6%	0.0%

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

Gender	Male	Female	TG
Knowledge Gap	40.7%	46.4%	59.9%
Unmet perceived need	0.4%	-6.3%	2.2%
Need-Receive Gap	2.3%	-6.0%	4.4%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	55.0%	35.2%	55.6%
Unmet perceived need	2.2%	0.8%	-5.8%
Need-Receive Gap	2.5%	3.3%	-5.6%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	48.8%	35.4%	48.2%
Need	2.4%	10.8%	13.6%
Ask	0.0%	4.6%	11.0%
Receive	2.4%	0.0%	2.8%
Knowledge Gap	51.2%	64.6%	51.8%
Unmet perceived need	-2.4%	4.6%	8.2%
Need-Receive Gap	0.0%	10.8%	10.9%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	48.9%	59.2%	56.9%
Need	6.6%	8.1%	11.6%
Ask	5.9%	6.5%	9.6%
Receive	9.6%	6.5%	5.3%
Knowledge Gap	51.1%	40.8%	43.1%
Unmet perceived need	-3.7%	0.1%	4.3%
Need-Receive Gap	-3.1%	1.6%	6.2%

Region	Total	San Mateo	Tender-loin
Aware	58.7%	38.9%	55.5%
Need	9.5%	2.8%	9.6%
Ask	7.7%	2.8%	9.1%
Receive	7.6%	2.8%	7.0%
Knowledge Gap	41.3%	61.1%	44.5%
Unmet perceived need	0.1%	0.0%	2.1%
Need-Receive Gap	1.8%	0.0%	2.5%

Summary

REGGIE service providers report serving about 124 PLWH/A with over 6,000 hours of adult care services, with an average of 49 hours provided per PLWH/A. On the other hand, consumers in the needs assessment report receiving an average of 10 hours of day care service. This lower level of utilization may reflect the higher health status of consumers ale to participate in the needs assessment. Without meaningful, measurable eligibility criteria regarding stage of disease, an eligibility gap, theoretical need, nor absolute service need gap can be calculated.

Compared to many other services offered in the San Francisco EMA, there is a somewhat low level of awareness of adult day care services. For most groups, less than 50% have indicated awareness of this service.

The data also show:

- The need for adult day care services is also low, with 10% or less of most groups indicating a need for this service. Anglos (12%), homeless PLWH/A (11%), MSM/IDU (20%), PLWH/A over 55 years (11%), recently incarcerated PLWH/A (14%) and PLWA (12%) have reported the highest need.
- There appears to be wide variation within unmet perceived need for this service. For some groups, such as women (-6%), Asian/Pacific Islanders (-4%), Latinos (-6%), heterosexuals (-13%), and PLWH/A over 55 years (-7%), far more service is being provided than is being asked for. While other groups, such as MSM/IDU (10%), recently incarcerated PLWH/A (8%), and homeless PLWH/A (5%) have high unmet perceived need gaps.

Child Day Care

Definition

Supervision and guidance of a child or children unaccompanied by a parent, guardian or custodian on an as needed basis. Services are intended particularly for HIV/AIDS infected primary caregivers, while attending physician /clinic appointments, counseling sessions, and other HIV-related treatment activities.

Service Unit, Eligibility, and Funding

Unit: Hours

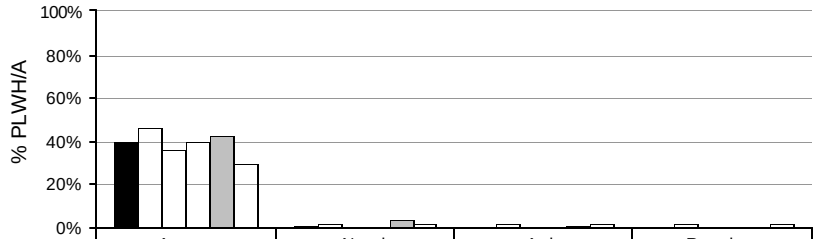
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	95
In Service – self rpt	NA
Estimated # Eligible	NA

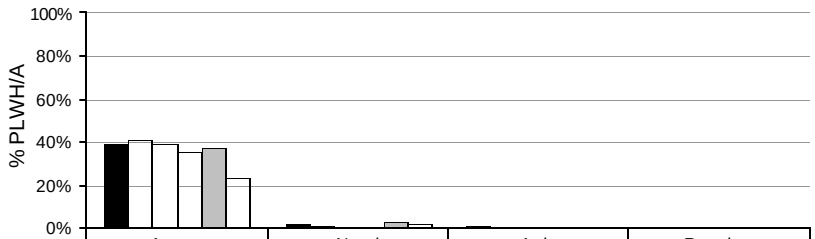
SERVICE UNITS 2001	
# of duplicated clients	386
Average # Units Received - REGGIE	116
Median# of Units Received – self rpt	9.5
Total # Units Received - REGGIE	11,028
Total # of Units Received – self rpt	NA
Theoretical need	NA

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	NA	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	NA	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	39.8%	0.7%	0.3%	0.2%
Female	46.5%	1.5%	1.5%	1.5%
TG	35.1%	0.0%	0.0%	0.0%
MSM	39.9%	0.0%	0.0%	0.0%
IDU	42.5%	3.4%	1.0%	0.4%
Het	29.2%	1.5%	2.2%	1.5%



	Aware	Need	Ask	Receive
AfAm	39.1%	1.4%	0.7%	0.3%
Anglo	41.2%	0.7%	0.2%	0.2%
API	38.9%	0.0%	0.0%	0.0%
Latino	34.9%	0.2%	0.3%	0.2%
OC	37.5%	2.5%	0.0%	0.0%
Hmlss	23.0%	1.6%	0.0%	0.0%

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

Gender	Male	Female	TG
Knowledge Gap	60.2%	53.5%	64.9%
Unmet perceived need	0.1%	0.0%	0.0%
Need-Receive Gap	0.5%	0.0%	0.0%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	60.9%	58.8%	65.1%
Unmet perceived need	0.4%	0.0%	0.2%
Need-Receive Gap	1.2%	0.0%	0.0%

Special Pops	Out-of-care	Home-less	Rec Inc
Aware	37.5%	23.0%	34.6%
Need	2.5%	1.6%	5.7%
Ask	0.0%	0.0%	1.9%
Receive	0.0%	0.0%	2.9%
Knowledge Gap	62.5%	77.0%	65.4%
Unmet perceived need	0.0%	0.0%	-1.0%
Need-Receive Gap	2.5%	1.6%	2.8%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	35.9%	44.2%	43.8%
Need	3.8%	0.8%	1.7%
Ask	2.3%	0.9%	1.1%
Receive	1.6%	0.9%	1.1%
Knowledge Gap	64.1%	55.8%	56.3%
Unmet perceived need	0.8%	0.0%	0.0%
Need-Receive Gap	2.3%	0.0%	0.7%

Region	Total	San Mateo	Tender-loin
Aware	40.1%	37.1%	41.0%
Need	0.7%	0.0%	1.1%
Ask	0.3%	0.0%	1.1%
Receive	0.2%	0.0%	0.6%
Knowledge Gap	59.9%	62.9%	59.0%
Unmet perceived need	0.1%	0.0%	0.6%
Need-Receive Gap	0.5%	0.0%	0.5%

Summary

According to the REGGIE system about 95 PLWH/A accessed, on average about 116 hours of childcare services for a total of about 11,000 hours. The system-wide eligibility would suggest that all PLWH/A within 300% of the federal poverty level would be eligible to receive without specifying whether services are available to affected as well as infected children. In the absence of a meaningful and measurable eligibility criteria regarding access to childcare services eligibility gaps, theoretical need nor absolute service need gaps can be calculated.

As might be expected, child day care services have the lowest level of awareness of most services. Among women, however, awareness is higher than most other groups. Approximately 47% of women are aware of this service compared to under 40% for most other groups.

The data also show:

- Need is extremely low at under 1% for the sample overall. Women, Native Americans, IDUs, youth, undocumented PLWH/A, recently incarcerated PLWH/A, PLWH/A out-of-care, and asymptomatic PLWH have expressed a higher need than for other groups.
- The unmet perceived need gap is at or under 1% for nearly every group, indicating that those who have requested this service have received it.

Summary Adult/Child Day Care

Approximately 10% of PLWH/A express a need for Adult Day Care services, and less than 10% receive this service. Child Day Care is the least demanded of all services available in the San Francisco EMA.

- MSM/IDU, incarcerated PLWH/A, and homeless PLWH/A have a demand for Adult Day Care that exceeds the level of service being provided.
- The unmet perceived need gap for Child Day Care is under 1%, indicating that those requesting this service are successful in receiving it.

Adult/Child Day Care Consumer Reported Top Barriers

- Criminal justice matter
- No childcare
- Service not available

Transportation

Van Transportation

Definition

Timely curb-to-curb, and as needed, door-to-door conveyance services provided to PLWH/A who are unable to use personal or public transportation. May be provided routinely, or on an emergency basis. Services will be provided with a priority to access health care, followed by psycho-social support services.

Service Unit, Eligibility, and Funding

Unit: Round Trips

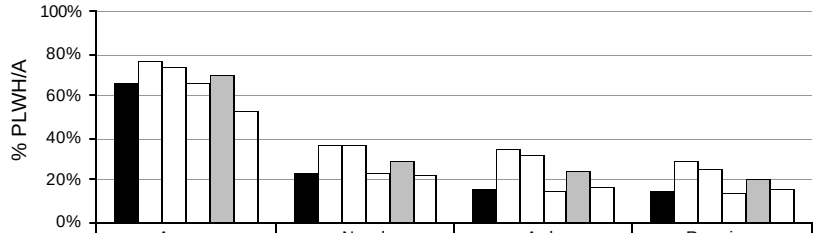
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	2,344
Estimated # Eligible	14,648

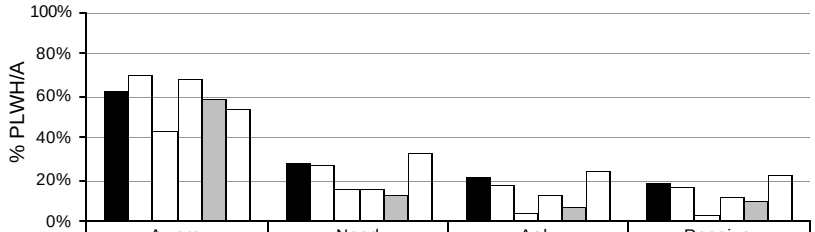
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	9
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	21,092
Theoretical need	131,828

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	

Summary Gaps				
Eligibility Gap:	84%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	84.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	66.7%	24.2%	15.9%	15.4%
Female	75.9%	37.1%	34.4%	29.4%
TG	73.2%	37.1%	31.8%	25.3%
MSM	66.2%	23.9%	14.8%	14.6%
IDU	70.1%	28.9%	25.0%	20.2%
Het	52.8%	21.9%	16.4%	15.8%



	Aware	Need	Ask	Receive
AfAm	62.7%	27.9%	21.8%	18.6%
Anglo	69.4%	26.7%	17.5%	17.3%
API	42.6%	15.6%	4.5%	3.7%
Latino	68.2%	15.6%	12.9%	11.6%
OC	58.5%	12.2%	7.3%	9.8%
Hmlss	53.8%	33.3%	24.2%	22.7%

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

Gender	Male	Female	TG
Knowledge Gap	33.3%	24.1%	26.8%
Unmet perceived need	0.4%	5.0%	6.4%
Need-Receive Gap	8.8%	7.8%	11.8
Ethnicity	**Af Am**	**Anglo**	**Latino**
Knowledge Gap	37.3%	30.6%	31.8%
Unmet perceived need	3.2%	0.2%	1.4%
Need-Receive Gap	9.3%	9.4%	4.0%
Special Pops	**Out-of-care**	**Home-less**	**Rec Inc**
Aware	58.5%	53.8%	61.5%
Need	12.2%	33.3%	34.9%
Ask	7.3%	24.2%	25.7%
Receive	9.8%	22.7%	23.1%
Knowledge Gap	41.5%	46.2%	38.5%
Unmet perceived need	-2.4%	1.5%	2.5%
Need-Receive Gap	2.4%	10.6%	11.7%
Stage of Infection	**HIV Asymp**	**HIV Symp**	**AIDS**
Aware	58.1%	65.6%	70.2%
Need	16.1%	28.8%	30.5%
Ask	6.7%	17.7%	25.6%
Receive	6.7%	16.3%	21.9%
Knowledge Gap	41.9%	34.4%	29.8%
Unmet perceived need	0.0%	1.5%	3.7%
Need-Receive Gap	9.4%	12.5%	8.5%
Region	**Total**	**San Mateo**	**Tender-loin**
Aware	67.3%	77.8%	63.4%
Need	25.2%	33.3%	29.8%
Ask	17.2%	33.3%	20.2%
Receive	16.4%	30.6%	17.6%
Knowledge Gap	32.7%	22.2%	36.6%
Unmet perceived need	0.8%	2.8%	2.7%
Need-Receive Gap	8.8%	2.8%	12.3%

Summary

In the REGGIE system the major service category of transportation is measured in "transportation hour" and not round trips and it is therefore not comparable to the self-reported data. According to self-reports about 2,300 PLWH/A receive, on average, about nine round-trips per year. A total of 21,092 round-trips were provided during 2001. With a very broad system-wide eligibility criteria there is a theoretical need of over 131,800 round trips provided annually, Using this eligibility criteria, 84% of the PLWH/A are not receiving this type of transportation.

The data also show:

- Need for van transportation services is highest among women (37%), transgender persons (37%), Native Americans (44%), recently incarcerated PLWH/A (35%), and symptomatic PLWA (38%).
- Women (5%), transgender persons (6%), and symptomatic PLWA (5%) have a higher unmet perceived need than the relatively low levels found among other groups.
- Women (34%), transgender persons (32%), Native Americans (32%), San Mateo county residents (33%), and symptomatic PLWA (31%) are more likely to have asked for van transportation services than other groups.

Taxi Vouchers or Bus Tokens

Definition

Providing vouchers for the transportation of eligible clients.

Service Unit, Eligibility, and Funding

Unit: Voucher/tokens

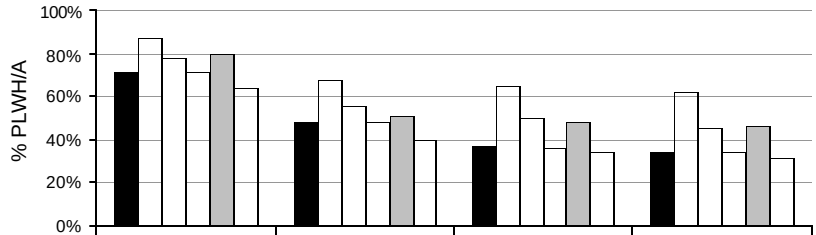
Eligibility: Diagnosis of HIV infection, resident of EMA, no income to 300% of Federal Poverty Level.

ESTIMATED PLWH/A	
TOTAL	21,000
Know HIV	15,750
In Service – REGGIE	NA
In Service – self rpt	5,420
Estimated # Eligible	14,648

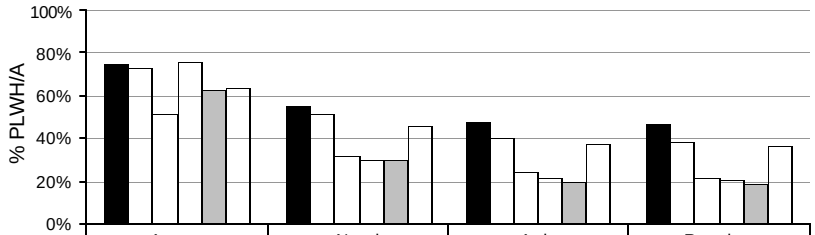
SERVICE UNITS 2001	
# of duplicated clients	NA
Average # Units Received - REGGIE	NA
Median# of Units Received – self rpt	12
Total # Units Received - REGGIE	NA
Total # of Units Received – self rpt	65,035
Theoretical need	175,770

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated

Summary Gaps				
Eligibility Gap:	63%	Reported minus Theoretical Need – REGGIE	NA	
		Reported minus Theoretical Need: - self rpt	63.0%	Units Received minus Units Funded:



	Aware	Need	Ask	Receive
Male	71.8%	47.5%	36.7%	34.9%
Female	87.8%	67.8%	64.2%	61.6%
TG	77.5%	56.0%	50.6%	45.3%
MSM	71.5%	47.5%	36.2%	34.2%
IDU	79.4%	51.5%	48.0%	46.4%
Het	63.4%	39.9%	34.2%	32.1%



	Aware	Need	Ask	Receive
AfAm	74.6%	55.2%	47.4%	46.0%
Anglo	72.8%	51.9%	40.3%	38.4%
API	52.0%	31.5%	24.1%	21.4%
Latino	75.9%	29.2%	21.5%	20.2%
OC	62.5%	29.3%	19.5%	19.0%
Hmlss	63.1%	45.5%	37.9%	36.4%

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

Gender	Male	Female	TG
Knowledge Gap	28.2%	12.2%	22.5%
Unmet perceived need	1.8%	2.6%	5.4%
Need-Receive Gap	12.6%	6.2%	10.7%

Ethnicity	Af Am	Anglo	Latino
Knowledge Gap	25.4%	27.2%	24.1%
Unmet perceived need	1.4%	2.0%	1.3%
Need-Receive Gap	9.1%	13.5%	8.9%

Special Pops	Out-of-care	Homeless	Rec Inc
Aware	62.5%	63.1%	72.7%
Need	29.3%	45.5%	57.7%
Ask	19.5%	37.9%	48.6%
Receive	19.0%	36.4%	46.8%
Knowledge Gap	37.5%	36.9%	27.3%
Unmet perceived need	0.5%	1.5%	1.8%
Need-Receive Gap	10.2%	9.1%	10.8%

Stage of Infection	HIV Asymp	HIV Symp	AIDS
Aware	65.9%	72.8%	77.6%
Need	39.1%	53.6%	48.2%
Ask	27.9%	43.5%	41.4%
Receive	27.3%	39.7%	37.3%
Knowledge Gap	34.1%	27.2%	22.4%
Unmet perceived need	0.6%	3.9%	4.2%
Need-Receive Gap	11.8%	13.9%	10.9%

Region	Total	San Mateo	Tenderloin
Aware	72.8%	86.1%	74.9%
Need	48.8%	58.3%	50.3%
Ask	38.6%	58.3%	40.2%
Receive	36.6%	55.6%	38.0%
Knowledge Gap	27.2%	13.9%	25.1%
Unmet perceived need	1.9%	2.8%	2.2%
Need-Receive Gap	12.2%	2.8%	12.2%

Summary

According to self-reports about 5,400 PLWH/A received transportation vouchers or token during the past year. With an average of 12 vouchers provided during the year for a total of 65,035 total vouchers and a theoretical need of 175,770, about two thirds of the PLWH/A are not receiving the service. REGGIE captures vouchers and tokens under "other" and "other support" services. Without uniform reporting by service providers it is difficult to calculate the total number of units provided and clients served.

Approximately half of all PLWH/A have expressed a need for this service. Generally, the level of need exceeds the amount of service being provided for nearly all populations. However, those who ask for the service are successful in receiving it, with just a 2% unmet perceived need gap among PLWH/A.

- Transgender persons, Native Americans, and undocumented PLWH/A have asked for more service than has been provided.
- Women are more likely to receive taxi vouchers than any other population of PLWH/A.

Summary Transportation

The need for taxi vouchers is higher than that for van transportation services. Among all populations of PLWH/A, women express high need and high demand for transportation services generally, and also receive less of this service than they ask for.

Transportation : Qualitative Comments – Services

An African American female said *"They limit that service for Black people. They are mostly giving that to foreigners. It's harder for Black people to get on it that have HIV I have heard. I haven't tried it yet. I just said, 'Well I'm not going through that.' I just have to catch the bus."* A transgender mentioned her need for taxi vouchers. Another participant said, *"I heard they had them, but I don't even know where they have them."*

A transgender said the service needed the most was transportation. She said, *"Transportation to go to doctor appointments makes a big difference, because this city is not that big of a city, but still if you have to walk to these places and it's difficult if you're sick."* When a focus group participant suggested that funding could be cut for van services, a homeless male responded, *"I have to disagree.. I rely on that van sometimes to get me back and forth to the hospital. If they start giving out taxi vouchers to us then I would give up the van, but the van has helped me out in the past to get back and forth to the hospital, go to federal court. They've been doing really good for me. But if they were giving out taxi vouchers to us like once every month or something that would be beautiful. Then I could give up the van."*

Transportation Consumer Reported Top Barriers

- Treatment knowledge
- Communication w/ provider
- Not knowing location
- Not eligible
- Service not available/ discontinued

Transportation : Qualitative Comments – Barriers

Consumers

A homeless male said, *"Transportation is important because climbing up and down those stairs on the bus is killing me. I can't do it. I've got neuropathy like this now and it hurts. It's like somebody sticking knives in your legs, but you have to give up an arm to get taxi vouchers from your case manager. You can only get one of these taxi vouchers, one every six months. My other case manager was supposed to help me get the transit service because I was financially burdened and I'm still financially burdened and I still haven't gotten that thing. It's going to cost me $9 for $90 worth of taxi vouchers. They would not help me out when I was financially burdened."*

An African American female said, *"The agency that provides van services has this new thing now because I don't think that they're getting much money from the Ryan White Fund as they usually do. So they had to eliminate some of the other things that were going on. Now it's like every so many months you have to bring a letter in to your doctor for your doctor to fill out to see if you still qualify. If you are not qualified for it they feel like there are other people that might need it worse than you."*

Providers

"Resources are not enough to employ enough drivers to ensure all requests are honored. Requests are honored 90% of the time. We are searching for additional funds by becoming a para transit contractor. Funds from these programs will be used to enrich our services to PLWH/A."

"The primary reason clients do not receive services is that after completing the assessment and intake, the client still faces the challenge of getting to the program, varies due to chaotic nature of client's lifestyle, but contributors are substance use and mental health complications. The staff works with clients to develop ways of supporting them, including pick up by our vans, buddies to assist getting here, etc... Also, containing education for primary care providers around appropriate referrals - all clients must have a documented need for skilled nursing. Often, referrals are not appropriate and [our] staff works with providers to improve referrals, both context and diagnosis."

13. SUMMARY AND CONCLUSION

Epidemiological Estimates and Trends

At the beginning of 2001, San Francisco and San Mateo counties had an estimated 19,000 to 21,000 PLWH/A. At the end of 2000 there were about 8,900 persons known living with AIDS, leaving over 12,000 people living with HIV or who don't know they are living with AIDS. The trend is for an increased number of PLWH/A in the care system. Since 1997 there has been an 11% increase in PLWA, and it is estimated that there will be an even greater increase in persons newly infected with HIV. This suggests an annul growth rate of between 4% and 5% in people needing care services a year. MSM will continue to be the majority of PLWH/A. New infections will increase disproportionately among African Americans, Latinos, women, and heterosexuals.

Demographics of PLWH/A

The distribution of PLWH/A according to the weighted data in the survey is:

- 92% males, 6% females, and 2% transgender
- MSM represent the largest proportion of PLWH/A at 74%, followed by MSM/IDU at 13%, (non-MSM) IDUs at 11%, and heterosexuals at 3%. According to the 2000 Epidemiological report, MSM are 86% of living AIDS cases and an estimated 87% of PLWH/A in San Francisco and 72% of PLWA in San Mateo. The most recent HIV prevalence and incidence estimates produced by the San Francisco Department of Public Health (SFDPH) project a significant increase in new HIV infections among MSM in San Francisco, especially MSM/IDU. Young gay men, particularly young gay men of color, are becoming infected at an alarming rate.
- The majority of the PLWH/A is non-Latino Anglo (69%), followed by African Americans (14%), Latinos (13%), Asian/Pacific Islanders (4%), and Native Americans (<1%).
- African Americans and Anglos are both disproportionately infected with HIV when compared to their share of the total population, and Native Americans have a slightly higher proportion of HIV cases.
- People of color, especially African Americans, make up an increasing percentage of new AIDS cases and estimated HIV infections in San Francisco. One-third of all PLWH are people of color. African Americans comprise only 5% of the San Francisco EMA's population yet they are nearly 15% of PLWA, 18% of estimated HIV infections, and 23% of people newly diagnosed with AIDS.
- Latinos are not disproportionately affected by HIV. Latinos are 17% of the EMA population, 13% of those living with AIDS, and 13% of estimated HIV infections. According to the Title I application, Latinas are 14% of cases among women but they are disproportionately represented among women who are not IDUs, with 21% of living AIDS cases.
- Women represent between 5% and 6% of all PLWH/A. According to the survey, 37% are African American.

- Almost three-quarters of heterosexuals living with HIV/AIDS are women, and they represent over a third of the IDUs.
- Women with AIDS are much more likely to be symptomatic than asymptomatic. Women are particularly vulnerable to Hepatitis C, with a co-morbidity with HIV infection of over 60%.
- About 80% of the women living with HIV/AIDS are living with others, including infected children and adults. This is more than double the percentage of men living with others.
- Transgender persons represent about 2% of all PLWH/A, but they are among the most vulnerable population for HIV infection. Over three-quarters are people of color and they were largely infected through sexual contact.
- Transgender PLWH/A have high rates of homelessness and drug use, and are much more likely than other populations to have contact with the jails or prisons. They are more likely to be out-of-care than most other populations living with HIV/AIDS, and they are more likely to have stopped taking their medication. By any measure, transgender PLWH/A have the greatest unmet needs and highest barriers of all subpopulations.

Education and Workforce

- PLWH/A in San Francisco are fairly educated. About 12% have less than a high school education, and 19% have post graduate education.
- Latinos, undocumented PLWH/A, those out-of-care, and recently incarcerated PLWH/A (many individuals are in most or all these categories) have the lowest education level.
- The majority of PLWH/A are not currently working (63%). Twenty percent of those not working are actively looking for work and 38% are not looking for work. Twelve percent of the sample is retired and 25% are either employed part- or full-time.
- More women (55%) and transgender PLWH/A (64%) are not working and not looking for work than are men (36%). However, a larger percentage of women are employed full time (15%) than men (10%).
- Among ethnic populations, APIs have the highest percent of PLWH/A who are currently employed full-time at 33%. Native Americans have the lowest percent of persons employed full-time at 3%.
- More Latinos (29%) report looking for work than any other ethnic group.
- Interestingly, being symptomatic is a better indication of being out of work and not looking for work than having AIDS. Over 40% of HIV symptomatic (43%) and AIDS symptomatic (46%) report not working and not looking for work.

Income

- In general, the participating PLWH/A have low incomes. About 75% report earning less than $16,500, and approximately 36% report earning less than $8,600.
- Females report significantly lower income than males. Transgender PLWH/A report the lowest income of any gender group with 69% earning $8,600 or less per year compared to 34% of males and 47% of females.

- Among risk groups, the vast majority of IDUs (93%) and MSM/IDU (87%) have incomes of $16,500 or less per year. MSM have the highest income with 21% making more than $23,000 followed by heterosexuals (15%), MSM/IDU (11%), and IDUs (6%). Even among MSM, less than 3% report earning more then $35,000 – the usual limit to qualify for ADAP.
- Over half the Latinos and African Americans report earning $8,600 per year or less.
- Not surprisingly, homeless PLWH/A and those out-of-care report the lowest income.
- For drug reimbursement, a PLWH/A has to be below 400% of the federal poverty level. Over 95% of the participants in the needs assessment survey would meet the financial criteria for ADAP.

Age

Not surprisingly the newly infected populations are younger than those with AIDS. Among ethnic groups, Latinos are the youngest group, and among risk groups heterosexuals are the youngest. Both these groups have relatively high rates of new infections.

State of Infection

- About 59% of PLWH/A have been diagnosed with AIDS (slightly higher than the most current estimates by SFDPH).
- Those with AIDS have a low mortality rate, and those infected with HIV are likely to progress to AIDS slowly. With the current growing infection rate among young gay men and communities of color, those newly infected will increase the proportion of those HIV positive who have not progressed to AIDS.
- Perhaps more important to the care system, just over 60% of the participants of the survey said they were symptomatic. Throughout the data, one finding that stands out is that the onset of symptoms is a better predictor of service need than a diagnosis of AIDS.
- Those newly infected – the poor, those with co-morbidities of substance use, homelessness, and mental illness – are more likely to be symptomatic and thus require more services.
- Based on the criteria for antiviral treatment, 70% of the HIV positive populations, or nearly 8,000 persons in the care system are candidates for treatment because of an AIDS diagnosis, low t-cell counts, or OIs.

Co-Morbidities

<u>Homelessness and Housing</u>

- Almost half of the newly diagnosed PLWA have been homeless for some length of time since being diagnosed. This again highlights the heightened vulnerability of and greater need of this population.
- African Americans are more likely to have a history of unstable housing and live in transitional housing than other ethnic groups.

- Among risk groups, IDUs and MSM/IDU are much more likely to have been homeless or lived in transitional housing than MSM or heterosexuals.
- Recently incarcerated PLWH/A are far more likely to experience a period of homelessness than other populations. Nineteen percent of all PLWH/A report having a history of being homeless compared to 77% of those who have been incarcerated in the last two years. This may reflect the financial challenges and rules and regulations of public housing one faces after being released from the jail system.
- About half (52%) of the out-of-care and symptomatic PLWH (49%) report being homeless in the last two years.
- Men are less likely to have a history of homelessness or living in transitional housing than women or transgender PLWH/A.
- APIs (8%) and Latinos (17%) report a much lower incidence of homelessness.

Substance Abuse

- Just under a quarter of PLWH/A can trace their infection back to drug use, although current use is much lower.
- Still, drug use has been mentioned by many PLWH/A as their reason for not seeking care or delaying care.
- Of the opiates, 47% of the PLWH/A report ever using crack/cocaine and 19% report ever using heroin. About 13% have used crack/cocaine in the last six months and 9% of PLWH/A who use crack or cocaine say they continue to use the drugs more than once a week. About two percent of those who ever used heroin have used it in the last six months.
- The recently incarcerated (22%), out-of-care (27%) and the currently homeless PLWH/A are more likely to use crack than other populations. The recently incarcerated, homeless, symptomatic PLWH and women are among the highest current users of heroin, indicating the high level of co-morbidities among these populations.
- While almost half (45%) of PLWH/A in San Francisco say they have used crystal meth, less than 10% report using it frequently (once a week or more).
- "Party drugs" include poppers, ecstasy, and Gamma Hydroxybutyrate (GHB) are known to be related to unsafe sexual practices. Nearly half (47%) of the PLWH/A report using poppers, with more than 20% saying they use it monthly. One quarter (24%) of all PLWH/A say they have used ecstasy, but it is not frequently used. MSM/IDU, API and symptomatic PLWH tend to use GHB more than other populations, with more than 40% of the API reporting monthly usage.

STDs

- 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 (76%) and MSM/IDU (41%).
- Among ethnic communities, the incidence of hepatitis C is highest among African Americans (50%). An alarming 61% of the women report having been diagnosed with hepatitis C over

the past year. This is particularly true for 78% of the African American women who report having hepatitis C. Also, half of recently incarcerated PLWH/A report having had hepatitis C.

- The next highest incidence of STDs is hepatitis A or B (14%). It is significantly higher among women (25%), Native Americans (34%), and IDUs (25%). Among the special populations, PLWH/A living in the Tenderloin district, undocumented PLWH/A, recently incarcerated PLWH/A and persons with symptomatic AIDS report the highest incidence of hepatitis A and B.
- Herpes is the third most frequently reported STD (11%). It is highest among transgender PLWH/A, recently incarcerated PLWH/A, and symptomatic PLWA.

Mental Illness

- Depression has been diagnosed among 51% 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 Native American (57%) and IDUs (58%). API (42%) report less than the average incidence of depression.
- Women (69%) and transgender PLWH/A (65%) have the highest incidence of depression. Asymptomatic PLWA (40%) report the lowest.
- More than one third of PLWH/A (38%) report a diagnosis of anxiety in the past two years. Native Americans (52%), Anglos (40%) and IDUs (44%) tend to have received a diagnosis of anxiety more than any of the other ethnic and risk groups.
- Thirteen percent of PLWH/A report bipolar disease, with Native Americans (34%) reporting a significantly higher incidence than any of the other populations.

Health Care System for PLWH/A

Insurance

- More than 40% of the PLWH/A who were surveyed reported having no form of insurance. Transgender PLWH/A (63%), APIs (60%) and PLWH/A in San Mateo (71%) are more likely to report not having insurance than other populations of PLWH/A.
- Medi-Cal / Medicaid are by far the most common form of insurance for all populations infected with HIV/AIDS in the San Francisco area, with transgender PLWH/A, Native Americans, and MSM/IDU being the groups most likely to have this type of insurance.
- Forty percent of all those with insurance report Medi-Cal / Medicaid as their sole form of insurance. Medi-Cal / Medicaid is the sole insurer for more than half of the women, transgender PLWH/A, African Americans, IDUs, and heterosexuals
- One-third of the insured PLWH/A report having some form of private insurance as their only source of insurance. Men are much more likely to report having private insurance and about 40% of the APIs, MSM and asymptomatic PLWA report having private insurance as their sole coverage.

- Twenty-two percent of the insured PLWH/A report Medicare as their sole coverage. Medicare is the primary insurer for youth and persons 55 years of age or older. Also, more than one third of the APIs report Medicare as their sole insurer.
- Over 55% of the PLWH report not having any form of insurance, while fewer PLWA (47% asymptomatic and 20% symptomatic) report no insurance.
- A slightly larger percentage of women (62%), on the other hand, report having insurance than men (58%). This is the usual pattern for EMAs because of the various Medicaid programs for families and single mothers with children.
- Sixty-two percent (62%) of Anglo PLWH/A report having insurance compared to about 50% of African Americans and Latinos. Interestingly, MSM/IDU (70%) are the group most likely to be insured while heterosexuals (48%) are the group least likely to report having any form of health insurance.
- Symptomatic PLWA report the highest levels of insurance (80%).

Drug Reimbursement

- The data suggest that PLWH/A do not have a clear sense of how their medication is purchased with up to 20% report not knowing the amount of prescriptions paid for by any of their sources of drug reimbursement.
- Sixty-one percent and fifty-seven percent of the PLWH/A report that ADAP or Medi-Cal / Medicaid paid for their medications, respectively.
- Forty-five percent of the PLWH/A report that their medication was reimbursed by private insurance, 30% report out of pocket medication cost, and nine percent report receiving VA benefits to cover their medications.

Disability

Less than 30% 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, and symptomatic PLWA. Latinos, heterosexuals, women, and youth are the least likely to receive long term disabilities.

Entitlements and Benefits

- Indicative of the low income of PLWH/A, more than one-third (36%) report receiving SSI and 17% report receiving a housing subsidy. Females, transgender, MSM/IDU, IDUs, African Americans, persons over 55 years old, and PLWA are more likely to receive SSI. However, these same groups are not necessarily more likely to receive rental subsidies. Males and transgender PLWH/A are more likely than females to receive rent subsidies; APIs and Native American are more likely to receive rent subsidies than other ethnic populations; and MSM/IDU and MSM are more likely to receive rental subsidies than other risk groups.
- About 19% of the PLWH/A report receiving direct emergency financial assistance (DEFA), usually used for utilities, rent, or emergency medical treatment. However, women, African

Americans, Latinos, and heterosexuals, San Mateo residents, homeless, the out of care, youth and PLWH are the least likely to receive DEFA.

- Surprisingly, only 11% report receiving food stamps and three percent report receiving TANF/CalWorks. African Americans (21%), youth (32%), recently incarcerated (31%), homeless (33%), the out of care (30%) are much more likely to receive food stamps than any other group.

Out-of-Care and Delayed Care Seekers

- Based on the REGGIE system and San Mateo and Marin county records there are about 11,000 PLWH/A in the EMA who receive one or more of the Ryan White funded services. An estimated 12,760 PLWH/A receive outpatient care, including 4,260 reported from REGGIE plus about 8,500 receiving care outside the Ryan White Care System. This would leave an estimated 13% who know their status, are eligible for Ryan White outpatient funded care, and are not receiving services.
- A newly diagnosed PLWH/A who has not seen a primary care physician within six months is considered to be unconnected to care. Thirty-four PLWH/A report waiting more than six months to see a physician after receiving their HIV diagnosis, or about six percent of the sample, but this is unlikely to be generalizable due to small sample sizes.
- Any PLWH/A who knows his/her infection for over six months, and has not seen a physician in over a year, regardless of previous care practices, would be considered unconnected to care. Nine PLWH/A report not seeing a doctor in more than 12 months and are considered to be currently out of care, or less than 2% of the sample would be considered currently out-of-care. Notably the sample is mostly recruited from providers of HIV/AIDS care services. Again small sample sizes may make this unreliable, but it does indicate that those who are connected to the care system are currently out-of-care.
- Based on the consumer survey, the majority of the delayed care seekers (78%) as well as the unconnected to care (67%) are men. However, a greater proportion of the women are more likely to delay or to be unconnected to care than the proportion of women in care. Also, women are more likely to be unconnected to care than to be delayed care seekers.
- African Americans are disproportionately represented among those out-of-care. While the same proportion of Anglos and African Americans delay care, Native Americans, Latinos and African Americans are proportionately much more likely to delay care.
- Among the risk groups, heterosexuals are the smallest group among those that delay or are unconnected to medical care. However, MSM/IDU, IDU, and heterosexuals are disproportionately represented among those unconnected to and delaying medical care.
- About one third of the delayed care seekers (31%) and the unconnected to care (35%) have known their HIV status for less than three years compared to less than 20% of the total sample of PLWH/A. A greater proportion of the unconnected to care (53%) report being asymptomatic compared to the delayed care seekers (35%) or the overall sample of PLWH/A.
- Among all PLWH/A, whether in care or not, forgetting to take the medications was the number one reason for not adhering to medications. For the delayed care seekers and the

unconnected to care, running out of medicines was also among the top reasons for not adhering. For the unconnected to care, difficult scheduling was also an important factor.

- A higher proportion of the delayed care seekers and the unconnected to care report high incidence of hepatitis C compared to the overall sample of PLWH/A. About 30% of the unconnected to care and 47% of the delayed care seekers have had hepatitis C since being diagnosed with HIV. Delayed care seekers and those unconnected to care report a higher incidence of syphilis than other PLWH/A.
- Delayed care seekers and the unconnected to care are much more likely to currently be using substances that other PLWH/A. More than half report using alcohol, crack/cocaine, and marijuana.
- Qualitative comments emphasize the relationship between active drug use and delaying care or being out-of-care.

Improved Outcomes (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. Those with AIDS appear to show the greatest improvements. HIV symptomatic populations are having the worst outcomes, indicating that the newly infected with symptoms are having the most difficulty in the care system.

Medication and Adherence

- Seventy-seven percent of all PLWH/A report taking medicines to treat their HIV infection, but there is a linear relationship with stage of disease, with 93% of symptomatic PLWA reporting taking medication.
- Females are more likely to have taken HIV medications (82%) than either males (77%) or transgender persons (56%). Undocumented PLWH/A, persons out-of-care, recently incarcerated PLWH/A, and homeless PLWH/A report a much lower use of medication. Over two-thirds (67%) of undocumented, 62% of the recently incarcerated, and 51% of the homeless, and fewer than 50% of people who are currently out-of-care have a history of taking medications to treat their HIV.
- Thirty-nine percent of PLWH/A report never skipping their medications, and at the other extreme, seven percent have stopped taking their medicines.
- Among gender groups, transgender PLWH/A are far more likely to have stopped taking their medications (31%) than either males (6%) or females (13%).
- Latinos adhere substantially more than other ethnic populations.
- Persons 24 years old or younger have a very high rate of stopping medications (20%) compared to all PLWH/A.
- Among all groups, forgetting to take them (69%) is typically the major reason for skipping medication, with Asian/Pacific Islanders (83%), Native Americans (77%), and MSM (72%) the most likely to forget.

- The next two most common reasons cited for skipping doses were side effects of medications (44%) and the difficult medication schedules (42%).

Services

Funding Sources for HIV/AIDS Services

- Based on the 2001 Title I application, the San Francisco EMA has $203,676,646 in public funding for HIV/AIDS care. That includes about $38.7 million in Ryan White Title I funds, $20.3 million in ADAP (Title II), over $75 million in Medi-Cal and Medicare, $45 million in local funds , and about $9 million allocated from HOPWA.
- The largest source of funding in the system is Medi-Cal and Medicaid (combined both Federal and State contributions). Next is local funding that includes general funds, in-home support, housing, funds allocated to San Mateo and Marin counties, MOUs for various services, funds for incarcerated programs, and child welfare funds. Ryan White Title I funds account for 18% of all funds, followed by Title II funds, including ADAP.

Top Needs

Each PLWH/A who participated in the survey was asked if "you needed the service in the past year."

- Fifty-three percent named primary care as their top need which exceeded other needs significantly. The top two most needed services are within the health care service category: 1) outpatient medical care and 2) dental care.
- Food pantry services is ranked third by PLWH/A. Food vouchers, one of the subservices within the food service category, are ranked eighth by the PLWH/A. Women report the highest need for food vouchers. Transgender PLWH/A rank food services (food pantry, food vouchers, nutritional education, and home meals) higher than men.
- Three of the top ten services are within the housing service category. Rental assistance is ranked fourth by PLWH/A, DEFA is ranked sixth, and housing information is ranked ninth.
- Case management, ranked seventh by the Council, is ranked fifth by PLWH/A.
- Taxi vouchers are ranked seventh by consumers. Women are more likely than men to report a need for taxi vouchers
- Under client advocacy, benefits counseling is ranked 10th by PLWH/A.
- Notably, the perceived need for substance abuse treatment is relatively low even though it is ranked fifth out of nine service categories by the Council. While ranked higher among IDUs, it is not near their top needs that include outpatient medical care, food pantry, rental assistance, and case management. Transgender persons report a greater need for substance abuse outpatient counseling.
- PLWH/A in general do not rank any of the mental health sub-services as a top need, while mental health is ranked fourth out of nine by the Council. Women do say they need more

interaction with peers for peer counseling. Transgender persons have a greater need for residential mental health

- Women express a need for peer advocacy and also have a greater need than men for treatment advocacy.
- Women and transgender are much more likely than men to report a need for detoxification and methadone maintenance and crisis intervention.
- Men are more likely to say they need medication reimbursement, complementary treatment, legal services, and employment assistance than women or transgender PLWH/A. They are more likely to need insurance continuation than women.
- In general, African Americans and Native Americans report higher needs for most services, including food pantry, DEFA, taxi vouchers, food vouchers, housing information, peer counseling, psychological assessment, van transportation, money management, outpatient substance abuse treatment, supportive housing, residential substance abuse treatment, and detoxification/methadone maintenance.
- Latinos typically report the lowest need for services with the sole exception of reporting they need more heath education and risk reduction information. In surveys of this type Latinos often indicate a lower need for services, and this is likely to be due to lower expectations and the perception of lack of eligibility.
- APIs report a greater need than other ethnic groups for dental care, case management, benefits counseling, treatment advocacy, and insurance continuation.
- Anglos are more likely to report needing complementary care (along with Native Americans), legal services, psychological assessment (along with African Americans), consumer advocacy, employment assistance, and adult day care.
- Undocumented PLWH/A report higher than average needs for peer counseling, outpatient substance abuse counseling, supportive housing, residential mental health services, and residential substance abuse counseling.
- Recently incarcerated PLWH/A report higher than average needs for several services including: food pantry, case management, DEFA, taxi vouchers, food vouchers, housing information services, treatment advocacy, van transportation, home delivered meals, supportive housing, detox and methadone maintenance, and residential substance abuse counseling.
- Homeless PLWH/A indicate greater than average need for DEFA, housing information services, treatment advocate, outpatient substance abuse counseling, detox and methadone maintenance, and residential substance abuse counseling.
- Those at a later stage of infection tend to report a greater need for basic services, including food pantry, food vouchers, DEFA, money management, and home delivered meals.

Asking For and Receiving Services

Participants in the survey were instructed to indicate whether they had asked for each of the 35 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.
- The demand for services, however, follows reported need, with the exception of food vouchers, where PLWH/A are considerably less likely to ask for them than other top ranked services.
- Demand is also usually greater than utilization, with the exception of outpatient medical care and health education and risk reduction.
- The difference in the rank order of utilization and need reflects the much lower utilization of housing services, including rental assistance, DEFA, and housing information. There is also low utilization of food vouchers relative to the high reported need for food vouchers.
- While over 20% of the populations report currently using crystal meth, crack/cocaine, or heroin use, substance abuse services, including outpatient and residential substance treatment, is used by well under 20% of PLWH/A.
- While about 20% of the PLWH/A report significant adherence problems (skipping medication more than twice a month or stopping medications), the demand and utilization of adherence support is under 8% of PLWH/A.

Gaps

- The overall message is that unmet need and unmet demand is small. With the exception of the large unmet need for food vouchers, other gaps are under 15%.
- Outpatient medical care shows that there is no unmet demand; in fact more people receive the service than ask for it. The likely explanation is that most PLWH/A don't ask for the service; rather appointments are set. That would mean that more people receive services than "ask" for them. There is, however, an unmet need with over 10% of PLWH/A saying they need it, but not asking for it. This could reflect several things. As suggested in the out-of-care section, reasons for not asking for care were discussed in focus groups and include substance abuse issues, problems with confidentiality, access, and perceived lack of service for specific subpopulations.
- The service with the greatest unmet demand is housing. Thirteen percent of PLWH/A ask for, but did not receive housing information. Ten percent asked for but did not receive rental assistance, 8% asked for but did not receive DEFA, and 7% asked for but did not receive supportive housing. Rental assistance also had a relatively high unmet need, but other housing services had a lower unmet need. This suggests that housing is high on the agenda of PLWH/A and they ask for it when they perceive they need it. As is clear by the survey and focus group responses, however, the demand for housing far exceeds the systems capacity to provide it.
- Dental and peer advocacy are the other two services with a demand gap above 5% suggesting that, when PLWH/A ask for services they report not receiving it.
- Dental care is in the top five unmet needs. This may reflect the realization of many PLWH/A that services do not cover some dental needs or that they have used their allocation of

services. It may also reflect difficulty in obtaining appointments or traveling to the dental clinic.

- Taxi and van vouchers show an unmet need of greater than 5% suggesting that, based on focus groups, consumers find the system difficult to use or unresponsive to their needs.
- Other services with a difference of more than 5% between needing and asking for the service, include: case management, legal, psychiatric assessment, employment assistance, treatment advocacy, nutritional education, food pantry, van transportation, consumer advocacy, money management, and complementary care.

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, which can be classified into the more general categories of "organizational", "structural, or "individual" barriers.

Problems Faced

- Structural barriers refer to "rules and regulations" and levels of access. On average, more than half the PLWH/A are likely to have a problem with these types of barriers.
- Among structural barriers, over 50% of PLWH/A have some problem with waiting for appointments, navigating the system, and red tape. Between 40% and 50% have a problem with eligibility, insurance, and cost.
- Among structural rules and regulation barriers, none were ranked as a big barrier. Yet, for those naming cost and red tape, on average, these represented moderate barriers.
- Structural "access" barriers have to do with lack of transportation, access to specialists, or lack of family-oriented services. These are mentioned much less frequently than "rules and regulations" with less than 30% of PLWH/A registering that they had a problem with these types of barriers.
- Although more PLWH/A say waiting for an appointment and navigating the system are a problem than other barriers, PLWH/A say they are small to moderate barriers.
- Organizational barriers refer to provider sensitivity and provider expertise. On average, about 40% of PLWH/A note that they have experienced these types of barriers.
- Among organizational barriers, sensitivity of the organization and feeling like a number are reported by over 50% of PLWH/A. Among those naming these barriers, it is considered a moderate barrier.
- Lack of provider expertise and provider referrals are named by over 50% of PLWH/A. However, among those reporting these barriers, they say they are small to moderate barriers.
- Forty percent of PLWH/A named discrimination as a barrier and rank it as a relatively high barrier.
- Not knowing treatment and not knowing the location of providers were named as barriers by over 60% of PLWH/A. Not knowing treatments is perceived of as a moderate barrier, while not knowing locations is viewed as a small to moderate barrier.

- Individual barriers refer to the individual's knowledge and well-being. Like "rules and regulation" barriers, on average about half the PLWH/A mention knowledge and well-being barriers. Over 50% of PLWH/A name not knowing who to ask, their own state of mind, and their own physical health as barriers. They are ranked as small to moderate barriers.

Severity of a Problem

Although the highest average barrier was rated as a moderate barrier, different populations reported considerably higher barriers.

- Overall, transgender PLWH/A report significantly higher barriers than average for most of the 30 problems they ranked. The exception were that transgender PLWH/A tend to be in less denial than other PLWH/A, they are less likely to feel like a number, and do not have greater barriers related to cost than other PLWH/A.
- The most significant barriers for males are not knowing what service is available, followed by provider sensitivity to issues, and discrimination. The highest barriers for females are different and include red tape, waiting for an appointment, no transportation, and not knowing what services they need to treat their HIV infection.
- Females report greater problems than males with their physical health, state-of-mind, understanding instruction, not getting along with their providers, communicating with providers, getting bad referrals from providers, finding specialists, fear of losing confidentiality, no childcare, and lack of or inadequate insurance.
- Among the risk groups, IDUs report higher barriers than other groups. Their highest barrier is transportation, which they rank as a moderate to large problem. They are more likely to name red tape, being treated like a number, and not accessing specialists as a barrier than other risk groups.
- Heterosexuals also cite transportation as one of their highest barriers. They are more likely than other risk groups to report their own physical health, not knowing what medical services are available, red tape (along with IDUs), and rules and regulations as barriers.
- MSM tend to rank barriers lowest among the risk groups with the exception of discrimination by providers, which they rank as a moderate barrier.
- MSM/IDU rate most barriers as quite low, but are more likely to say that they have been denied or have been afraid to seek services due to a criminal justice matter, and along with IDUs are more afraid than other risk groups of being reported to authorities.
- African American populations rate most barriers higher than other risk groups. Among top barriers, they are more likely to say they don't know where to go for services than other ethnic populations. Also, African Americans are more likely than other ethnic populations to say they face the barriers of transportation, lack of confidentiality, ability to communicate with their provider, and denial of services due to criminal justice history.
- Latinos are more likely than other risk groups to report higher barriers related to fear of being reported to authorities, lack of insurance coverage, and red tape. They are also more likely to note communication problems and that rules and regulations are problems for them in obtaining care.

- APIs say that lack of insurance coverage is a moderate to big problem, and say that cost of services is a moderate problem. They also cite a lack of childcare as a relatively high barrier. Along with Latinos, they say that getting along with providers is more a problem for them than for Anglos or African Americans.
- Native Americans rank feeling like a number and denial of services based on their criminal justice history as their top barriers. They are more likely than other ethnic populations to give a higher barrier score to their own physical health, expertise of providers, lack of helpfulness by providers, navigating the system, and lack of specialists.
- Those out-of-care between six months and one year say that not knowing who to ask for help and feeling like a number are moderate to big barriers for them. They also are more likely to say that sensitivity to their issues and denial are barriers for them.
- For the few PLWH/A who reported being out-of-care for a year or more, lack of insurance and cost of the service, not knowing the service was available, and lack of confidentiality are the main barriers cited.
- Symptomatic PLWH/A reported higher barriers than asymptomatic persons. Symptomatic PLWA reported moderate to big barriers for their own physical health and were more likely to say denial was a barrier to receiving care.

Overall Assessment

With close to $220 million dollars available to fund the continuum of care in the San Francisco EMA, the services provided meet the medical and social service needs of the vast majority of PLWH/A. Outcomes in terms of mortality and physical and emotional health show the continuum of care is affordable, available, and accessible for most PLWH/A.

Outpatient care, the top ranked service by the Council and every subpopulation is accessed by most persons eligible who know they are HIV positive. Once in the system, access to outpatient care becomes routine and most persons don't need to ask for it. There is a small perceived need gap for outpatient care, and that is likely to reflect a number of PLWH/A who perceive they have no access and therefore don't ask for it. Based on the epidemiology and utilization figures there may be 12% - 13% who are out-of-care. One plausible group are those that fall into a crack where they are insured or make sufficient income to disqualify from assistance, but don't make enough to obtain quality care. Another subpopulation are active drug addicts who may say they need the service, but their drug use or other things keep them from asking.

Housing is the one service that has a high demand, unmet perceived need, and unmet demand. The large waiting list for housing is good indication that there is greater demand than capacity. The unmet need cuts across all subpopulations. Housing Service needs are highest among women (49%), African Americans (56%), Native Americans (54%), IDUs (58%), and undocumented PLWH/A (51%). The size of the gap in housing services that Ryan White should fill is difficult to calculate given the broad system-wide eligibility criteria. Certainly the low income and high incidence of unstable housing among PLWH/A justifies the level of demand. However, the confusing array of housing services, lack of coordination, and poor data on housing make estimating the gap impossible. Clearly more streamlined and coordinated housing services welcomed by PLWH/A, and more consistent data collection would be make planning possible in the area of housing services.

Dental care is another service that crosses all subpopulations. It has a very large eligibility gap, and over 50% of those who are eligible do not report accessing the service. Dental care has the second highest perceived need, and has one of the largest need and demand gaps. Because dental care is often not covered by any other source, even among those with insurance, demand is likely to be high. One option currently being implemented is limiting access. Current restrictions on dental care at the provider level clearly mean that those perceiving they need the care don't often get it. An alternative that may be useful is increasing capacity and using the contact with dental providers to link PLWH/A to other services such as case management, adherence, secondary prevention, and information services.

Other services needs are defined by the demographics of subpopulations, and the San Francisco EMA is facing at least two simultaneous epidemics with different needs and consumer profiles. One is a maturing epidemic populated by gay, largely Anglo men who have a relatively stable, but serious and chronic condition that requires extensive medical monitoring and adherence to an often difficult medical regime that has toxic side effects. Still, these men tend to have more traditional, insurance-reimbursed access to care and to have their medical care reimbursed by

non-Ryan White CARE funds. They tend to have attained higher level of education and as long-term survivors have a better understanding of the system and have learned to be astute self-advocates.

The challenges facing them are housing, secondary prevention, particularly related to party drug use, adherence, moving from disability to work, and financial management. Moving a once disabled individual back to work is a challenge that requires legislative initiatives to assure continuity of care, awareness of the person living with AIDS, and training for case managers and benefit counselors.

Another challenge is making sure that there is the necessary training and capacity among private physicians and clinics. Already they are being used more to provide care among those that can afford it or have access to non-Ryan White reimbursement.

The second epidemic is among populations that are more recently infected and have serious co-morbidities with their HIV infection. The homeless or those in fear of losing their housing often do not have consistent care. Anecdotal evidence strongly suggests that homelessness goes hand in hand in unstable medical care, lack of adherence, and poor health outcomes.

Many of the newly infected come to the epidemic with emotional problems or serious mental illness. That is, in turn, often related to substance abuse. Strong links to mental health programs and substance abuse programs could improve options and access to care for those needing drug abuse or mental health services. The fact that many of those with substance abuse issues do not perceive a problem also indicates the need for greater and more persuasive outreach. There is a larger need gap than demand gap for psychiatric assessment, suggesting that there are barriers to asking for mental health services.

The parallel STD infection, particularly hepatitis C – which disproportionately affects women infected with HIV – must continue to be addressed. Links to STD programs, drug programs, and awareness program are essential. Providers might be targeted to increase their awareness of the consequences of hepatitis C and HIV.

Food is a basic concern among this population that tends to be overwhelmingly poor. Their largest need gap is food vouchers, indicating a basic need that most know they will not get and therefore don't ask to receive it. Nutritional education is not perceived of as a link to improved nutritional maintenance and is a service that could be enhanced to better serve the needs of PLWH/A. As for many other services, the broad system-wide eligibility criteria makes the service gaps larger than they may be. They also tend to raise expectations for food services that are beyond the capacity of the Ryan White Care funds to provide.

While poor gay men of color are most likely to be in this population, women and heterosexuals are disproportionately represented and they have asked for specific services. Women are likely to be caregivers for their children or partners – some of whom are infected. The lack of childcare represents a barrier for these women.

As new persons enter the system there is a continued demand for case management. This category, with its peer advocacy, HERR and, sometimes, treatment advocacy appears to be confusing to both providers and PLWH/A. In focus groups, we hear often that case mangers act more as gatekeepers to services rather than facilitating care. There is need to set standards, establish consumer expectations, and assure that case managers are trained to provide the appropriate linkages. Greater sensitivity to the lifestyles of a wide spectrum of clients is necessary for case management to provide adequate services.

By recognizing these two epidemics, the Council can better establish priorities and allocations. In addition, to better estimate services gaps and barriers, the system should have a mechanism to measure capacity of services in the continuum of care and create system-wide measurable and meaningful eligibility criteria. There is a separate document with recommendations for establishing a continuous data collection system for needs assessment that will build an infrastructure that will allow more precise measures of unmet need and barriers.

14. ATTACHMENTS

Attachment 1 Needs Assessment Task Force
Attachment 2 Participating Agencies
Attachment 3 San Francisco EMA Needs Assessment Survey of PLWH/A
Attachment 4 Focus Group Outline for PLWH/A
Attachment 5 Provider Information Form
Attachment 6 Focus Group Coding Schema
Attachment 7 PLWH/A Demographics
Attachment 8 Service Awareness
Attachment 9 Services Need
Attachment 10 Services Asked
Attachment 11 Services Received
Attachment 12 Service Usage
Attachment 13 Service Barriers